SCRUBS
MUTUAL ASSURANCE COMPANY
RISK RETENTION GROUP

PHYSICIAN MEMBER UNDERWRITING APPLICATION/PROFILE SHEET

(PLEASE ATTACH A CV)

I. GROUP: _____

A. Office Address: _____
Address City State Zip

B. Business Phone_____ Fax Number_____ E-mail _____

II. PHYSICIAN INFORMATION

A. First _____ MI___ Last Name_____Suffix_____Title_____

B. Group(s) where you practice:_____

C. Date of Birth: ____/____/_____ E. Male ___ Female ___

D. Work Start Date ____/____/_____ (this is the first day you worked, or will work, for the Group above)

F. Medical School Graduation Year ____

G. Graduate of a non-US medical school? yes ___ no ___

H. If yes, are you certified by the Educational Council for Foreign Medical School Graduates? Yes ___ no ___

Date Certified: _____ ECFMG Number: _____

I. Are you fellowship trained ? yes ___ no ___

J. If yes, date and place of completion: _____

L. Specialty Boarded: Certified? ___ Eligible? ___
Neither ___ Other Board? _____

M. Have you ever failed a Board exam? yes ___ no ___ If yes, please explain: _____

N. Secondary specialty? _____ % of practice ____ Board certified? yes ___ no ___

O. ACTIVE LICENSES

State	Expire Year	License #	Permanent/Temporary	Status

PRIOR LICENSES

State	Status

III. PRACTICE HISTORY

A. Average patients seen per month?_____ B. Average number of surgical cases per month?_____

D. Number of on-call shifts per month _____

E. Do you practice outside this group? yes ___ no ___

If "yes," do you have separate professional liability insurance for this exposure? yes ___ no ___

IV. COVERAGE BEING APPLIED FOR

A. Requested Effective Date: _____/_____/_____ (This is the date you wish coverage to begin with SCRUBS RRG)

B. Prior Acts Coverage: (check one)

___ I **DO NOT** wish to apply for prior acts coverage. It is understood that by not purchasing prior acts coverage, you acknowledge that SCRUBS RRG will not provide any coverage for claims or suits arising out of treatment that you rendered or failed to render prior to your effective date of coverage with SCRUBS RRG. If your prior coverage was on a claims-made basis, Tail coverage from your prior carrier must be purchased if you elect not to have SCRUBS RRG pick up this prior exposure (unless your prior exposure was on an occurrence form.)

___ I wish to apply for prior acts coverage. (coverage for occurrences and/or accidents which took place prior to the requested effective date listed above.)

Please complete Prior Acts section, page 3

C. Are you, as of this date aware of any claims against you that have not been reported to your present or prior insurer(s)? yes ___ no ___ [If yes, please describe in Remarks section]

D. Are you, as of this date, aware of any conduct, circumstances or incidents that occurred during the periods of coverage listed below that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)? yes ___ no ___ [If yes, please describe in Remarks section]

V. PREVIOUS INSURANCE

To assure there are no gaps in coverage, please list all previous medical professional liability insurance carriers for the past five (5) years, beginning with your current carrier. Use the Remarks section to list additional carriers.

Carrier Name	Policy Period From	Policy Period To	Limitsof Liability	Claims-Made/ Occurrence	Tail Coverage Purchased?

Please attach a copy of your most recent declarations page.

VI. ATTESTATIONS

If you answer "YES" to any of the following questions, **please give full details** in the "Remarks" section. Include dates and copies of any related documents.

A. Are you now being - or have you ever been - treated for alcoholism, narcotics addiction or mental illness; or are/were in a physician health or diversion program? yes ___ no ___

B. If yes, attach a copy of documentation from a physician health or diversion program or a letter of release from your treating physician.

C. Have you become aware of any health problem, illness, or physical condition that impairs or could impair your ability to safely practice medicine? yes ___ no ___

D. Have you ever had professional liability insurance declined, non-renewed, cancelled or restricted, or had an involuntary deductible and/or surcharge assessed against you? yes ___ no ___

E. Have you ever been investigated by any State Licensing Board, Narcotics Board, DEA or other governmental or regulatory agency or has your license to practice or your narcotics license ever been denied, revoked, suspended or limited in any way? yes ___ no ___

F. Has any hospital ever restricted or revoked your privileges or invoked probation for any cause other than for incomplete charts? yes ___ no ___

G. Have you ever been indicted for or convicted of a crime other than minor traffic violations? yes ___ no ___

H. Have you ever been suspended, restricted or put on probation by any governmental health program (e.g. Medicare or Medicaid)? yes ___ no ___

I. Have you been involved in a malpractice claim, suit or incident that might give rise to a claim in the past 10 years. Or are you currently involved in medical malpractice litigation? yes ___ no ___
If you answer "yes" to this question, please provide complete details on the Claim Information Form Complete a separate form for each claim.

VII. PRIOR ACTS COVERAGE

IMPORTANT: Prior Acts Coverage is optional and subject to separate underwriting evaluation and approval. Unless you are notified by SCRUBS RRG that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Reporting Endorsement Coverage ("Tail" coverage) from your current carrier.

Please include a copy of your most current Declaration Page and any attached endorsements form your current carrier.

A. Requested Retroactive Date: ____/_____/_____
(This date should be the same as the Retroactive Date that is shown on your current Declaration Page)

VIII. CHANGES IN PRACTICE

A. Describe any changes in your practice since the requested retroactive date, including all applicable dates. Attach additional pages as needed.

_____

_____

_____

IX. HEALTH CARE EXTENDER

A. Indicate below the Healthcare Extenders you employed, contracted with or supervised during the period for which you are requesting Prior Acts Coverage. Attach additional pages as needed.

Type of Extender	Name of Health Care Extender	Period employed, contracted with or supervised

X. SCOPE OF COVERAGE (prior acts period)

A. ___ I am requesting coverage for my entire medical practice as described in this application

B. ___ I do not want SCRUBS RRG coverage for the part of my medical practice listed below:

Practice, Procedure or Location	Insurance Carrier	Start date and End date of Exposure if applicable

XI. REMARKS

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTE: THE POLICY YOU ARE APPLYING FOR IS ISSUED BY A RISK RETENTION GROUP. A RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE AND SOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE TO YOUR RISK RETENTION GROUP.

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information and/or material misrepresentation will cause immediate rescission of the physician's insurance coverage.

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning the physician's professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter and insurance agent to furnish any information concerning the physician that the company may request.

No Known Claims Statement: The undersigned warrants that as of _____(date) all known claims or suits for incidents which occurred between the retroactive dates as per the attached location schedule and the date this statement is signed, and all acts, incidents and/or circumstances, of which _____(Named Insured), its agents, employees or physician contractors are aware, and which might reasonable be expected to result in a claim under the Prior Acts coverage afforded by this policy, were disclosed in writing to _____ Insurance Company prior to the binding of such coverages.

Further, the undersigned acknowledge and agree that any claims resulting from acts committed prior to the binding of coverage, and which (Named Insured), its agents, employees or physician contractors were aware, are specifically excluded from coverage under this policy. This warranty is material to the acceptance of coverage by SCRUBS Mutual Assurance Company Risk Retention Group and is made a part of the insurance policy.
ACKNOWLEDGED AND AGREED:

BY: _____
(Physician Signature)

_____
(Printed Name)

DATE: ____/____/_____