Application

PHYSICIANS & SURGEONS

Professional Liability Insurance

Physicians' PRI Reciprocal Insurers

Home Office: 1800 Northern Boulevard
Roslyn, New York 11576

Telephone: (516) 365-6690 (800) 632-6040

Fax: (516) 365-7522

Visit us on the web at PRI.com or email us at CONTACT-US@PRI.com

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and, a binder or Declarations Page together with any applicable endorsements has been issued to the named insured.

	We want to process your application as quickly as possible. **You can help us do this by:** Completing this form online or print legibly, return by email, fax or mail. Answering each question, if the answer is "not applicable" please record (N/A). Please use the "**Remarks**" section to explain your answers where requested If you have ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten years, or are presently involved in malpractice litigation, then complete the claims information form for each case in the last ten years (See page 14.) **Signatures are required on page 12 & 13.** Incomplete answers and/or missing attachments will delay our processing of the application. **Required Attachments:**
❒	Please attach a copy of your Curriculum Vitae (CV) if available.
❒	Please enclose a copy of your Declarations page and loss runs from your current policy.
❒	Proof of coverage and/or a copy of your I.D. badge if you are currently employed and covered elsewhere.
Thank you for choosing Physicians' Reciprocal Insurers. We are here to assist you, for questions, please call either of our offices at any one of the numbers listed above.	

A. Personal Information

If my application is approved, make coverage effective on _____/_____/_____ *(if possible)* otherwise on any other date set by the Exchange.

1. Name: _____ ☐ MD ☐ DO (Check One)
   First Middle Last
2. Date of Birth: _____ Gender ☐ Male ☐ Female NPI#_____
3. Social Security Number: _____ I.R.S. Tax I.D. Number: _____
4. N.Y.S. License Number: _____

License Type * ☐ Permanent ☐ Temporary

Do you have any other non-NY State License?* ☐ Yes ☐ No

List all non-N.Y.S. Medical License(s) (if applicable):

a. _____ c. _____
State Lic. # Status State Lic. # Status

b. _____ d. _____
State Lic. # Status State Lic. # Status

If you have more than four non-N.Y.S. licenses, explain in **Remarks #10**.

5. Home Address: _____ ( ) _____
   Number & Street Home Phone

   _____ ( ) _____
   City State Zip Code Fax
6. Mailing Address (choose one): ☐ Home ☐ Primary Office ☐ Other (specify) _____

   Billing Address (For Invoice ONLY): _____ ( ) _____
   Number & Street Phone

   _____ ( ) _____
   City State Zip Code Fax
7. E-Mail address (es) _____

B. Coverage Options

1. Limits of Liability (Please check the desired limits of liability)

   ☐ $500,000 per claim/$1,500,000 Annual Aggregate ☐ $1,300,000 per claim/$3,900,000 Annual Aggregate

   ☐ $1,000,000 per claim/$3,000,000 Annual Aggregate
2. Coverage Type (Select coverage type :)

   ☐ Claims-Made (A Claims-Made policy covers claims which arise and are made while the policy is in force.)

   ☐ Occurrence (An Occurrence policy covers you against any claim arising during your policy period irrespective of when the claim is reported.)

3. Prior Acts

If your expiring policy is on a Claims-Made basis, an extended reporting period endorsement (Tail Coverage) is generally available as an option of your expiring Claims-Made policy.

a. Are you purchasing extended reporting (tail) coverage from your prior carrier? ☐YES ☐NO
If yes, please provide proof of tail coverage. If no, please explain in **remarks #10**.

b. If no, do you want PRI to provide coverage for prior acts? ☐YES ☐NO
(claims or incidents which may have occurred but, as yet, no indication has been made to you that a patient will bring a claim/suit).
If yes, a Conversion Supplemental application must accompany this application along with a copy of your most recent declarations page.

Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

4. Excess Coverage

Do you currently have section 18 excess coverage through a hospital affiliation? ☐YES ☐NO

a. If you are eligible for section 18 excess coverage, do you want to apply through PRI? ☐YES ☐NO
b. If not eligible for section 18 excess coverage, would you like to purchase direct excess coverage through PRI? ☐YES ☐NO

C. Practice Information

1. Primary office location for which coverage is desired: ☐ Private Office ☐ Clinic ☐ Hospital

_____

Number & Street City State Zip Code % of Practice

_____

Telephone # Name of contact person Fax # Cell Phone #

2. Other practice location for which coverage is desired, *if any,* including all other offices, nursing homes, urgent care clinics and other non-hospital locations:

_____

Number & Street City State Zip Code % of Practice Type of Location

_____

Telephone # Name of contact person Fax # Cell Phone #

If this policy is for more than two locations, indicate other location(s) in **Remarks #10.**

3. Please answer the following in reference to the practice location where PRI coverage is desired including office hours, administrative activities, direct patient care, surgery, consultation, etc… (excluding on call)

a. What is your average weekly patient load? _____

b. What are your total weekly hours of practice time? _____

c. If semi-retired or practicing part-time, indicate approximate monthly practice time. _____

d. When did you begin practicing on a part-time basis? _____
(mm/dd/yy)

e. Do you use an electronic health record system? ☐YES ☐NO
If yes, which software do you use and when did you begin utilizing this system? _____

f. If no, are you planning to convert to EMR? ☐YES ☐NO

g. Do you e-prescribe? ☐YES ☐NO
What software do you utilize and when did you begin e-prescribing? _____

4. a. List all hospitals where you currently *have* or *have applied for* staff privileges (include courtesy staff privileges) and percentage of your hospital practice. (Note: PRI Policy information, including cancellation, will be released to these facilities.)

Hospital	City/State	% of practice
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. If you do not have admitting privileges, please describe in detail your mechanism for handling your patients who may require immediate in-patient care.

_____

_____

5. Scope of Coverage

I do not want coverage under this policy for the part of my medical practice listed below.

Practice Name	Address	City	State	Zip Code
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

6. Specialty:

a. Specialty for which you want coverage with PRI* _____

D. Medical Training

1. Medical Education: _____ _____ _____ _____
Medical School State Country Graduation Date

2. Postgraduate Medical Training:

a. Internship _____
Hospital From: Mo. /Yr. To: Mo. /Yr.

b. Residency: _____ Completed? ☐YES ☐NO
Hospital From: Mo. /Yr. To: Mo. /Yr.

Specialty: _____

c. Fellowship: _____ Completed? ☐YES ☐NO
Hospital From: Mo. /Yr. To: Mo. /Yr.

_____ _____
Type of Fellowship City State

d. Explain any additional years spent in a residency program: _____

_____

e. Explain any gaps in time from date of medical school graduation to completion of residency: _____

_____

3. Board Certification:

Are you American Board certified in your Specialty? ☐YES ☐NO Date Certified: _____
Are you American Board certified in your Sub-specialty? ☐YES ☐NO Date Certified: _____
Are you American Board eligible in your Specialty? ☐YES ☐NO Date Eligible: _____
If Board Eligible, give date eligibility expires: _____

E. Professional and Insurance History

1. Practice Locations
List all locations at which you have practiced in the last ten (10) years. (Do not list training locations from section D.)

Name of Practice/Employer Address From Mo./Yr. To Mo./Yr.

_____

_____

_____

2. Changes in Practice
Has your practice, procedures, specialty, location(s), etc., changed in the past ten years? ☐YES ☐NO
If yes, please explain noting dates of changes: _____

_____

3. Do you have prior insurance coverage?* ☐Yes ☐No

Provide name(s) of professional liability carrier(s), policy number(s), and coverage period(s) of all professional liability insurance policies under which you have been insured in the past ten (10) years.

