

Filing at a Glance

Company: The Medical Assurance Company, Inc.

Product Name: Health Care Professional SERFF Tr Num: PCWA-125232818 State: Arkansas

Liability Policy

TOI: 11.1 Medical Malpractice - Claims Made SERFF Status: Closed State Tr Num: AR-PC-07-025503

Only

Sub-TOI: 11.1023 Physicians & Surgeons Co Tr Num: AR-APP-0807

State Status:

Filing Type: Form

Co Status:

Reviewer(s): Betty Montesi, Edith Roberts, Llyweyia Rawlins

Author: LaQuita Goodwin

Disposition Date: 07-19-2007

Date Submitted: 07-17-2007

Disposition Status: Approved

Effective Date Requested (New): 09-01-2007

Effective Date (New):

Effective Date Requested (Renewal): 09-01-2007

Effective Date (Renewal):

General Information

Project Name: P & S Renewal Application

Status of Filing in Domicile: Authorized

Project Number:

Domicile Status Comments: None

Reference Organization: None

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 07-19-2007

State Status Changed: 07-19-2007

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please find attached PRA-A-030 01 07, Medical Professional Liability Renewal Application, to be used for physicians and surgeons and will replace the one that is currently on file with your department. I respectfully request the effective date of August 1, 2007 for this filing submission.

I believe you will find everything in order. If you have any questions, please contact me.

LaQuita B. Goodwin, Compliance Specialist

Company and Contact

Filing Contact Information

LaQuita Goodwin, Compliance Specialist

lgoodwin@proassurance.com

100 Brookwood Place

(205) 877-4426 [Phone]

Birmingham, AL 35209

(205) 414-2887[FAX]

Filing Company Information

Created by SERFF on 07-19-2007 03:06 PM

The Medical Assurance Company, Inc.
100 Brookwood Place

CoCode: 33391
Group Code: 2698

State of Domicile: Alabama
Company Type: Property &
Casualty

Birmingham, AL 35209
(205) 877-4426 ext. [Phone]

Group Name: ProAssurance
FEIN Number: 63-0720042

State ID Number: 03

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
001219	\$50.00	07-17-2007

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	07-19-2007	07-19-2007

Disposition

Disposition Date: 07-19-2007

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Form	Medical Professional Liability Renewal Application	Approved	Yes

Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Medical Professional Liability Renewal Application	PRA-A-030	01 07	Application/New Binder/Enrollment		0.00	PRA-A-030 - P & S Renewal App.PDF

Medical Professional Liability Renewal Application

Company Address

Policy #: _____ Expiration Date: _____
Agent/Agency Name: _____
Agent/Agency License#: _____

Important: Please complete and return this form **with a copy of your updated curriculum vitae and a copy of your current business letterhead** in the envelope provided. Your prompt, accurate reply will avoid any unnecessary delay of your policy's renewal. Please type or print legibly. Also, please verify that the pre-filled information below is correct. If it is not, please mark through the incorrect information and make the necessary changes/corrections. Thank you for your cooperation.

1. Personal Information

Name: _____ Social Security Number: _____

Date of Birth: _____ Gender: Male Female Place of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Practice Specialty: _____ NPI: _____ Client ID: _____

Medical License Number(s):	State	License Number	% of Practice
_____	_____	_____	_____
_____	_____	_____	_____

2. Office Information

Principal Office Street Address: _____

City: _____ Practice County: _____ State: _____ Zip: _____

Professional office located within the city limits of: _____

Office Phone: _____ Office Fax: _____ E-mail: _____

Contact Name and Title: _____

Preferred mailing address: Office Home Other, specify: _____

Preferred billing address: Office Home Other, specify: _____

3. Practice Information

A. Do you perform any surgical procedures utilizing nurse anesthetists for the administration of conscious sedation, general or regional anesthesia who are not directed by or responsible to an anesthesiologist? Yes No
If yes, indicate percent of total surgery involved: _____ %, **OR** average number of cases per month: _____

