PHILADELPHIA INSURANCE COMPANIES

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

PHYSICIANS QUESTIONNAIRE

NOTICE TO APPLICANTS: THE COVERAGE FOR WHICH YOU ARE REQESTING WILL APPLY ONLY TO CLAIMS ARISING OUT OF YOUR PROFESSIONAL SERVICES FOR THE NAMED INSURED.

Status: Employed Contracted Volunteer

A. GENERAL INFORMATION: (Please type or print)

1. Applicant Name: Date of Birth:
2. **Current Medical Licenses:**

   State/Number:

B. EDUCATION AND TRAINING:

1. Name and Location of Medical School Granting Degree:
   City/State: Year Graduated:

   If you are a graduate of a non-US medical school, have you obtained an ECFMG Certificate? Yes No
2. Independent memberships and professional societies:
3. Are you American Board Certified? Yes No

Medical Specialty	Date Certified

C. INSURANCE AND PROFESSIONAL HISTORY:

1. Have you ever been denied professional liability insurance coverage? Yes No
   NOTE: MISSOURI APPLICANTS DO NOT RESPOND
   If Yes, please attach a separate sheet containing a complete explanation.
2. Has your professional liability insurance coverage ever been cancelled or refused renewal? Yes No
   NOTE: MISSOURI APPLICANTS DO NOT RESPOND
   If Yes, please attach a separate sheet containing a complete explanation.
3. Has your application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions? Yes No
   If Yes, please attach a separate sheet containing a complete explanation.
4. Has your license ever been suspended or revoked? Yes No
   If Yes, please attach a separate sheet containing a complete explanation.
5. Have you ever been convicted of a crime? Yes No
   If Yes, please attach a separate sheet containing a complete explanation.

6. Prior Insurance: List your insurers or your employers' insurers the past three (3) years. Attach additional pages as needed.

Insurance Carrier	**Policy Period**	**Limits of Liability**	**Coverage Type (Occurrence / Claims Made)**

7. Practice Locations: List ALL locations at which you have practiced in the last five (5) years. **Explain** any gaps in time.

Name of Practice	**City / State**	**From (MM/YY)**	**To (MM/YY)**

D. PROFESSIONAL SERVICES PROVIDED:

1. Type of Practice/Services:

Family Medicine
OB /GYN
Abortions
Cardiology
Alternative Medicine
If checked, please describe:

Emergency Medicine
Pre-Natal Services
Orthopedics
Neurology

Surgery
If checked, please describe:

Drug Therapy
If checked, please describe:

2. Hours of Practice:
Full Time (≥ 35 hours per week of ALL covered professional activities and locations)
Part-Time (< 35 hours per week and ≥10 of ALL covered professional activities and locations)
Incidental (< 10 hours per week)

E. PRACTICE LOCATIONS:

1. Do you serve as the Medical Director for this entity? Yes No

F. PRACTICE PROFILE: Please attach a separate sheet for any required explanations.

1. Do you create and maintain medical records for each patient under your care? Yes No
   If No, please explain:

2. Do you obtain an informed consent, whether signed by patient or guardian before prescribing controlled substances? Yes No

3. Does your practice include telemedicine activities, e.g., the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved? Yes No

   a. **If Yes,** what is the percent of your total practice time devoted to this activity? %

   b. **If Yes,** on a separate sheet, please explain the exact type of telemedicine.

G. Declarations

REPRESENTATIONS: I/We affirm that the information contained here and in any addendum is true to the best of my/our knowledge and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We hereby authorize the release of claim information from any prior insurer to the Company or its representatives.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATENMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

NOTICE TO MINNESOTA AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO NEBRASKA AND OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A

FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO MAINE AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADINGINFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSUREROR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES.IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

Physician's Name (Print):

Physician's Personal Signature:

Date:

CLAIMS HISTORY- SUPPLEMENTAL APPLICATION

Full Name:

IMPORTANT**:** ***This section must be completed in its entirety. Any malpractice claims or suits in which you have been involved in during the past seven (7) years must be reported. Any incidents or circumstances of which you are aware, that are likely to give rise to a claim, must be reported. Provide copies of suit papers or claimant letters. If the claim is closed, provide copies of settlement or judgment documents or order of dismissal. If reporting more than one incident, suit or claim, photocopy this form for each.***

N/A (Please proceed to Signature.)

1. Name of Patient:

2. Allegation/Incident:

3. Incident Date:

4. Report Date:

5. Was suit filed? Yes No

6. Jurisdiction?

7. Names of Co-Defendants: (N/A)

8. Insurance Carrier(s) covering claim:

   Policy Period(s):

9. Final outcome of claim: ***(This information may be obtained by inquiry of your current or past insurer. Please note that you must personally contact your insurance carrier.)***

   Open (still pending)

   Indemnity reserve placed by insurer $
   Defense cost reserve placed by insurer$

   Closed:

   Method of closing:
   - Dismissed
   - Withdrawn
   - Judgment
   - Settlement

   Total Expenses
   Amount of settlement or judgment: $
   Defense cost: $

10. Please provide summary of clinical facts. Your summary must provide an adequate description of your care and treatment of the patient to allow proper evaluation. Please include the following: (Use additional sheets if necessary.)

    a) Patient age and sex:

b) Initial patient condition and diagnosis:

c) Condition and diagnosis at time of incident:

d) Dates and description of treatment rendered:

e) Condition of patient subsequent to treatment:

f) Copies of patient’s records and progress notes as appropriate.

Physician’s Personal Signature Date