

Renewal Application Questionnaire

Current Coverage				
Name:				
Policy Number:				
Policy Period:				
Specialty:				
Limits of Insurance:				
Policy Type:				
Additional Insured(s):				
Changes In Your Practice			Yes	No
1.	Have there been any changes in your office/hospital practices or procedures in the last year?			
2.	In the past year, has there been any manner of communication between you and the Board of Medical Examiners regarding your care and treatment of any patient?			
3.	Are there any procedures or treatments that you began performing or providing; that you ceased performing or providing in the past year or that you anticipate performing or providing in the coming year?			
4.	Have you signed any contracts with any company, agency, nursing facility, long term care facility, clinic or hospital to provide any manner of administrative or medical coverage for the facility?			
5.	In the past year, have you been contacted by the NJ Board of Medical Examiners about any potential Board action or investigation involving you or your practice?			
6.	Have you obtained privileges at any hospital other than those referenced on your original application?			
7.	Have your privileges at any hospital been revoked, denied, restricted or suspended in the past year?			
8.	Have you employed any physician, surgeon, podiatrist, nurse anesthetist, nurse midwife, nurse practitioner or physician's assistant in the past year or do you plan to in the near future?			
9.	Have you changed your corporation or partnership affiliation in the past year or do you plan to in the near future (e.g., formed a solo corporation, joined a partnership, etc.)?			
10.	Have you changed your office or mailing address, telephone or fax number?			
11.	In the past ten (10) years, have you ever filed for bankruptcy?			
Please use the space provided below to explain any questions answered "Yes" above:				

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Claims History (Required for Renewal)

Please be advised of the following status changes in my loss history (claims or suits) since the inception of my policy with NJ PURE.

No changes in my loss history. **Please send updated claims history statements from your previous carriers.**

Changes in my loss history are:
 (List any changes such as claims closings, payments, dismissals, new claims or suits, etc.):

#1. Date of Incident: _____ Date Filed: _____ Status: _____

#2. Date of Incident: _____ Date Filed: _____ Status: _____

(Please attach additional sheets if needed).

PLEASE OBTAIN AND FORWARD TO US AN UPDATED CLAIMS HISTORY STATEMENT FROM EACH OF YOUR PREVIOUS INSURERS, NAMED BELOW:

All Prior Carriers Within the Last Ten Years

I hereby declare that the statements on this questionnaire are true. I acknowledge that the submission of complete and accurate information to NJ PURE is necessary for proper underwriting and rating of my renewal application. I understand and agree that any false or misleading information or material misrepresentation or omission by me in this renewal application questionnaire will void coverage from the inception date of the contract. I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature:

Date:

Please contact the Underwriting Department at NJ PURE with any questions you may have regarding your medical professional liability insurance.