



PSYCHIATRISTS QUESTIONNAIRE – Renewal Application

NOTICE TO APPLICANT: THE COVERAGE FOR WHICH YOU ARE REQUESTING WILL APPLY ONLY TO CLAIMS ARISING WHILE IN THE COURSE OF YOUR EMPLOYMENT FOR THE NAMED INSURED.

SECTION I - GENERAL INFORMATION

(Please type or print)

Applicant Name:

Date of Birth:

Current Medical Licenses State / Number:

SECTION II - EDUCATION AND TRAINING

- Have you become Board Certified in any of the following specialties?

General Psychiatry	Yes	No	Date Attained:
Child & Adolescent Psychiatry	Yes	No	Date Attained:
Geriatric Psychiatry	Yes	No	Date Attained:
Administrative Psychiatry	Yes	No	Date Attained:
Other (Specify):	Yes	No	Date Attained:

- Have you successfully completed any of the following post-graduate training, accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons, Canada (RCPSC)?

General Psychiatry Residency	Yes	No	Date Attained:
Child & Adolescent Psychiatry	Yes	No	Date Attained:
Neurology Residency	Yes	No	Date Attained:

- Have you successfully completed any of the following other post-graduate fellowships?

Forensic Psychiatry	Yes	No	Date Attained:
Geriatric Psychiatry	Yes	No	Date Attained:
Consultation/Liaison Psychiatry	Yes	No	Date Attained:
Addictionology	Yes	No	Date Attained:
Psychiatric Research	Yes	No	Date Attained:
Other (Specify):	Yes	No	Date Attained:

- Have you successfully completed psychoanalytic training? Yes No
If Yes: Date Attained:
 Average weekly # of **total practice** hours:
 Average weekly # of **psychoanalytical** hours:
 Average weekly # of **psychoanalytical** patients:

- Have you participated in any Risk Management Seminar(s) during the last 12 months? Yes No
If yes, please attach a copy of the certification and brochure explaining the content of the seminar.

SECTION III - 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.

SECTION IV – COVERAGE REQUESTED

1. **Type of Practice:**
Psychiatry
Neurology without procedures
Neurology WITH procedures (including but not restricted to angiograms, arteriograms, myelograms, and pneumoencephalograms, CAT scans and NMR imaging)
2. **Hours of Practice:**
Full Time (over 20 hours per week of ALL covered professional activities and locations)
Part-Time (20 hours or less per week of ALL covered professional activities and locations)

SECTION V - PRACTICE LOCATIONS

Please complete a section for any changes in your practice location. Copy this page for additional locations as needed.

Name of Practice:

Street Address:

City:

State:

Zip:

County:

Telephone:

Fax:

Average weekly practice (in hours):

Average Number of patients per week:

Please list any changes to your practice/license during the last 12 months:

FRAUD STATEMENT

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 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 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 MAY SUBJECT 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 INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE 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 MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR 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."

Insured Signature : _____ Date:
Agent Signature: _____ Date:

SECTION VI - 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 of 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 the next section.)

1. Name of Patient:
2. Allegation/Incident:
3. Incident Date: Report Date:
4. Was suit filed? Yes No
5. Jurisdiction? N/A
6. Names of Co-Defendants:
7. Insurance Carrier(s) covering claim:
8. 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: Total Expenses:
 Dismissed Amount of settlement or judgment: \$
 Withdrawn Defense cost: \$
 Judgment
 Settlement

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