Florida Affiliated Academic Healthcare Providers
A Reciprocal Risk Retention Group
Florida Board of Governors Self-Insurance Programs

GUIDE: PROFESSIONAL LIABILITY COVERAGE QUESTIONNAIRE

Professional liability coverage provided by the Florida Affiliated Academic Healthcare Providers - A Reciprocal Risk Retention Group (AAHP-RRG) and created by the Florida Board of Governors self-insurance programs serving University of Florida (UF), Florida State University (FSU), University of Central Florida (UCF), Florida Atlantic University (FAU), and Florida International University (FIU) for healthcare providers who meet rigorous underwriting criteria.

The questionnaire determines eligibility for affiliated academic healthcare providers who are **sponsored by and support** the healthcare missions of UF, FSU, UCF, FAU, or FIU. Once started, you must fully complete and submit the online questionnaire; you cannot save and return at a later time. As such, we recommend you review the selected questions below and collect and/or prepare the necessary supporting documentation before starting. When ready, please visit the following webpage to complete our online questionnaire: **https://flbog.sip.ufl.edu/fl-aahp-rrg-online-application/.**

- **Requested Policy Start Date** (To allow time for underwriting and processing, the start date must be at least 30 days after the date this questionnaire is submitted to AAHP-RRG Insurance Services.)
- **Select Your University Sponsor**
  - ○ University of Florida
  - ○ Florida State University
  - ○ University of Central Florida
  - ○ Florida Atlantic University
  - ○ Florida International University
- **List your University Sponsor Contact Name, Title, and Email Address or Phone # (**AAHP-RRG underwriting must confirm sponsorship before processing can proceed. To avoid delays, please be sure to provide all necessary contact information.)
- **Florida Board License #** (Must include the prefix. E.g., ME, OD, PA)
- **Select the county where the majority of your patient care will be provided**.
  - ○ Dade & Broward
  - ○ Palm Beach
  - ○ Martin & St. Lucie
  - ○ Clay, Duval, & St. Johns
  - ○ Remainder of State
  - ○ Out of Florida
- **List the names and address of the facilities where you will be providing clinical services.**
- **If providing on-site clinical services outside the state of Florida, need to list the states where such services will be provided and the % of time performing at these locations.**
- **If providing telemedicine, need to list the states where such services will be provided and the % of time performing at these locations.**

- **Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntary surrendered or any other way limited, or has it been or is it currently under investigation? If YES, please attach a detailed written explanation.**

- **Have you ever been or are you currently under a consent order? If YES, attach a copy of the consent order and its termination if applicable.**

- **Have your hospital staff privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered or in any other way restricted, or have they been or are they currently under investigation? If YES, please attach a detailed written explanation.**

- **Has any insurance company ever cancelled, declined to issue or refuse to renew your professional liability insurance, or offered such insurance only on special terms, or have you been notified of such intent? If YES, please attach a copy of the cancellation notice or letter if applicable.**

- **Have any claims been asserted or civil actions filed against you alleging errors or missions or against your employer or any other entity responsible for or alleged to be responsible for your patient care activities, or have you been notified that such an action will be filed? If YES, please complete a Claim Supplement form for each claim and civil action.**

- **Have any judgments been made against you, or any out-of-court settlements been made on your behalf, from an event alleging medical errors or omissions that were not addressed above? If YES, please fully complete a Claim Supplement form for each claim.**

- **Have you ever been convicted of a criminal offense or are or are you under investigation for criminal offense? If YES, please attach a detailed written explanation.**

- **Have you been treated for alcoholism or drug addiction within the last five years? If YES, please attach a detailed written explanation including dates and locations of all treatments and the names of your supervising and monitoring physicians.**

- **Have you incurred or become aware of having a condition that impairs your ability to practice your specialty? If YES, please attach a detailed written explanation**.

You will need to upload the following at the time of submission:

- **a copy of your Curriculum Vitae** (note: If you have employment gaps greater than 3 months, please include an explanation with your submission), and
- a current **National Practitioner Data Bank report**, and
- a **10-year Claim History report** from your insurance carrier(s).
- Explanations and claim forms, as required, for specific YES responses above. Underwriting - Claim Supplement Forms can be found on our website (SIPSAAHP.org under the FL AAHP-RRG tab's "Coverage Questionnaire" subtab.

Applicants will receive **notification of their application status within 7 business days of submission**. If Professional Liability coverage is offered, a premium amount will be provided and, **if accepted by applicant, payment to FL AAHP-RRG will be required at least 3 business days prior to the policy start date.**