



# Physicians & Surgeons Professional Liability Application

## PHYSICIAN RENEWAL APPLICATION

Mailing Address:

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Web Site: [www.ind-insurance.com](http://www.ind-insurance.com)

**PLEASE RETURN THIS COMPLETED APPLICATION,  
INCLUDING REQUESTED ATTACHMENTS, TO YOUR  
BROKER**

**AN INCOMPLETE APPLICATION MAY DELAY  
PROCESSING**

Broker: \_\_\_\_\_  
\_\_\_\_\_

Name (First, Middle, Last): \_\_\_\_\_

Primary Practice Location\* (to be used on the policy):

Street \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Renewal Effective Date: \_\_\_\_\_ Medical Specialty: \_\_\_\_\_

**Since your last application, have any of the following occurred:**

1. Change in your practice's name or DBA? Yes  No
2. Change in legal status/conversion of your corporation? Yes  No
3. Addition or deletion of another physician to your practice? Yes  No
4. Addition or deletion of a physician assistant, nurse practitioner or other ancillary healthcare provider?  
Yes  No
5. Change in affiliation with another physician or group? Yes  No
6. Change in medical specialty? Yes  No
7. Change in the average number of hours practiced per week? Yes  No
8. Change in hospital privileges? Yes  No
9. Change in board certification? Yes  No
10. Change in types of procedures performed? Yes  No
11. Indictment or investigation for a criminal suit? Yes  No
12. Indictment or investigation by a medical board or government agency? Yes  No
13. Change in your medical or narcotics license? Yes  No
14. Diagnosed with and/or treated for alcoholism, drug addiction, mental or chronic physical illness? Yes   
No
15. Any claim or suit for alleged malpractice brought against you, or, any circumstances that might lead to  
such a claim or suit, not previously reported? Yes  No
16. Change or status of any claim reported to your previous carrier? (Example: settlement) Yes  No
17. Any other changes in your practice and/or procedures performed not mentioned above? Yes  No

**INDEPENDENT NEVADA DOCTORS INSURANCE EXCHANGE  
Physicians & Surgeons Professional Liability Application  
PHYSICIAN RENEWAL APPLICATION**

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**IMPORTANT**

If you answered "Yes" to any of the above, please attach a detailed written explanation.

**THIS APPLICATION MUST BE SIGNED**

I hereby warrant that the information contained in this application is accurate and complete to the best of my knowledge. Any occurrence or event that takes place prior to the issuance of the policy applied for, and which may render any statement made herein inaccurate, untrue or incomplete, will be immediately reported in writing to IND. I acknowledge and agree that the submission and IND's receipt of such written report, prior to the inception of the policy applied for, is a condition precedent to coverage.

I further represent that I am not aware of any fact, circumstance or situation from a medical incident indicating the probability of a claim or suit for which coverage is or would be afforded by the insurance for which application is now being made. It is understood that this coverage will not apply to any claim or suit that arises out of any fact, circumstance or situation that is known to the insured prior to the effective date of this policy if a reasonable physician would have foreseen that such circumstances would result in a claim or suit against the insured.

The signing of this application does not bind me to purchase the insurance, nor does review of the application bind IND to issue a policy.

I acknowledge that receipt or negotiation of a check, cashier's check, money order or other form of payment by IND does not constitute acceptance of my application and is not an agreement by IND to bind, renew or reinstate coverage. I understand coverage will be bound, renewed or reinstated only when I have received written notice of such binding, renewal or reinstatement from IND.

I understand that this application shall be considered a part of the terms and conditions of my insurance policy with the Independent Nevada Doctors Insurance Exchange (IND) if a policy is issued.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature