APPLICATION for: **Miscellaneous Medical Malpractice Insurance**

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

1. Name of Applicant: _____

2. Physical Address: _____ Phone: _____

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

   No. of Locations: _____ **(If multiple names and locations, please attach list.)**

3. a) Date Established: _____ Corporation ☐ Partnership ☐ Professional Assoc. ☐
   Individual ☐ For Profit ☐ Not for Profit ☐

   b) In what states is the Applicant registered and licensed to practice? _____

   _____

   c) Please specify any professional societies or associations of which you are a member: _____

   _____

4. If the Applicant is an entity:

   a) Is the entity engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No

   b) Is the entity owned by any physician? ☐ Yes ☐ No

   c) Is the entity owned by any hospital or are any services hospital-based? ☐ Yes ☐ No

   d) Have there been any changes in ownership of the business since the date the entity was established? ☐ Yes ☐ No

   If "Yes", to any of the above, please provide details: _____

   _____

   _____

5. Professional Activities and Specialty: **(Attach narrative description, if necessary,)**

   Check all that apply:

☐	Acupuncturist/Naturopathic Medicine	☐	Medical Spa (Please complete Medical Spa Supplemental)
☐	Alcohol/Drug/Psychiatric Rehabilitation	☐	Medical Testing/Laboratory
☐	Ambulance Services	☐	Nurse Registry
☐	Ambulatory Surgery Center	☐	Optometry
☐	Diagnostic Imaging	☐	Out-Patient Medical Clinic
☐	Dialysis Center	☐	Out-Patient Mental Health Clinic
☐	Health/Fitness Center	☐	Pharmacy (Please complete Pharmacy Supplemental)
☐	Home Healthcare Agency	☐	Residential Facility
☐	Hospice	☐	Speech Therapy
☐	Other (Specify): _____		

6. State approximate division of Applicant's patients among:

a)	Alcoholics	(%)	k)	Obstetrical	(%)
b)	Counseling/Family Planning	(%)	l)	Pediatric	(%)
c)	Communicable Disease	(%)	m)	Prisoners	(%)
d)	Dental	(%)	n)	Psychiatric	(%)
e)	Drug Addicts	(%)	o)	Research or Experimental	(%)
f)	General	(%)	p)	Senile or Aged	(%)
g)	Hemodialysis	(%)	q)	Stress Testing	(%)
h)	Holistic Medicine	(%)	r)	Surgical	(%)
i)	Medical	(%)	s)	Tubercular	(%)
j)	Mentally Retarded	(%)	t)	Other: _____	(%)

7. a. List the number and type of Applicant's employees and volunteers below: If "None", state None. _____

	Number	Type of Profession		Number	Type of Profession
i)	_____	Acupuncturist	xv)	_____	Opticians
ii)	_____	Counselor	xvi)	_____	Optometrist
iii)	_____	Chiropractor	xvii)	_____	Paramedics
iv)	_____	Dentist	xviii)	_____	Perfusionist
v)	_____	Dental Assistant	xix)	_____	Pharmacist
vi)	_____	EMT	xx)	_____	Pharmacist Tech
vii)	_____	Home Health Aide	xxi)	_____	Physician Assistant
viii)	_____	Inhalation Therapist	xxii)	_____	Physician/Surgeon
ix)	_____	Laboratory Technician	xxiii)	_____	Physiotherapist
x)	_____	Licensed Practical, Nurse	xxiv)	_____	Psychologist
xi)	_____	Massage Therapist	xxv)	_____	Registered Nurse
xii)	_____	Medical Director	xxvi)	_____	Social Worker
xiii)	_____	Nurse Anesthetist	xxvii)	_____	Speech Therapist
xiv)	_____	Nurse Practitioner	xxviii)	_____	Other _____

b. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet, if necessary. If "None", state None. _____

_____

_____

c. Are all of the individuals listed in questions 7.a. and 7.b. licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
If "No", attach explanation.

d. Are all employed/contracted physicians board-certified in their specialty? ☐ Yes ☐ No ☐ N/A

e. Do all physicians, surgeons and dentists who provide professional services on behalf of the Applicant maintain their own Med Mal coverage with limits of at least $1million/$3million? ☐ Yes ☐ No ☐ N/A

f. 1) Are criminal background checks conducted on all employees, volunteers and independent contractors? ☐ Yes ☐ No
If "No", attach explanation.

