Nevada Mutual Insurance Company

PROFESSIONAL LIABILITY RENEWAL QUESTIONNAIRE

775 Prairie Center Drive, Suite # 420, Eden Prairie, MN))'((
Phone: (952) 974-2200 * Fax: (952) 974-2240

IMPORTANT: Complete and return this form in to your NMIC agent. Your prompt, accurate reply will avoid any unnecessary delay of your policy's renewal. Please type or print legibly. Thank you for your cooperation.

CURRENT POLICY #______________________________

Name ______________________________ Date of Birth ____/____/____

Social Security Number ______________________ Medical License Number ______________

Office Address ______________________________

Office Phone ______________ Office Fax ______________ E-mail Address ______________

City ______________________ State ______________ Zip ______________

Professional office located within the County of: ______________

I. PREMIUM CLASSIFICATION

A. Please classify your surgical practice, if applicable:

- ☐ Cardiac
- ☐ Cardiovascular Disease
- ☐ Colon and Rectal
- ☐ Emergency Medicine
- ☐ General
- ☐ Gynecology
- ☐ Hand
- ☐ Head and Neck
- ☐ Laryngology
- ☐ Neurology
- ☐ Obstetrics/Gynecology
  - ☐ Normal Deliveries
  - ☐ C-Sections
- ☐ Ophthalmology
- ☐ Orthopedic
  - ☐ Spine Surgery
  - ☐ No Spine Surgery
- ☐ Otology
- ☐ Otorhinolaryngology
  - ☐ Including elective cosmetic procedures
  - ☐ Not including elective cosmetic procedures
- ☐ Plastic
- ☐ Rhinology
- ☐ Thoracic ______________%
- ☐ Urology
- ☐ Vascular ______________%
- ☐ Other

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A. Please check any of the following procedures you will perform:

- ☐ Elective Abortions
- ☐ Acupuncture
- ☐ Adenoidectomy
- ☐ Anesthesia
  - ☐ Spinal
  - ☐ Caudal
  - ☐ General
  - ☐ Local
  - ☐ Other ______________
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Assist in Major Surgery
  - ☐ On Own patients
  - ☐ On Patients of Others
- ☐ Blepharoplasty
- ☐ Breast Biopsy
- ☐ Breast Implants
  - ☐ Cosmetic ______________% of Practice
  - ☐ Reconstructive ______________% of Practice
- ☐ Bronchoscopy
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Cholecystectomy, Laparoscopic
- ☐ Colonoscopy
- ☐ Cryosurgery (other than external lesions)
- ☐ Dermatological Surgery
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Dermabrasion
  - ☐ Fat Transfer
  - ☐ Hair transplants
  - ☐ Silicone Injections
  - ☐ Tumescent Liposuction
  - ☐ Other ______________

    ____
- ☐ D&C
- ☐ Encephalography
- ☐ Endoscopic laser Therapy
- ☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy
- ☐ ERCP
- ☐ Exchange Transfusions in newborns How many per year? ______________
- ☐ Fluoroscopy
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Hip nailings
- ☐ Hyperbaric Medicine
- ☐ Intensive care for newborns within a Tertiary Care Unit
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Left Heart Catheterization
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Lumbar Fusion
- ☐ Mammography
- ☐ Myelography
- ☐ Norplant Insertion/Extraction
- ☐ Organ Transplant
- ☐ Pain Management
  - ☐ Dorsal Root Gangliotomies
  - ☐ Thoracic Sympathectomies
  - ☐ Spinal Cord Stimulators
  - ☐ Implantation of Drug Infused Pumps
  - ☐ Sphenopalatine Lesioning
  - ☐ Trigeminal Lesioning
  - ☐ Cordotomies
  - ☐ Other ______________
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Permanent Pacemaker
- ☐ Polypectomy
- ☐ Prenatal Care
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye
- ☐ Scoliosis Surgery
- ☐ Shock Therapy
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Vasectomy
- ☐ Weight Control ________% of practice
  - ☐ Gastric Bubble
  - ☐ Gastric Stapling
  - ☐ Medications Prescribed:

    ____

    ____
- ☐ **None of the above**
- ☐ **Other Procedures (List):**

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I. PREMIUM CLASSIFICATION (continued)

B. Have you altered your practice by changing the types of procedures you perform or significantly changed the amount of any procedure you perform during the last two years? Yes No If yes, explain briefly______________
____.

C. Do you perform any surgical procedures for which you do not have current hospital privileges?Yes No If yes, explain ____.