Policy Period From Mo. /Yr.	/ To Mo. /Yr.	Insurance Carrier	Policy #	Medical Specialty	Type of Policy CM/OCC	No. of Claims
_____		_____	_____	_____	_____	_____
_____		_____	_____	_____	_____	_____
_____		_____	_____	_____	_____	_____

4. Insurance (If yes to a, b, c, or d explain in **Remarks #10.**)

a. Have you ever practiced without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage? ☐YES ☐NO
b. Have you ever had professional liability insurance refused, declined, non-renewed, cancelled, or accepted on special terms? ☐YES ☐NO
c. Have you ever been required to pay a premium surcharge or have you ever been involved in an appeal concerning the imposition of such a surcharge? ☐YES ☐NO
d. Have you ever withdrawn an application for professional liability insurance? ☐YES ☐NO

F. Medical Conduct Information

1. Have you ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten years, or are you presently involved in malpractice litigation? If yes, submit a separate Claims Information Form for each case in the last 10 years (see page 14). ☐YES ☐NO

2. a. Has any government agency ever investigated, suspended, revoked, or taken any other action against either your narcotic license or your license to practice medicine? ☐YES ☐NO
   b. Have you ever been convicted of a crime? ☐YES ☐NO
   c. Have you ever had privileges at any hospital or other institution reduced, revoked, restricted, or suspended? ☐YES ☐NO
   d. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty? ☐YES ☐NO
   If yes, please submit a letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect the practice of your medical specialty.

   If yes to a, b, c or d above, explain in **Remarks #10.**

3. Are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit?
   a. A request for records from a patient and/or attorney related to an adverse outcome? ☐YES ☐NO
   b. A letter from an attorney regarding your medical treatment of a patient? ☐YES ☐NO
   c. Intra-operative complications or other complications resulting in death, paralysis, or other significant disabilities? ☐YES ☐NO
   d. Patient dissatisfaction with the outcome of a procedure, treatment, or diagnosis? ☐YES ☐NO
   e. Have all circumstances that might reasonably lead to an incident, claim or suit (EVEN IF YOU BELIEVE THE POSSIBLE CLAIM OR SUIT WOULD BE WITHOUT MERIT) been reported to your current, OR, prior professional liability carrier? ☐YES ☐NO
   If yes, how many _____, AND please attach documents of all such reports.
   If no, please explain (i.e. none to report, uninsured, etc.): _____

If yes to any of the above, please explain in **Remarks #10** and attach any additional documentation. The Incident/Claim Information Form on page 14 must be completed for each incident, potential claim, claim, or suit.

G. Physician Underwriting Information

REMINDER: Answers to the questions in this section should reflect your intended practice as of the date you wish this policy to become effective.

1. Practice Situation

   a. Indicate all practice situations that apply to you:

- ☐ "Solo" Physician
- ☐ "Solo" Medical Corporation
- ☐ Medical Corporation with more than one physician shareholder
- ☐ Medical Partnership
- ☐ Independent Contractor/Contractee
- ☐ Use of assumed name (DBA)
- ☐ Employed by another physician
- ☐ Employ another physician
- ☐ Other _____

If you check any boxes above *other than* "Solo" Physician or "Solo" Medical Corporation, list below the name of the applicable entity(ies) and/or any physician(s).

Name of Entity(ies)	Name of Physician Employer or Employee	Professional Liability Insurance Carrier
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Do you wish to purchase coverage for any of the above entities under a medical entity policy? ☐YES ☐NO

If yes, please contact Underwriting or Marketing for an application and pricing.

2. Other Physicians: Do you practice with other physicians not listed above? ☐YES ☐NO

If yes, list the physician(s) with whom you practice and describe the association.

Physician(s)	Association
_____	
_____	

3. Discounts:

a. Are you currently receiving a premium discount as a result of having completed a New York State Department of Financial Services (NYSDFS) approved Risk Management Course with your present carrier? ☐YES ☐NO
If yes, submit proof of completion of such course, including date discount became effective.

b. **"No Consent" Option** ☐YES ☐NO
By checking yes, I hereby authorize PRI to act on my behalf to settle any claim reported, or to appeal any judgment against me without first obtaining my written consent. I understand that I will receive a 5% premium reduction by choosing this option.

c. Have you had continuous insurance and no claims open, pending or paid within the last 5 years? ☐YES ☐NO

d. Have you had continuous insurance and no claims open, pending or paid within the last 10 years? ☐YES ☐NO

e. Medical Associations or Societies to which you belong_____

4. Do you participate in telemedicine or teleradiology? ☐YES ☐NO

For purposes of this question, telemedicine is defined as "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of an individual as a result of transmission of data by electronic means".

