

**Catlin Underwriting Agency, U.S., Inc.**

3700 Buffalo Speedway, Ste. 600

Houston, TX 77098

**CORRECTIONAL FACILITY MEDICAL PROFESSIONAL UNDERWRITING QUESTIONNAIRE AND  
APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE**

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

**I. GENERAL INFORMATION**

Name of Organization: \_\_\_\_\_

Street Address:	City:	State:	Zip Code:	County:
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Type of Ownership:	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Sole Practitioner
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Number of years under present ownership \_\_\_\_\_

Contact Person for Billings: \_\_\_\_\_

Name	Title	Phone Number
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Contact Person for Claims: \_\_\_\_\_

Name	Title	Phone Number
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Corporate Medical Director(s) \_\_\_\_\_

**II. COVERAGE REQUESTED**

Effective Date:	Retroactive Date:	Deductible/SIR:
<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$200,000/\$600,000	<input type="checkbox"/> \$250,000/\$750,000
<input type="checkbox"/> \$500,000/\$1,000,000	<input type="checkbox"/> \$500,000/\$1,500,000	<input type="checkbox"/> \$1,000,000/\$3,000,000

Is Prior Acts coverage needed? \_\_\_\_\_ For Prior Acts coverage, please attach a schedule of physicians and retroactive dates.

Do any of the physicians maintain their own limits of Insurance? \_\_\_\_\_ If yes, please provide listing and limit amounts.

**III. PROFESSIONAL LIABILITY INSURANCE COVERAGE** (for previous three year period).

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability	\$	\$	\$
Deductible or SIR and Amount	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$
Coverage Form	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
Prior Acts Date			
Policy Period	Fr.:    To:	Fr.:    To:	Fr.:    To:

\* If Claims Made, attach copy of policy.



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**V. MEDICAL INDEPENDENT EMPLOYEES/CONTRACTORS**

Category						
a. MEDICAL SPECIALTY	EMPLOYEES				CONTRACTORS	
		Full Time	Part Time		Full Time	Part Time
Registered Nurses						
Licensed Practical Nurse						
Physician Assistants						
Physicians						
Others (list type)						

- b. Are references listed by new applicants checked in writing?  Yes  No
- c. Are diplomas, licenses and other credentials for applicants verified prior to employment?  Yes  No
- d. Is the initial employment for a specified probationary period?  Yes  No  
if yes, what is the probationary period? \_\_\_\_\_
- e. Are any non-medical employees associated with your organization?  Yes  No  
If yes, please describe: \_\_\_\_\_

**VI. CLAIMS INFORMATION**

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit?  Yes  No If yes, complete a claims supplement for each claim.

Total Number of Claims	Open	Closed
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**VII. CONDITIONS OF APPLICATION**

- By applying for Medical Malpractice Insurance from Catlin Underwriting Agency, U.S., Inc. , I hereby:
- consent to inspection by Catlin Underwriting Agency, U.S., Inc. or their agents of all documents that may be material to an evaluation of the group's qualifications and competence;
  - release from liability Catlin Underwriting Agency, U.S., Inc., their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications;
  - release from liability any and all individuals and organizations who provide information to Catlin Underwriting Agency US, Inc., in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such

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falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

\_\_\_\_\_  
Date

X  
\_\_\_\_\_  
Applicant's Signature

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.