D. Do you perform deliveries?Yes No If yes, indicate: [a] the average number of deliveries per month:___________
[b] Do you have privileges to perform C-sections at each hospital where you provide obstetrical care? Yes No

E. Do you or any members of your group currently supervise any paramedical listed on page 3 who is not in your employ?Yes No or plan to do so in the future?Yes No

F. How many patients do you see on average per week?______ Average hours of practice per week?___________

G. If you are presently in a residency or fellowship program or completed such a program within the past twelve months, please provide the month/year of completion: ______________________.

H. Are you Board certified? Yes No If yes, please provide name of Board:_________________________________.
Are you required to recertify?Yes No If yes, please provide date of recertification: ____________________.
If you are not Board certified, have you ever failed a Board certification examination?Yes No If yes, how many times? _____________

I. If you did not check "Emergency Medicine" under I. A. Premium Classification on page 1 of 4, do you or will you staff an emergency department? Yes No If yes, is this emergency department work required to maintain hospital staff privileges?Yes No If no, how many hours per month will you practice in the emergency department? _______ _____________ Hours per Month

II. MEDICAL ASSOCIATION MEMBERSHIP

Are you currently a member in good standing of the Nevada State Medical Association?Yes No

III. CME CREDITS

Please describe the number and nature of Category I CME hours you have received over the past 36 months:

____

____

IV. GROUP MEMBERSHIP

A. Please give us the name of any newly formed solo P.A./P.C. or professional group practice:

____

B. Do you desire coverage for this practice entity? Yes No

C. If a member of a group practice, check the appropriate relationship: partner shareholder employee

D. Have you or your group practice employed any new physicians or other medical professionals that you have not previously reported? Yes No If yes, please describe:

____

E. At this time how many physicians are associated with your group practice? ____________ Does Nevada Mutual insure all of them? Yes No If no, how many are not insured by Nevada Mutual?__________________

F. Please give us the name of any practice entity which has dissolved and the effective date of the dissolution:

____

G. Please tell us of any name change to any practice entity: ____

____

V. PERSONAL HISTORY—IF YOU ANSWER 'YES' TO ANY OF THESE QUESTIONS, ATTACH COMPLETE DETAILS ON SEPARATE SHEET.

A. Have any of the following been denied, suspended, restricted, revoked or voluntarily surrendered for any reason:

Any State Medical License? Yes No
Hospital Privileges Yes No
License to prescribe or dispense medicine? Yes No

B. Have you:

Undergone psychiatric treatment? Yes No
Been treated for alcohol or narcotics addiction? Yes No
Had any chronic illness or physical defect? Yes No
Been convicted of any misdemeanor or felony other than minor traffic violations? Yes No

Appeared before any Professional Standards/Quality Assurance Review Committee? Yes No

Appeared before the Board of Medical Examiners or Medical Licensure Commission? Yes No

VI. CLAIM HISTORY

B. Has any claim or suit for alleged malpractice been made against you other than those already reported to Nevada Mutual since you became insured by Nevada Mutual? Yes No

C. Other than those previously reported, has any claim or suit for alleged malpractice resulted in payment by you or on your behalf by any insurance company? Yes No

D. **Include with your renewal application current loss reports from any other insurer that has insured you over the past eight years.**

VII. ADDITIONAL EMPLOYEES

Please indicate the number of paramedicals you or your group employs, provide their full legal names, and attach a copy of their current professional liability declarations page.

Employee Classification	# Employed	Full Legal Name(s)
Physician's Assistant	______________	____
		____
		____
Surgeon's Assistant	______________	____
		____
		____
Certified Nurse Midwife	______________	____
		____
		____
Certified Registered Nurse Anesthetist	______________	____
		____
		____
Certified Nurse Practitioner	______________	____
		____
		____
Psychologist	______________	____
		____
		____
Perfusionist	______________	____
		____
Emergency Medical Technician	______________	____
		____
		____
Cytotechnologist	______________	____
		____
Optometrist	______________	____
		____

VII. HOSPITAL AFFILIATIONS

Please list the hospitals where you now hold staff privileges and, based on your own best estimate, also list the number of admissions at each during the past 12 months.

	Hospital(s)	Number of Admissions*
Primary:	______________________	______________
2nd Most Used:	______________________	______________
3rd Most Used:	______________________	______________
4th Most Used:	______________________	______________

*If you don't routinely admit patients (as in the case of radiologists, pathologists, etc.) or if "number of admissions" doesn't accurately reflect your total practice, please indicate your percentage of practice in each hospital. If you are a pediatrician, please include newborn admissions in your total number of admissions.

VIII. RISK MANAGEMENT

A. Have you attended a Loss Prevention Seminar in the last year?

[Yes - Date Attended and sponsor______________________________ ,No]

IX. Additional Comments

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Please attach additional sheets as necessary.

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I here by declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, completer and that I have not willfully concealed or misrepresented any material fact or circumstances concerning this insurance or the subject thereof:

Date: ______________ Signature of Insured Physician: ______________________