Please describe your telemedicine/teleradiology activities:

_____

5. Do you provide "concierge" practice services? ☐YES ☐NO
If yes, please describe the services you provide, hours of availability, etc._____

H. Practice and Procedures

1. Non-Hospital Procedures

a. Do you perform procedures in a non-hospital setting where anesthesia/sedation is administered? ☐YES ☐NO

If yes, check type used:

☐General Anesthesia ☐Deep Sedation/Analgesia ☐Moderate Sedation/Analgesia ("Conscious Sedation") ☐Minimal Sedation (Anxiolysis)

If yes:

i) Location ☐Surgicenter ☐Office ☐Other Non-Hospital Facility

ii) Who administers the anesthesia? _____

b. Is the office or facility accredited? ☐YES ☐NO
If yes, by what agency? _____

c. For Surgicenters or other Non-Hospital Facilities, please provide the name and address of each.

_____

d. List the surgical procedures you perform in your office or other non-hospital facility:

Procedure	# Weekly	Where Performed
_____	_____	_____
_____	_____	_____
_____	_____	_____

e. Do you maintain a full emergency cart in your office? ☐YES ☐NO

i) Do you follow a protocol for checking the cart on a regular basis? ☐YES ☐NO
ii) Are the checks documented? ☐YES ☐NO

2. Do you perform procedures or use equipment that are not customarily used within your practice specialty but for which you believe you are trained and credentialed to perform? ☐YES ☐NO
If yes, please describe: _____

3. Do you perform any aesthetic and or cosmetic procedures or employ or contract with anyone who does? ☐YES ☐NO
If yes, please describe: _____

4. Do you own, operate, or have any legal affiliation with a Medi-Spa? ☐YES ☐NO
If yes, what it your average # of visits per week_____ and average # of hours worked per week_____?

5. Weight Control

a. Does your practice involve weight reduction or control, other than prescribing exercise? ☐YES ☐NO
(Percentage of patients exclusively for weight reduction or control: ____%.)

If yes, please explain fully, including names of medication(s) prescribed or dispensed, or surgery performed:

_____

_____

b. Do you solicit or advertise for weight control patients? ☐YES ☐NO
If yes, submit copies of all advertisements.

6. Experimental and Investigative Procedures

Are you currently treating or do you intend to treat any patient by means of an experimental, investigative or unconventional drug or therapy? ☐YES ☐NO

If yes, indicate which of the following applies and *attach a detailed, narrative outline, IRB approval, indemnification agreement and a copy of the patient consent form*.

☐ Use of experimental drug, device or material under U.S. Food and Drug Administration or other governmental agency investigational protocol and licensure.

☐ Other experimental, investigative or unconventional drug or therapy.

Please describe: _____

7. Please indicate with an 'X' below which of the following procedures, techniques or practices you perform or contemplate performing.

☐ Acupuncture *(Please submit copy of NYS Certification.)*
☐ Angiograms
☐ Angioplasty
☐ Aspiration of cyst of breast
☐ Assisting in Major Surgery
☐ Botox
☐ Breast biopsy
☐ Bronchoscopy
Cardiac catheterization
☐ Left Heart
☐ Swan Ganz
☐ Cervical biopsy
☐ Cervical cautery
☐ Chelation therapy (other than for the treatment of heavy metal poisoning)
☐ Chemobrasion
Type_____
☐ Chemotherapy
☐ Chorionic villus sampling
☐ Circumcision of adults

☐ Closed reduction of fracture (other than temporizing)
☐ Colonoscopy
☐ Culdocentesis
☐ D & C
☐ Dermabrasion
☐ Duodenoscopy
☐ Endometrial biopsy
☐ Esophagoscopy
☐ Gastroscopy
☐ Hair transplants
☐ Hemorrhoidectomy
☐ Hydrocelectomy
☐ Hydrogen peroxide therapy
☐ Hysterectomy
☐ Injection of bursa
☐ Insertion of IUD
☐ Laser therapy (explain type)
_____
☐ Nasal polypectomy
☐ Needle biopsy (explain type):
_____
☐ Pain Management (If yes, explain in **Remarks #10**)
☐ Peritoneal dialysis
☐ Permanent pacemakers
☐ Phalloplasty
☐ Polypectomy by endoscopy
☐ Prenatal care
☐ Restylane
☐ Scalp reductions
Sclerotherapy
☐ Superficial
☐ Deep vein
☐ Stress testing
☐ Suction lipectomy *(submit proof of training if outside of residency)* (explain type)
_____
☐ Temporary pacemaker
☐ Ultraviolet light therapy
☐ Vein stripping