B. Do you perform deliveries? Yes No

i. If yes, indicate average number of deliveries per month: _____

ii. Percentage of high risk deliveries: _____ %

iii. Average number of VBAC deliveries per year: _____

iv. Do you have privileges to perform C-sections at each hospital where you provide obstetrical care? Yes No

v. Do you utilize the approved ACOG prenatal form or an acceptable substitute?..... Yes No

C. How many patients do you see on average per week? _____

D. How many hours do you practice per week? _____ (Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, paramedical supervision and on-call hours involving patient contact, whether direct or by telephone.)

E. If you are presently in a residency or fellowship program or completed such a program within the past twelve months, please provide the month/year of completion: _____

Name _____ Policy # _____ Expiring Date _____

F. Is your practice less than full time? Yes No

If yes, please check any of the following applicable reason(s):

- Semi-retirement Disability Pregnancy or dependent care Employer-provided insurance
 Teaching role insured elsewhere Practice in bordering state insured elsewhere

i. List the name and address of each location and employer(s), if applicable, for which our coverage is needed. Additional space is available on page 7 or you may attach separate sheet.

Location 1 _____

Location 2 _____

Location 3 _____

ii. Indicate total number of hours per week and per month devoted to the following activities at each location described above:

PRACTICE ACTIVITIES	LOCATION 1		LOCATION 2		LOCATION 3	
	Hrs/wk	Hrs/mo	Hrs/wk	Hrs/mo	Hrs/wk	Hrs/mo
Total number of hours the practice is open						
Your actual patient care, including hospital rounds						
Your time on-call for urgent care/emergency room						
Your time spent at a lab, or other medical facility						
Your administrative tasks/duties related to your practice						
Your consult time with other health care providers						
Your surgeries and assisting in surgeries						
Your house calls and/or nursing home visits						
Your other patient care related activities						

iii. Specialty practiced at the above location(s): _____

iv. List the name and address of all other locations of employment for which coverage with the Company is not needed. Additional space is available on page 7 or you may attach separate sheet.

v. Please indicate:

a. Number of hours worked per week at the above location: _____

b. Specialty practiced at the above location: _____

c. Insurance carrier providing coverage at the above location: _____

G. Have you ever failed a medical licensing examination? Yes No

If yes, specify the section(s) and indicate the number of times for each section. _____

H. Are you board certified? Yes No

i. If yes, please indicate which board and specialty/subspecialty:

American Board of _____

American Osteopathic Board of _____

ii. If not boarded, when do you plan to take your Boards? _____

iii. Are you required to recertify? Yes No

If yes, please provide date of recertification: _____

iv. Have you ever failed a Board certification examination? Yes No

If yes, how many times? _____

I. Please indicate below, your current certification(s):

- ACLS Certified BCLS Certified ATLS Certified PALS Certified CPR Certified Not Certified

J. List the names of others in your office who are currently certified and specify ACLS, BCLS, ATLS, PALS or CPR:

Full name of Employee _____ Type of Certification _____

K. Do you provide services to any nursing home or similar facility? Yes No

If yes, how many hours per week do these services constitute? _____

Name _____ Policy # _____ Expiring Date _____

- L. Do you serve as a Medical Director? Yes No
- i. If yes, please list the name of the facility(s): _____
- ii. Is professional liability insurance provided by the facility for your duties as Medical Director? Yes No
- M. Do you provide services to any local, state or federal correctional facility, jail or prison? Yes No
- i. If yes, how many hours per week do these services constitute? _____
- ii. Please list the name of the facility(s): _____
- N. Are you a sports team physician for any high school, college, university, semi-professional or professional team? Yes No
- If yes, please explain: _____
- O. Do you, or any partnership or corporation of which you are a member or shareholder, own or operate a surgi-center, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice? If yes, please describe on page 7. Yes No
- P. Do you perform medical or surgical procedures at a surgi-center, office-based surgical suite or similar facility?..... Yes No
- Q. Do you have a website for your practice? Yes No
- If yes, please indicate the website address: _____

