Louisiana Premier Physicians Program
Renewal Application

1. All questions must be answered. Please do not leave any blanks. If a question is not applicable, please write N/A.
2. Please indicate any desired changes in the appropriate area.
3. Application must be signed and dated by applicant in ink.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued. Additional Information may be required upon review of the application

Policy Number:	Renewal Date:
Name:	Retro Date:
Address:	Social Security #:
Phone:	Fax:
Email:	
Legal Entity Name (if any):	

Primary Practice:	Surgical Specialty:
Secondary Practice:	Surgical Specialty:

Education (List most recent first)

Certification Currently Held:		Institution	Dates of Attendance MM/YYYY to MM/YYYY		Date Graduated MM/YYYY	Cert or Degree Received
States in Which you Actively Practice						
State	License No.					

Has your certification/license in any state ever been (voluntary or otherwise) suspended, denied, revoked, restricted or limited in any way? If Yes explain.

No Yes

List any association / society / memberships related to your profession

During the previous 12 months, have any of the following occurred which have NOT previously been reported to the insurance company? If **"Yes",** provide details on a separate sheet of paper.		
A. Have you had a change in the status of your hospital privileges?	Yes	No
B. Has any governmental agency, including a state licensing board, ever taken action against either your physicians and/or narcotics license including suspension, revocation, probation, restriction, denial or other sanctions?	Yes	No
C. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency?	Yes	No
D. Have you been convicted of any criminal charges?	Yes	No

Loss History

Enter all claims (regardless of fault) or occurrences that may give rise to claims for the prior 5 years				Check here if none	See attached loss summary
Date of occurrence	Type / Description of occurrence or claim	Date of Claim	Amount Paid	Amount Reserved	Claim Status
					Open Closed
					Open Closed
					Open Closed
					Open Closed

Medical Professional Liability Limits — Limits

	Coverage	Limits	
☐	Individual Physician Coverage	Per Claim	$100,000
☐	Related Practitioner Coverage Certificate Aggregate	Certificate Aggregate	$300,000
☐	Entity Coverage	Master Policy Program Aggregate	$2,000,000
☐	Full Prior Acts Coverage		
☐	Limited Prior Acts Coverage As described below	Excess Limits (if any stated)	$ ________

Additional Provisions: This physician has qualified under ACT 817, the Louisiana Patients' Compensation Fund

Signature in full ____________________ Date

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize Louisiana Premier Physicians Program to release the information on this application and associated underwriting information.