8. Non-Hospital Births:

Do you provide direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperal and/or neonatal period) in any facility other than a licensed acute care hospital? ☐YES ☐NO
If yes, give full details: _____
_____

9. Termination of Pregnancy:

a. Do you perform terminations of pregnancy? ☐YES ☐NO

If yes, please provide the following information:

Location		# Performed Monthly at Each Location	Maximum Gestational Age at Each Location
Office	☐	_____	_____
Hospital	☐	_____	_____
Other	☐	_____	_____

b. List hospitals, clinics, or other facilities where you perform terminations of pregnancy:

_____
_____

SPECIALTY SPECIFIC INFORMATION (PLEASE ANSWER ALL THAT APPLY TO YOUR PRACTICE)

Anesthesiology

1. Do you administer anesthesia in a non-hospital setting? ☐YES ☐NO
   If yes, state location(s): _____

2. Do you employ or supervise any CRNAs? ☐YES ☐NO
   If yes, please complete the following: Number employed _____ Number supervised _____

3. Do the CRNAs give anesthesia while not under your personal direction, control, and supervision? ☐YES ☐NO
   If yes, please describe: _____

Family Practice/Internal Medicine/General Practice

1. Percentage of your practice derived from treatment of children _____% (i.e. treatment of patients under age 21)

Nurse Practitioner

1. Are you currently involved in a collaboration agreement with a nurse practitioner? ☐YES ☐NO
   If yes, if this nurse practitioner is not employed by you and not currently insured through PRI, coverage is available to protect you from liability you incur as a result of this collaboration agreement.

   Are you interested in obtaining this coverage? ☐YES ☐NO

Obstetrics and Gynecology

1. Do you limit your practice to gynecology only? ☐YES ☐NO
   If yes, is your practice strictly office based? ☐YES ☐NO

2. Do you render prenatal care exclusive of delivery? ☐YES ☐NO

3. How many deliveries do you perform annually? _____

   What percentage of your deliveries are done at a birthing center outside the hospital setting? _____

Ophthalmology (Surgery)

1. How many major surgical procedures (excluding laser refractive surgical procedures) have you performed in the last 12 months as the primary surgeon? _____

2. How many laser refractive surgical procedures have you performed in the last 12 months as primary surgeon? _____

Physical Medicine and Rehabilitation/Pain Management

		# of Annual Procedures
A. Do you perform any of the following procedures?		
1. Cervical epidural injections?	☐YES ☐NO	_____
2. Thoracic epidural injections?	☐YES ☐NO	_____
3. Celiac plexus blocks?	☐YES ☐NO	_____
4. Epidural-caudal, translumbar or selective injections?	☐YES ☐NO	_____
5. Facet-cervical or Lumbar injections?	☐YES ☐NO	_____
6. Sacroiliac joint and gleno-humeral joint injections?	☐YES ☐NO	_____
7. Hip joint injections? If yes, explain _____	☐YES ☐NO	_____
8. Insertion of spinal stimulator wires in the epidural space?	☐YES ☐NO	_____
a) Do you go higher than vertebral level T4?	☐YES ☐NO	_____
9. Insertion of epidural catheter for drug infusion? (Do not include post-op epidural for acute pain management)	☐YES ☐NO	_____
a) Do you go higher than vertebral level T4?	☐YES ☐NO	_____
10. Insertion of intrathecal catheter for drug infusion?	☐YES ☐NO	_____
a) Do you go higher than vertebral level L2?	☐YES ☐NO	_____
B. Does your practice include chronic pain management? If yes, what percentage of your practice? _____%	☐YES ☐NO	

Pediatrics

1. Percentage of your practice derived from neonatology _____%

2. Percentage of your practice derived from treatment of adults _____% (i.e. treatment of patients age 21 and above)

The following section should be completed by all physicians who perform surgical procedures.