4. Out of State Exposure

- A. 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
- i. If yes, please indicate all states in which the patients being treated reside: _____
- What percentage of your total practice does this activity constitute? _____%
- B. Do you read, interpret or diagnose films, slides or specimens taken from patients who reside in states other than your indicated state of practice? Yes No
- If yes, please list all states in which the patients reside: _____

5. Premium Classification – Please check any of the following that apply to your practice:

<input type="checkbox"/> Elective Abortions <input type="checkbox"/> Prescribe Preven, or related derivatives <input type="checkbox"/> Prescribe Mifepristone, or related derivatives <input type="checkbox"/> Prescribe Mifepristone, or related derivatives in combination with Cytotec <input type="checkbox"/> Acupuncture <input type="checkbox"/> Anesthesia <input type="checkbox"/> Spinal <input type="checkbox"/> Caudal <input type="checkbox"/> General <input type="checkbox"/> Local <input type="checkbox"/> Other _____ <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arteriography <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Assist in major surgery <input type="checkbox"/> On own patients <input type="checkbox"/> On patients of others <input type="checkbox"/> Bariatric Surgery <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Implants <input type="checkbox"/> Cosmetic _____% of practice <input type="checkbox"/> Reconstructive _____% of practice <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Cardiac – major surgery <input type="checkbox"/> Cardiovascular Disease – major surgery <input type="checkbox"/> Chelation therapy (for other than heavy metal poisoning) <input type="checkbox"/> Chemonucleolysis <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Cholecystectomy, laparoscopic <input type="checkbox"/> Circumcision (other than newborns) <input type="checkbox"/> Colon and Rectal-major surgery <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Colposcopy <input type="checkbox"/> Cryosurgery (other than external lesions) <input type="checkbox"/> Cosmetic/Dermatologic Procedures <input type="checkbox"/> Botox injections <input type="checkbox"/> Chemical peels <input type="checkbox"/> Chemabrasion <input type="checkbox"/> Collagen Injections <input type="checkbox"/> Cryosurgery (superficial only) <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Eye Liner Pigmentation <input type="checkbox"/> Fat Transfer <input type="checkbox"/> Hair Transplants <input type="checkbox"/> Laser Hair Removal <input type="checkbox"/> Laser Skin Resurfacing <input type="checkbox"/> Lipodissolve <input type="checkbox"/> Mesotherapy <input type="checkbox"/> Microdermabrasion <input type="checkbox"/> Silicone Injections <input type="checkbox"/> Tumescant Liposuction <input type="checkbox"/> Other _____ 	<input type="checkbox"/> D&C <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Echocardiography <input type="checkbox"/> Electrocardiography <input type="checkbox"/> Emergency Medicine <input type="checkbox"/> Endoscopic Laser Therapy <input type="checkbox"/> Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy <input type="checkbox"/> ERCP / EGD / ERC <input type="checkbox"/> Exchange Transfusions in Newborns <input type="checkbox"/> How many per year? _____ <input type="checkbox"/> Fertility Treatment <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture Reductions <input type="checkbox"/> Open <input type="checkbox"/> Closed <input type="checkbox"/> Gastroscopy <input type="checkbox"/> General – major surgery <input type="checkbox"/> Gynecology – major surgery <input type="checkbox"/> Hand – major surgery <input type="checkbox"/> Head and Neck – major surgery <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia Repair <input type="checkbox"/> Hip Nailings <input type="checkbox"/> Hyperbaric Medicine <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Hysteroscopy <input type="checkbox"/> IMES _____% of change <input type="checkbox"/> Intensive Care for newborns within a Tertiary Care Unit <input type="checkbox"/> Laminectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Laryngology – major surgery <input type="checkbox"/> Laser Surgery <input type="checkbox"/> Left Heart Catheterization <input type="checkbox"/> Liposuction <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Lumbar Fusion <input type="checkbox"/> Mammography <input type="checkbox"/> Myelography <input type="checkbox"/> Myomectomy <input type="checkbox"/> Neonatology <input type="checkbox"/> Neurology – major surgery <input type="checkbox"/> Norplant Insertion/Extraction <input type="checkbox"/> Obstetrics/Gynecology – major surgery <input type="checkbox"/> Normal Deliveries <input type="checkbox"/> C-Sections <input type="checkbox"/> VBAC <input type="checkbox"/> By Induction? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Induction agent: _____ <input type="checkbox"/> Ophthalmology – major surgery <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Orthopedic – major surgery <input type="checkbox"/> Spines <input type="checkbox"/> No Spines <input type="checkbox"/> Osteopathic Manipulative Medicine <input type="checkbox"/> Otolaryngology – major surgery <input type="checkbox"/> Otorhinolaryngology – major surgery <input type="checkbox"/> Including elective cosmetic procedures <input type="checkbox"/> Not including elective cosmetic procedures 	<input type="checkbox"/> Pain management <input type="checkbox"/> Medication Only <input type="checkbox"/> Facet Blocks <input type="checkbox"/> Selective Nerve Root Blocks <input type="checkbox"/> Rhizotomy <input type="checkbox"/> Spinal Injections <input type="checkbox"/> Dorsal Root Gangliotomies <input type="checkbox"/> Thoracic Sympathectomies <input type="checkbox"/> Spinal Cord Stimulators <input type="checkbox"/> Implantation/Removal of Drug Infused Pumps <input type="checkbox"/> Sphenopalatine Lesioning <input type="checkbox"/> Trigeminal Lesioning <input type="checkbox"/> Cordotomies <input type="checkbox"/> Other _____ <input type="checkbox"/> Pedicle Screws for Spinal Surgery <input type="checkbox"/> Percutaneous Vertebroplasty <input type="checkbox"/> Permanent Pacemaker <input type="checkbox"/> Plastic – major surgery <input type="checkbox"/> Polypectomy <input type="checkbox"/> Prenatal Care <input type="checkbox"/> Prolotherapy <input type="checkbox"/> Radiation/X-ray Therapy <input type="checkbox"/> Radiopaque Dye <input type="checkbox"/> Rhinology – major surgery <input type="checkbox"/> Roux-en-y <input type="checkbox"/> Sclerotherapy <input type="checkbox"/> Scoliosis Surgery <input type="checkbox"/> Shock Therapy <input type="checkbox"/> Thoracic Surgery _____% <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy/Adenoidectomy <input type="checkbox"/> Transgender Surgery and/or Hormonal Gender Conversion <input type="checkbox"/> Trigger Point Injections <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Urology – major surgery <input type="checkbox"/> Vascular Surgery _____% <input type="checkbox"/> Peripheral Vascular Surgery <input type="checkbox"/> Vasectomy <input type="checkbox"/> Weight Control _____% <input type="checkbox"/> Bariatric Bypass <input type="checkbox"/> Gastric Bubble <input type="checkbox"/> Gastric Stapling <input type="checkbox"/> Other <input type="checkbox"/> Medications Prescribed (please list): <input type="checkbox"/> None of the above procedures apply to my practice. (Please Initial) _____ <input type="checkbox"/> Other procedures (please list):
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If you did NOT check Emergency Medicine above, do you or will you staff an emergency department? Yes No

If yes, is this emergency department work required to maintain hospital staff privileges? Yes No

Do you qualify for a senior staff exemption from emergency call coverage? Yes No

How many hours per month do you practice in the emergency department? _____

6. Group Membership

- A. Please give us the name and Federal Tax ID Number of any newly formed or not previously reported solo or professional group practice entity (e.g., P.A.,P.C.,L.L.C., L.L.P., Inc., etc.) related to your practice:

