

1. Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

2. Shared practice address: \_\_\_\_\_

3. Please provide the names of all partners, associates and physician employees:

\_\_\_\_\_  
\_\_\_\_\_

4. Please provide the names of their professional liability insurance carriers:

\_\_\_\_\_  
\_\_\_\_\_

5. Does the public view you as associates or partners?  Yes  No

6. Do you have a trade name?  Yes  No

If yes,

a. Please list the name: \_\_\_\_\_

b. Is it a legal entity?  Yes  No

What type:

- |   |  |
|---|--|
| <input type="checkbox"/> Professional Service Corporation | <input type="checkbox"/> Other Corporation       |
| <input type="checkbox"/> Partnership                      | <input type="checkbox"/> Other (please describe) |

**Please provide a copy of the articles of Incorporation if applicable.**

c. Who are the owners?: \_\_\_\_\_

\_\_\_\_\_

7. Do you have a common waiting room or entrance?  Yes  No

8. Do you share office space?  Yes  No  
If yes, does each physician have separate areas and or  
examining rooms?  Yes  No

9. Do you have a lease?  Yes  No

Whose name appears on the lease? \_\_\_\_\_

Are there formal agreements to sublet space?  Yes  No

10. Do you share employees?  Yes  No

Which employees? \_\_\_\_\_

Who employs the staff? \_\_\_\_\_

What are your arrangements to remunerate the shared employees?

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11. Do you each have your own stationery?  Yes  No  
PLEASE ENCLOSE A SAMPLE.
12. Do you have a common billing system?  Yes  No  
If yes, is it clear from the statement which physician  Yes  No  
rendered medical services?
13. Do you have a joint bank account?  Yes  No
14. Do you file patient records together?  Yes  No
15. Do you treat each other's patients other than during after  Yes  No  
hours calls?

If yes, please describe the circumstances under which you might do so:

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Name of person completing this questionnaire:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

**Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**

**Please return to:**

Seattle Office:  
Physicians Insurance A Mutual Company  
Attn: Underwriting Department  
PO Box 91220  
Seattle, WA 98111  
(206) 343-7300 (800) 962-1399  
F (206) 343-7100

Eastern Regional Office:  
Physicians Insurance A Mutual Company  
Attn: Underwriting Department  
421 W. Riverside Avenue, Suite 1200  
Spokane, WA 99201  
(509) 456-5868 (800) 962-1398  
F (509) 456-0821

