Medical Mutual℠
PROTECTING OUR PROFESSION

PREVIOUS COVERAGE AND EXPERIENCE QUESTIONNAIRE

(Please TYPE or PRINT in black ink.)

I, the undersigned, have submitted an application for professional liability coverage to Medical Mutual Insurance Company. As part of the Company's underwriting review process to determine my acceptability for coverage, I am required to submit documentation from my previous, or present, carrier related to my professional liability coverage and loss experience.

This form has been developed for your convenience in responding to the request for the information indicated below and to indicate that I authorize the release of the requested information to the Company. If you choose to use your own form or letter style, be certain to include all the information requested on this form. Unless your company guidelines require that the information be submitted directly to me as the insured, please return the information to the Company at the following address:

Southeast - Attention: Underwriting Department
PO Box 98028
Raleigh, NC 27624-8028

OR

Mid-Atlantic - Attention: Underwriting Department
PO Box 11820
Harrisburg, PA 17108-1820

Your cooperation and prompt reply will assist me in completing the application process and will enable the Company to expedite its decision.

(Applicant should complete Items 1 - 3.)

1. Insured Name as it appears on Policy:_____

2. Signature of Insured:_____ Date:_____

3. Insured Mailing Address:_____

_____

(Insurance Carrier receiving this form should complete Items 4 – 12.)

4. Name of Professional Liability Carrier:_____

5. Indicate (x) type of coverage:

☐ Claims Made Coverage Retroactive
Date:_____
Original Date Written:_____

☐ Occurrence Coverage
Original Date Written:_____

☐ Claims Made Plus Coverage (includes pre-paid tail)
Retroactive Date:_____
Original Date Written:_____

6. Premium based upon exposure from practice of: _____
(Specialty)

7. If no longer insured:
   a. Date coverage terminated: _____

   b. What was the reason for termination? _____

8. If premium paid by the individual above, indicate which best describes payment history:
   ☐ No late payments or non-pay cancellations.
   ☐ More than two late payments and/or cancellations due to non-payment.
   ☐ Other (please explain): _____

9. Was a premium surcharge or a deductible ever applied to the individual above? ☐ Yes ☐ No
   If "Yes", please explain reason: _____

10. Was coverage ever restricted or limited? ☐ Yes ☐ No
    If "Yes", please explain reason: _____

11. Is the applicant eligible for renewal or rewrite with your company? ☐ Yes ☐ No
    If "No", please explain reason: _____

12. The past experience of the applicant is essential to proper underwriting. Due to the unique nature of medical professional liability exposure, **consideration of past experience must include incidents reported but not resulting in a settlement or award, as well as incidents that are pending or resulting in payment for settlement or award by a court or jury. Please review the applicant's experience with your company and advise the following:**

    Has the applicant reported any incidents? ☐ Yes ☐ No
    If "Yes", advise the date of occurrence, date reported, allegation and current status (open or closed) of each incident reported or claim-made. If closed with loss payment, indicate amount paid.

    _____

    _____

    _____

    _____

Completed by: _____(signature)
Name:
Title:
Date:
(_____) _____
Telephone Number