

**COASTAL INSURANCE RISK RETENTION GROUP, INC.**

**P.O. Box 211359  
Montgomery, Al 36121-1359**

**RENEWAL QUESTIONNAIRE FOR PROFESSIONAL LIABILITY  
INSURANCE FOR PHYSICIANS AND SURGEONS (HOSPITALS)  
CLAIMS MADE**

**NOTICE**

**THIS POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.**

Hospital \_\_\_\_\_ Percentage of admission \_\_\_\_\_  
Physician's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone Number \_\_\_\_\_

**On a separate sheet of paper, please explain any affirmative answers (other than current Medical Licensure) to the following questions**

**1. In the past year have you:**

- (a) Been the subject of investigative or disciplinary proceedings or reprimand by a government agency, hospital or professional association?  Yes  No
- (b) Has your state license or narcotic license been surrendered (voluntarily or involuntarily), denied, revoked or suspended?  Yes  No
- (c) Been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses.  Yes  No
- (d) Failed any medical licensing or specialty organization examination?  Yes  No
- (e) Been named in a claim or suit for professional malpractice?  Yes  No
- (f) Had any judgments made against you or any out-of-court settlements made in your behalf?  Yes  No
- (g) Have you been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including, but not limited to depression and/or chronic fatigue?  Yes  No
- (h) Have you had or do you presently have any chronic or life-threatening illness?  Yes  No

2. Is your medical license and D.E.A current?  Yes  No

3. Has there been any change in your practice, procedures or profession during the past year?   \_\_Yes       \_\_No  
If yes, explain on a separate sheet of paper.
4. Are you aware of any incidents, which may result in a malpractice claim or suit being filed   \_\_Yes       \_\_No  
If yes, please provide a brief description on a separate piece of paper.

**Signing this application does not bind Coastal Insurance Risk Retention Group, Inc. (Coastal) to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information or attempt to defraud or lie to Coastal about any matter contained in this application, then coverage provided by virtue of this application may be void.**

I, the undersigned, have provided Coastal information in their application in order for Coastal to evaluate my insurability under their policy of insurance.

Therefore, I hereby authorize all persons, firms, corporations, including but not limited to, prior liability carrier, hospitals and their officers, directors, medical staff and employees, medical association, medical society, the State Board of Medical Examiners for any state in which I have practiced and any other entity, either public or private, to provide Coastal with any information, whether written or otherwise. Furthermore, I release any of the above or their agents from liability to me in any way for furnishing such information to Coastal. I consent to Coastal to use photocopies of this authorization for release of information. Each photocopy is to be considered an original copy.

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
DATE