- B. Do you desire coverage for this practice entity?..... Yes No
- C. If you have a group affiliation, give the name and Federal Tax ID Number of the group and check the box (or boxes) that correctly identify your affiliation. If other, please explain on page 7 or a separate sheet.
Name of Group: _____
I am a: sole owner partner shareholder employee independent contractor other _____
- D. Have you or your group practice employed any new physicians or other medical professionals that you have not previously reported? Yes No
If yes, please describe and provide proof of current liability coverage. _____
- E. Please give us the name and Federal Tax ID Number of any practice entity which has dissolved since the date of your last renewal and the effective date of the dissolution: _____
- F. At this time how many physicians are affiliated with your group organization? _____
Does the Company insure all of them? Yes No
If no, how many are not insured by the Company? _____
Please list: _____
NOTE: You must provide proof of current professional liability coverage for all physicians insured elsewhere.
- G. Please tell us if any practice entity of which we were previously aware has had a name change: _____
- H. Do you rent, lease or share office space with any physician or surgeon not listed above? Yes No
- I. Are you practicing under a d/b/a (doing business as) name? Yes No
If yes, please list all d/b/a names including the effective date of each: _____

7. Personal History – If you answer yes to any of the following questions, provide complete details on page 7 or a separate sheet.

- A. Have any of the following ever been denied, investigated, suspended, restricted, placed on probation, revoked or voluntarily surrendered for any reason:
 - i. State Medical License? Yes No
 - ii. Hospital Privileges? Yes No
 - iii. License to prescribe or dispense medicine? Yes No
- B. Have your Medicare/Medicaid billing procedures ever been investigated? Yes No
- C. Have you ever:
 - i. Undergone psychiatric treatment? Yes No
 - ii. Been evaluated for, diagnosed with, treated or recommended for treatment of alcohol, narcotics or any other substance abuse, sexual addiction (including but not limited to misconduct, harassment or boundary violations) or mental illness? Yes No
 - iii. Been diagnosed with any chronic illness or physical defect? Yes No
 - iv. Been convicted of, pled guilty to, or entered into a plea agreement for a violation of any law or ordinance other than minor traffic offenses but including "driving under the influence"? Yes No
 - v. Had a patient or a patient representative complain or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical Examiners or other medical review committee? .Yes No
 - vi. Appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state Board of Medical Examiners, licensing Board or other medical review committee? Yes No
- D. Has any claim or suit for alleged malpractice been made against you and reported to another insurance carrier or hospital self-insured trust since you became insured by the Company? Yes No

Name _____ Policy # _____ Expiring Date _____

E. Has any claim or suit for alleged malpractice made against you and reported to another insurance carrier or hospital self-insured trust resulted in payment by you or on your behalf since you became insured by the Company? Yes No

8. Professional Employees

A. List all current allied health professionals employed by you or your organization, for the following categories: Cytotechnologist, EMT – Paramedic, Nurse Midwife, Nurse Practitioner, Occupational Therapist, Perfusionist, Pharmacist, Physical Therapist, Physician Assistant w/o surgery, Psychologist, Respiratory Therapist, Social Worker, Surgical Assistant/ PA with surgery, Technician, Nurse Anesthetist, or Optometrist.

Employee Name	DOB	SSN	Specialty	Date
				Begin/Terminate

If you desire coverage from the Company for any paramedicals not currently insured by us, please contact your agent or the Marketing Department for applications. NOTE: You must provide proof of current liability coverage for each paramedical insured elsewhere.

B. Do any of the persons listed above see patients on the initial visit who are not seen by you or any member of your group at the same visit? Yes No

C. Do you or any member of your group supervise or are responsible (e.g., a collaborative agreement with a nurse practitioner) for patient care rendered to your patients by anyone other than yourself? Yes No

i. Are any of these persons involved in patient care/contact at facilities where you are not physically present? These include but are not limited to nursing homes, correctional facilities, extended care facilities and satellite offices. Yes No

ii. Is a supervisory or collaborative agreement on file with the State Board of Medicine and/or Nursing for each paramedical? Yes No

iii. Is the agreement on file in your office? Yes No

iv. Do you review the medical records generated by paramedicals for your patients?
If yes, indicate: _____% or #____ charts reviewed every day / week / month / quarter. (circle one)

D. Do you or any member of your group currently supervise any paramedical who is not in your employ? ... Yes No

I agree to notify the Company of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to the following:

- A. A change in specialty or medical procedures performed;
- B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
- C. Investigation, restriction, suspension or surrender of any state medical license, DEA license or hospital privileges;
- D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing;
- E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

Failure to notify the Company of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

GENERAL FRAUD WARNING – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Name _____ Policy # _____ Expiring Date _____

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and that I have not willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof:

Date: _____ **Signature of Insured Physician:** _____

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Satisfied -Name:	Uniform Transmittal Document- Property & Casualty	Review Status: Approved	07-19-2007
Comments:			
Attachment:	P&S renewal app eff 9-1-07.PDF		

Property & Casualty Transmittal Document

1. Reserved for Insurance Dept. Use Only	2. Insurance Department Use only a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: PCWA-125232818 h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

3. Group Name	Group NAIC #
ProAssurance Group	2698

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
The Medical Assurance Company, Inc.	Alabama	33391	63-0720042	

5. Company Tracking Number	AR-APP-0807
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Contact Info of Filer(s) or Corporate Officer(s) [include toll-free number]

6. Name and address	Title	Telephone #s	FAX #	e-mail
LaQuita B. Goodwin 100 Brookwood Place Birmingham, AL 35209	Compliance Specialist	800-282-6242 Ext. 4426	205-414-2887	lgoodwin@proassurance.com

7. Signature of authorized filer	
8. Please print name of authorized filer	LaQuita B. Goodwin

Filing information (see General Instructions for descriptions of these fields)

9. Type of Insurance (TOI)	11 - Medical Malpractice
10. Sub-Type of Insurance (Sub-TOI)	Physicians and Surgeons
11. State Specific Product code(s)(if applicable)[See State Specific Requirements]	
12. Company Program Title (Marketing title)	Health Care Professional Liability
13. Filing Type	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
14. Effective Date(s) Requested	New: 8/1/2007 Renewal: 8/1/2007
15. Reference Filing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
16. Reference Organization (if applicable)	
17. Reference Organization # & Title	
18. Company's Date of Filing	
19. Status of filing in domicile	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input checked="" type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

Property & Casualty Transmittal Document—

20.	This filing transmittal is part of Company Tracking #	AR-APP-0807
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21.	Filing Description [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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Please find attached PRA-A-030 01 07, Medical Professional Liability Renewal Application, to be used for physicians and surgeons and will replace the one that is currently on file with your department. I respectfully request the effective date of August 1, 2007 for this filing submission.

I believe you will find this submission in order. If not, contact me at (800) 282-6242, ext. 4426 or e-mail me at lgoodwin@proassurance.com.

22.	Filing Fees (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
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Check #: 001219
Amount: \$50.00

Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.

*****Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

1.	This filing transmittal is part of Company Tracking #	AR-APP-0807
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2.	This filing corresponds to rate/rule filing number (Company tracking number of rate/rule filing, if applicable)	
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3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	Medical Professional Liability Renewal Application	PRA-A-030 01 07	[] New [<input checked="" type="checkbox"/>] Replacement [] Withdrawn	PA-A-030 01 02 AR	
02			[] New [] Replacement [] Withdrawn		
03			[] New [] Replacement [] Withdrawn		
04			[] New [] Replacement [] Withdrawn		
05			[] New [] Replacement [] Withdrawn		
06			[] New [] Replacement [] Withdrawn		
07			[] New [] Replacement [] Withdrawn		
08			[] New [] Replacement [] Withdrawn		
09			[] New [] Replacement [] Withdrawn		
10			[] New [] Replacement [] Withdrawn		

PC FFS-1