Surgery

1. List the number of major surgical procedures performed in the last 12 months
   a) As primary surgeon _____
   b) As assisting surgeon _____

2. Indicate the percentage of surgical time devoted to the following surgical activities:

_____% Bariatrics	_____% Hand	_____% Thoracic
_____% Cardiovascular	_____% Orthopedic	_____% Urological
_____% Gynecology	_____% Otorhinolaryngology	_____% Vascular
_____% General	_____% Cosmetic-Reconstructive	_____% Plastic
_____% Other _____		

10. REMARKS

Question #	Remarks

(Appl. 2018)

I. Authorization

11. Paragraph 44 of the Subscriber's Agreement provides for the return of a portion of the amount in the Subscriber's separate account which represents the Subscriber's share of the earnings of the Exchange during his/her term as a Subscriber. Such amount must be returned to the Subscriber after he/she is no longer insured by the Exchange. However, in instances where the Subscriber's premium will be paid by a person or entity other than the Subscriber, the Subscriber may agree in advance to assign such distribution and designate the person or entity which has paid the premium to receive such distribution by signing below and naming such recipient:

_____ _____

Subscriber's Signature: Date:

_____

Name of Recipient

12. You may appoint a policy administrator authorized to receive all communications, make requests and give instructions on your behalf with regards to your policy, except for consenting to settlement of a claim if such consent is required by the policy. Please identify the policy administrator by completing the below:

Name: _____

Title: _____

Address (mailing) _____

_____

_____

Phone _____

Fax _____

E-mail _____

I understand that in order to underwrite professional liability insurance, The Exchange must have access to all pertinent information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to The Exchange pursuant to this consent and direction, together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information, even though the information may be wrong.

I understand and agree that, if I am approved as a Subscriber to The Exchange and a policy is issued to me, that there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.

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.

Signature: _____ Authorization Date: _____
(Applicant's Signature)

_____
PRINT NAME

Please check box if you are submitting electronically only.

☐ By checking this box, I understand and agree that I am signing this application electronically. I understand and agree that the electronic signature is the legal equivalent of my manual signature.

Please make additional copies of this page, as necessary

CLAIM INFORMATION

1. Name of patient _____
2. Age _____
3. Your relationship to patient (e.g. attending physician, primary surgeon, assistant surgeon, etc.): _____
4. Details of allegation(s): _____
5. Date of incident _____ 6. Report date _____
7. Insurance carrier _____
8. Other defendants _____
9. Location of Incident _____
10. Condition and diagnosis at time of incident _____
    _____
11. Dates and description of treatment rendered _____
    _____

    Condition of patient subsequent to treatment (including DATES OF FOLLOW-UP TREATMENT)
    _____
    _____

12. Present status of claim (check applicable answer and fill in amounts where requested):

☐ Precautionary/Incident report only
☐ Suit threatened, no action taken
☐ Dropped by claimant
☐ Summary judgment in your favor
☐ Court trial in your favor

☐ Settlement:
Date Paid _____ Amount Paid _____
MM/DD/YY

☐ Judgment:
Date Paid _____ Amount Paid _____
MM/DD/YY

Was the corporation under which you provided medical care sued? ☐ Yes ☐ No
Was payment made on its behalf? ☐ Yes ☐ No If Yes, amount paid: $_____

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.

Signed: _____ Date Signed: _____

Please take a moment to complete this brief survey, please check one.

How did you hear about PRI?

- ☐ I was contacted by PRI
- ☐ I was referred by a colleague
- ☐ I am joining a group that uses PRI_____
  Group Name
- ☐ I met a marketing representative at a convention
- ☐ I saw an advertisement in a trade magazine_____
  Publication Name
- ☐ PRI's website/Submitted a quick quote
- ☐ I was referred by a broker _____
  Broker of origin
- ☐ I received a mailing
- ☐ Other_____

We are always looking for ways to improve at PRI. If you have any suggestions regarding products/services we can offer which will enhance your practice, please let us know.

_____

_____

_____

Thank you for your interest in PRI, we appreciate your business and as always if you have any questions please do not hesitate to contact us at 800 632-6040 or visit us on the web www.PRI.com.

(Appl. 2018)