SOUTH CAROLINA | JUA *the medical liability experts*

South Carolina Joint Underwriting Association
550 South Main Street, Suite 525, Greenville, SC 29601 *corporate office*
Lock Box 932523, Atlanta, GA 31193-2523 *payment remittance address*
864.240.5449 *main* 866.893.6270 *toll-free* 864.240.2750 *fax*
www.scjua.com

RENEWAL QUESTIONNAIRE FOR: CARDIOLOGY / PATHOLOGY / AND RADIOLOGY

Instructions:

1. Please answer all questions completely, leaving no blanks.
2. If more space is needed for responses, please use the Additional Comments Section of this questionnaire, or continue on a separate sheet with the question noted.
3. This questionnaire must be signed and dated by the insured.
4. Please submit this completed questionnaire, along with required attachments and any additional requested information to the JUA Underwriting Department via fax.
5. Please contact the SCJUA Underwriting Department if you have any questions.

Important: *80% of your practice must be in South Carolina. 20% may be across state lines. This exposure typically occurs in border areas such as Rock Hill / Charlotte, North Augusta / Augusta or Hilton Head / Savannah. All out of state exposure requires prior approval by the JUA.*

Important: *No action can be taken on this application until it is complete. "Complete" means all questions have been answered, with separate explanations provided as requested. It must be signed and dated in the appropriate places, and ALL required attachments must be included.*

A. INSURED IDENTIFICATION, PRACTICE LOCATION AND CONTACT INFORMATION:

1. Full Name of Insured:

   First: _____ Middle: _____ Last: _____

2. Insured Date of Birth: _____ / _____ / _____

3. Insured Billing Address:

   Street or PO Box: _____ Suite: _____

   City: _____ State: _____ ZIP: _____

4. Primary Practice Address (if different from billing address)

   Street or PO Box: _____ Suite: _____

   City: _____ State: _____ ZIP: _____

   Telephone: _____ Fax: _____

5. Business E-mail: _____ 5a. May we contact you by e-mail?: ☐ .Yes ☐ .No

(Please list other practice locations in the *Additional Comments Section*.)

B. POLICY AND UNDERWRITING INFORMATION:

6. JUA Policy #:_____ 6a. Policy Effective Date: _____ / _____ / _____ 6b. Policy Expiration Date: _____ / _____ / _____

7. What is your present specialty? _____ 7a. Percentage of Practice: _____%

8. What is your present sub-specialty? _____ 8a. Percentage of Practice: _____%

9. Are you American Board Certified? ☐ Yes ☐ No

   9a. If "**Yes**": Specialty Board _____

   9b. If "**Yes**": Date Certified: ____ / ____ / ____

   9c. If "**No**": are you board eligible? ☐ Yes ☐ No

   9d. If not board eligible, provide explanation in the *Additional Comments Section*.

10. Please check any of the following that apply to your practice:

- ☐ Angiography
- ☐ Angioplasty
  - ☐ Diagnostic
  - ☐ Interventional
- ☐ Arteriography
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Biopsy
  - ☐ Bone Biopsy
  - ☐ Breast Biopsy
  - ☐ Kidney Biopsy
  - ☐ Lung Biopsy
  - ☐ Prostate Biopsy
  - ☐ Other Biopsy: _____
- ☐ Cardiac – major surgery
- ☐ Cardiovascular disease – major surgery
- ☐ Chelation therapy **(Excluded under JUA policy)**
- ☐ Echocardiography
- ☐ Electrocardiography
- ☐ ERCP / EGD / ERC
- ☐ Kyphoplasty
- ☐ Left Heart Catheterization
- ☐ Lithotripsy
- ☐ Mammography
- ☐ Myelography
- ☐ Nuclear Medicine
- ☐ Permanent Pacemaker
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye
- ☐ Stent Placement
- ☐ Vertebroplasty

☐ **Other Interventional Procedures:**

_____
_____
_____

☐ **Other Diagnostic Procedures:**

_____
_____
_____

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11. Do you perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as the medium for rendering medical services, medical opinions or medical advice (telemedicine or internet medicine)? ☐ Yes ☐ No

    11a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No

    11b. If "**Yes**", provide details in the *Additional Comments Section,* and attach verification of coverage.

12. Do you read, interpret or diagnose films, slides or specimens taken from patients who are receiving medical treatment in other states? ☐ Yes ☐ No

    12a. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No

    12b. If "**Yes**", provide details in the *Additional Comments Section,* and attach verification of coverage.

13. If you answered "**Yes**" to questions 11 and 12 please complete the following:

State	License Number	# of Patient Interactions	# of Separate Procedures

(If additional space is needed, please provide details in the Additional Comments Section)

14. Do you own or operate any type of medical practice that performs consultations or readings for patients who are located outside the state of South Carolina? ☐ Yes ☐ No

14a. If "**Yes**", please provide further details in the *Additional Comments Section*.

14b. If "**Yes**", do you have coverage under a separate policy for this exposure? ☐ Yes ☐ No

14c. If "**Yes**", please attach a copy of your policy.

C. MEDICAL TRAINING:

15. Name of medical school(s) attended: _____

15a. Date graduated: _____ / _____ / _____

16. Name of hospital where residency served: _____

16a. Date residency completed: _____ / _____ / _____

17. Name of hospital where fellowship served: _____

17a. Date fellowship completed: _____ / _____ / _____

D. ADDITIONAL COMMENTS:

Section	Question #	Explanation/Comments
_____	_____	_____
		_____
		_____
_____	_____	_____
		_____
		_____

E. AGREEMENT AND AUTHORIZATION:

I hereby warrant that the information contained in this questionnaire is accurate and complete to the best of my knowledge. I understand that this questionnaire shall be considered a part of the terms and conditions of my policy with the South Carolina Medical Malpractice Liability Insurance Joint Underwriting Association and that my JUA Policy is issued in reliance upon the truth of such representations and that my policy and my questionnaire therefore embody all agreements existing between myself and the JUA or any of its brokers relating to this insurance.

_____
Name of Insured (Please Print)

_____ _____ / _____ / _____
Signature of Insured (Required) Date