Curi

**Underwritten by a Curi Company**

Medical Mutual Insurance Company of North Carolina
MMIC Insurance, Inc. | UMIA Insurance, Inc.
Medical Security Insurance Company
MMIC Risk Retention Group, Inc.

# PHYSICIAN
## RENEWAL QUESTIONNAIRE

**Required Documents**

In addition to this renewal questionnaire, the following information is **required**:

- Obstetrical Services Underwriting Questionnaire if obstetrical services are provided

| Provider Name: | Curi Policy Number: |
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## A. PRACTICE CHANGES

**1.** Please check the box below and use the Comments section to inform us of any changes to the following:

☐ Address ☐ Phone/Fax ☐ Contact Information ☐ Name Change

**2.** Please provide your home address:

**3.** Please provide updated email:

**Please explain all "yes" responses in the Comments section.**

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| **4.** Considering the **past twelve (12) months**, have there been any changes to your practice, including your medical specialty and/or surgical procedures performed? | ☐ Yes ☐ No |
| **5.** Considering the **next twelve (12) months**, do you anticipate any changes to your practice, including your medical specialty, medical/surgical procedures offered or expanding into new state(s)? | ☐ Yes ☐ No |
| **6.** Since your last application, have you formed, incorporated or become a member of a new legal entity (e.g., professional corporation, LLC or partnership) through which you currently provide or intend to provide services? | ☐ Yes ☐ No |
| **7.** Do you employ or contract with other medical professionals? | ☐ Yes ☐ No |

**8.** Specify below the practice locations where coverage under your current policy is currently intended to apply. For number of hours, **use average hours per week**.

| Practice/Facility Name | Street Address, City & State | Specify Employee, Contractor or Owner | # of Hours |
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**9.** Specify below other practice locations for which you are working and **NOT** requesting coverage.

| Practice/Facility Name | City & State | Carrier | Specify if Employee, Contractor or Owner | # of Hours |
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| **10.** Do you work part-time? If yes, answer the following questions:<br>a) Total number of hours worked **per week** (on average), including patient care, hospital rounds, phone consultations and administrative responsibilities:<br>b) On call hours:<br>c) Provide month, day and year when you started part-time work: | ☐ Yes ☐ No |

## B. UNDERWRITING QUESTIONS

**Please explain all "yes" responses in the Comments section with the exception of question #1.**

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| **1.** Does your practice have a comprehensive risk management program in place to minimize liability, enhance patient safety and ensure compliance with relevant regulations? | ☐ Yes ☐ No |
| **2.** Are you a sports team physician for any high school, college, university, semi-professional or professional team?<br>If yes, include team name, percentage of practice and contractual relationship in your explanation. | ☐ Yes ☐ No |

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| **3.** Are you using telehealth to provide services? If yes, answer the following questions.<br>a) Specify the percentage of your practice that utilizes telehealth services:<br>b) What types of services are being provided?<br>c) Do you offer these services to patients in states outside your primary practice location? If yes, list each state:<br>d) Are you compliant with state licensing requirements for telehealth services in the state you are located in and each state where patients reside? | ☐ Yes ☐ No<br><br>☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| **4.** Do you provide services at a correctional institution, including jail, prison or state psychiatric facility?<br>If yes, include facility name and percentage of practice in your explanation. | ☐ Yes ☐ No |
| **5.** Do you provide services at a senior living, nursing home or long-term care facility?<br>If yes, include facility name and percentage of practice in your explanation. | ☐ Yes ☐ No |
| **6.** Are you working on behalf of an organization in a role such as administrator, medical director, officer, or a similar position, where the organization is insured elsewhere?<br>If yes, include the name of the organization, description of services you provide and specify if you have coverage elsewhere for these duties in your explanation. | ☐ Yes ☐ No |
| **7.** Are you currently utilizing or planning to utilize any novel or experimental medical procedures, treatments, devices or technologies in your practice? This may include the use of non-FDA-approved devices or medications.<br>If yes, please provide details on the procedures, including the type, purpose and any relevant clinical trials or regulatory approvals. | ☐ Yes ☐ No |
| **8.** Do you serve as an expert witness or litigation consultant?<br>If yes, please include within your explanation the frequency and circumstances under which you offer these services and specify if you have coverage elsewhere for these duties? | ☐ Yes ☐ No |
| **9.** Are you storing and/or dispensing medications? If yes, answer the following questions:<br>a) List types of medications here:<br>b) Are you in compliance with all applicable state regulations, including state pharmacy laws? | ☐ Yes ☐ No<br><br>☐ Yes ☐ No |
| **10.** Are you writing prescriptions for compounded medications or compounding medications on site?<br>If yes, explain in Comments section including types of medication. | ☐ Yes ☐ No |
| **11.** Do you perform Independent Medical Examinations or Aviation Medical Exams as part of your practice?<br>If yes, include percentage of practice in your explanation. | ☐ Yes ☐ No |
| **12.** Are you engaging in any procedures outside the scope of your specialty, licensure and/or training? | ☐ Yes ☐ No |
| **13.** Have you ever been investigated, arrested, indicted or convicted of any crime, including allegations of sexual misconduct of any kind that has not been reported to us? | ☐ Yes ☐ No |
| **14.** Have you ever been under investigation by a state medical licensing agency, medical review board, hospital or healthcare facility that has not been reported to us? | ☐ Yes ☐ No |
| **15.** Have your hospital privileges ever been suspended, denied, revoked, restricted, voluntarily surrendered or otherwise sanctioned or has probation been invoked that has not been reported to us? | ☐ Yes ☐ No |
| **16.** Has your medical license or DEA Registration ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked or restricted that has not been reported to us? | ☐ Yes ☐ No |
| **17.** Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? | ☐ Yes ☐ No |

## C. CLAIM INFORMATION

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| **1.** Is the Policyholder aware of any claims, suits or potential claims that have not been reported to us?<br>If yes, provide a description of each claim(s) in the Comments section and answer the following:<br>a) Will the claim(s) be reported to us? ☐ Yes ☐ No (If no, provide an explanation.) | ☐ Yes ☐ No |
| **2.** Since joining us, have any claims involving the Policyholder or providers been reported to your previous carrier? If yes, provide details in the Comments section. | ☐ Yes ☐ No |
| **3.** If the Policyholder or any providers had open claims pending with your previous carrier at the time of joining us, have there been any updates or developments in those case(s)? If yes, provide details in the Comments section. | ☐ Yes ☐ No |

## D. COMMENTS SECTION

**Please include section and question number.**

I declare the information provided herein is complete and accurate. Providing false or misleading information may result in limiting or voiding coverage. I acknowledge a duty to timely inform you of any changes to answers provided herein.

| Applicant Signature | Print Name | Date |
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