TDC Specialty Underwriters
TDCGROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Neurosurgery Supplemental Questionnaire

THIS QUESTIONNAIRE IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS QUESTIONNAIRE.

Applicant Name:

Expiring Policy Number (if applicable):

1. What is your Subspecialty?

	As Surgeon		As Assistant	
	Yes	No	Yes	No
(a) Trauma	☐	☐	☐	☐
(b) Cerebrovascular	☐	☐	☐	☐
(c) Stereotactic & Functional	☐	☐	☐	☐
(d) Pain	☐	☐	☐	☐
(e) Spine	☐	☐	☐	☐
(f) Pediatric	☐	☐	☐	☐
(g) Peripheral Nerves	☐	☐	☐	☐
(h) Tumors	☐	☐	☐	☐
(i) Endovascular	☐	☐	☐	☐
(j) Epilepsy	☐	☐	☐	☐
(k) Skull Base	☐	☐	☐	☐
(l) Other (please specify):	☐	☐	☐	☐

2. Indicate below any other procedures that you perform which are commonly considered to be surgery:

	As Surgeon		As Assistant	
	Yes	No	Yes	No
(a) _____	☐	☐	☐	☐
(b) _____	☐	☐	☐	☐
(c) _____	☐	☐	☐	☐
(d) _____	☐	☐	☐	☐
(e) _____	☐	☐	☐	☐

3. If you perform spinal surgery, describe special training or experience:

Please answer "Yes" or "No" as to whether you perform or desire to perform the following procedures. Additionally, please include the estimated number of times you have performed each procedure in the past 12 months as well as how many times you anticipate performing each procedure in the next 12 months.

	As Surgeon				As Assistant			
	Yes	No	# in past 12 mos	# in next 12 mos	Yes	No	# in past 12 mos	# in next 12 mos
Acoustic Tumor Removal	☐	☐			☐	☐		
Aneurysm Clipping	☐	☐			☐	☐		
Arteriovenous Malformation Removal	☐	☐			☐	☐		
Anterior Cervical Discectomy	☐	☐			☐	☐		
Brachial Plexus Exploration	☐	☐			☐	☐		
Brain Tumor (Intrinsic) Removal	☐	☐			☐	☐		
Carotid Endarterectomy	☐	☐			☐	☐		
Carpal Tunnel Release	☐	☐			☐	☐		
Cervical Discectomy	☐	☐			☐	☐		
Cervical Stabilization Posterior	☐	☐			☐	☐		
Craniofacial Reconstruction	☐	☐			☐	☐		
Craniosynostectomy	☐	☐			☐	☐		
Craniotomy	☐	☐			☐	☐		
Deep Brain Stimulator	☐	☐			☐	☐		
Epidural Hematoma Evacuation	☐	☐			☐	☐		
Foraminotomy – Cervical	☐	☐			☐	☐		
Foraminotomy – Lumbar	☐	☐			☐	☐		
Gamma Knife	☐	☐			☐	☐		
Glioma Resection	☐	☐			☐	☐		
Joint Implants	☐	☐			☐	☐		
Laminectomy – Cervical	☐	☐			☐	☐		
Laminectomy – Lumbar	☐	☐			☐	☐		
Lumbar Fusion	☐	☐			☐	☐		
Lumbar Discectomy	☐	☐			☐	☐		
Lumbar Puncture	☐	☐			☐	☐		
Lumboperitoneal Shunt Insertion	☐	☐			☐	☐		
Meningioma Removal	☐	☐			☐	☐		
Microvascular Decompression	☐	☐			☐	☐		
Morphine Pump Insertion	☐	☐			☐	☐		
Myelomeningocele Closure	☐	☐			☐	☐		
Neck Exposure	☐	☐			☐	☐		
Neuro Implant Surgery for Pain	☐	☐			☐	☐		
Pallidotomy	☐	☐			☐	☐		
Pedicle Screws – Insertion	☐	☐			☐	☐		
Pedicle Screws – Removal	☐	☐			☐	☐		
Posterior Fossa Decompression	☐	☐			☐	☐		
Prolotherapy	☐	☐			☐	☐		
Scoliosis Surgery	☐	☐			☐	☐		
Spinal Fusion	☐	☐			☐	☐		
Stereotactic Neurosurgery	☐	☐			☐	☐		
Subdural Hematoma Evacuation – Acute	☐	☐			☐	☐		
Subdural Hematoma Evacuation – Chronic	☐	☐			☐	☐		
Suboccipital Craniectomy	☐	☐			☐	☐		
Sural Nerve Biopsy	☐	☐			☐	☐		
Temporal Lobectomy	☐	☐			☐	☐		
Transsphenoidal Craniotomy	☐	☐			☐	☐		

	As Surgeon				As Assistant			
	Yes	No	# in past 12 Mo's	# in next 12 mo's	Yes	No	# in past 12 Mo's	# in next 12 mo's
Vagal Nerve Stimulator Insertion	☐	☐			☐	☐		
Ventriculoperitoneal Shunt Insertion	☐	☐			☐	☐		
Ventriculoperitoneal Shunt Revision	☐	☐			☐	☐		
Vertebroplasty	☐	☐			☐	☐		

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this questionnaire are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this questionnaire.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	