Worldwide Facilities, LLC
Experience a World of Difference

PRACTICE SHIELD™ Renewal Application

APPLICANT INFORMATION

Name of Applicant: _____

Business Address: _____

City: _____ State: _____ Zip: _____

GENERAL INFORMATION

Number of Full-Time Physicians: _____ Number of Part-Time Physicians: _____

Number of Physicians who have departed over the most recent policy period: _____

Projected Annual Medical Billings: $_____ Past Annual Medical Billings: $_____

Over the past year have you experienced any of the following (if so please provide details on a separate sheet):

Been investigated or sanctioned by any local, state or federal government agency regarding the delivery of health care services or reimbursement?	**Yes** ☐	**No** ☐
Been investigated or sanctioned by any commercial payor regarding the delivery of health care services or reimbursement?	**Yes** ☐	**No** ☐
Been investigated or sanctioned by a state medical licensing board?	**Yes** ☐	**No** ☐
Refunded more than 10% of annual billings to public and/or private payors?	**Yes** ☐	**No** ☐
Lost any medical practice privileges?	**Yes** ☐	**No** ☐
Aware of any specific claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the proposed coverage?	**Yes** ☐	**No** ☐

IF A MATERIAL CHANGE OCCURS TO ANY OF THE ANSWERS PROVIDED ABOVE PRIOR TO THE INCEPTION OF ANY INSURANCE, THE APPLICANT MUST NOTIFY THE INSURER, AND AT THE SOLE DISCRETION OF THE INSURER, ANY OUTSTANDING QUOTATIONS MAY BE MODIFIED OR WITHDRAWN.

THE UNDERSIGNED AGREES THAT IN THE EVENT THIS APPLICATION CONTAINS MISREPRESENTATIONS OR FAILS TO STATE FACTS MATERIALLY AFFECTING THE RISK ASSUMED BY THE INSURER, ANY INSURANCE ISSUED SHALL BE VOID IN ITS ENTIRETY.

_____ _____

APPLICANT SIGNATURE DATE

_____

PRINT NAME and TITLE