TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES AND PROVIDERS PHYSICIAN SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

1. Applicant Name (as Identified in the Liability Insurance Application for proposed insurance):

PHYSICIAN INFORMATION

2. Physician Name:

NOTE: THE PHYSICIAN IDENTIFIED MUST ATTACH A COPY OF HIS/HER CV WITH THIS SUPPLEMENTAL APPLICATION.

3. Does your employment with the facility identified above require that you provide services to any other organization? ☐Yes ☐No

   If "Yes," please provide details:

4. My work for the facility above is: ☐ Full Time ☐ Part Time

   Hours per week: _____ How many patients do you see per week? _____

5. List all states where you are licensed to practice and the applicable license number:

   State/License Number: _____

   State/License Number: _____

   State/License Number: _____

   State/License Number: _____

6. Do you have active hospital privileges? ☐Yes ☐No

AREAS OF PRACTICE

7. Do you practice telemedicine? ☐Yes ☐No
   If "Yes," please provide details:

8. Do you work in correctional institutions? ☐Yes ☐No
   If "Yes," please provide details:

9. Do you work in research or clinical trials? ☐Yes ☐No
   If "Yes," please provide details:

MEDICAL SPECIALTY

10. Are you certified by an approved specialty board? ☐Yes ☐No

If "No," are you Board Eligible? ☐Yes ☐No

Name(s) of approved specialty board(s): _____

Cert. # _____ Date Issued: _____ Expiration Date: _____

Cert. # _____ Date Issued: _____ Expiration Date: _____

If you are not board certified, please explain:

11. Primary Specialty: _____ Sub-Specialty: _____

Is your practice limited to your sub-specialty? ☐Yes ☐No

CURRENT AND REQUESTED COVERAGE

12. Current Carrier: _____ Retroactive Date: _____

Limits (Each Claim/Aggregate: $_____ / $_____

13. Are you requesting Prior Acts coverage? ☐Yes ☐No

If "Yes," specify retroactive date desired if not provided above:

CLAIMS HISTORY

14. Have you ever:

a. Been investigated, disciplined, censured or reprimanded by a medical society, professional review board or licensing entity board? ☐Yes ☐No

b. Been convicted of an act committed in violation of any law or ordinance other than a traffic offense? ☐Yes ☐No

c. Been treated for any alcohol, narcotics or any substance abuse? ☐Yes ☐No

d. Had Medicaid, Medicare or any health program authorities initiate an investigation for alleged billing fraud? ☐Yes ☐No

e. Had hospital privileges reduced, suspended or revoked? ☐Yes ☐No

f. Had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐Yes ☐No

15. MISSOURI RESIDENTS – DO NOT ANSWER. Has any professional liability insurer ever canceled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for you? ☐Yes ☐No

16. Do you have knowledge of any claim, suit or potential claim in which you are named or may become involved, including, without limitation, knowledge of any actual or alleged injury arising out of the rendering of, or failure to render, professional services which may give rise to a claim? ☐Yes ☐No

If "Yes," have these been reported to your current carrier? ☐Yes ☐No

Please complete and attach a Claim Information Form for EACH such claim, suit or potential claim or provide a current carrier loss run for such claim, suit or potential claim.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	