2) Does the Applicant conduct pre-employment screenings and background investigations prior to hiring all employees, volunteers and independent contractors? ☐ Yes ☐ No
If "No", attach explanation.

g. Has the Applicant or any of the individuals listed in questions 7.a. and 7.b:

i) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

ii) Ever been convicted of an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

iii) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered same? ☐ Yes ☐ No

If "Yes" to any of the above, attach explanation.

8. a) Does the Applicant have a written/formalized risk management/quality assurance program? ☐ Yes ☐ No
b) Does the Applicant have a written credentialing process for all staff? ☐ Yes ☐ No
c) Does the Applicant have written procedures for reporting all incidents? ☐ Yes ☐ No

If "No" to any of the above, attach explanation.

9. State approximate division of services being provided among the following settings:

a) Assisted Living Facilities	(%)	e)	Nursing Homes	(	%)
b) Clinics	(%)	f)	Physician Offices	(	%)
c) ER/ICU/Labor, Delivery	(%)	g)	Private Homes	(	%)
d) Hospitals	(%)	h)	Other_____	(	%)

10. If the Applicant provides AMBULANCE/TRANSPORT SERVICES, answer the following:

Number of Ground Ambulances _____ Number of Emergency Calls (per year) _____
Number of Non-Emergency Calls (per year) _____
Number of Air Ambulances _____ Number of Transport Calls (per year) _____
Number of Body Transports (per year) _____
Radius of Services _____ Is the Applicant part of a Fire Department? ☐ Yes ☐ No

11. For AMBULATORY SURGERY CENTERS, answer the following:

Number of Surgical Procedures in the next 12 months _____
Percentage of procedures using general anesthesia _____

12. Do you perform obstetric surgeries, bariatric surgeries or abortions? ☐ Yes ☐ No

13. For DIALYSIS CENTERS, answer the following:

Number of hemodialysis treatments in the next 12 months _____
Number of peritoneal treatments in the next 12 months _____
Hours of service in the next 12 months for in-home treatments _____
Number of stations _____

14. For ALCHOHOL/DRUG/PSYCHIATRIC REHABILITATION CENTERS, answer the following:

Number of total licensed beds _____
Do you provide off-site counseling services? ☐ Yes ☐ No
Are all counselors licensed? ☐ Yes ☐ No
Number of intern counselors? _____

15. For HEALTH/FITNESS CENTERS, answer the following:

Is there a pool?	☐ Yes	☐ No
Are there tanning beds?	☐ Yes	☐ No

16. Does the Applicant perform: **(Attach detailed explanation for any "Yes" answers to the following)**

a.	Acupuncture or acupuncture anesthesia?	☐ Yes	☐ No
b.	Angiography/Arteriography/Venography?	☐ Yes	☐ No
c.	Cardiac catheterization?	☐ Yes	☐ No
d.	Catheterization (other than cardiac, urinary or umbilical)?	☐ Yes	☐ No
e.	Closed reduction of compound fractures?	☐ Yes	☐ No
f.	Normal deliveries?	☐ Yes	☐ No
g.	Microdermabrasion?	☐ Yes	☐ No
h.	Injection of radioisotopes and/or use of irradiated substances?	☐ Yes	☐ No
i.	IV/Infusion Therapy?	☐ Yes	☐ No
j.	AIDS therapy?	☐ Yes	☐ No
k.	Radiation therapy and/or chemotherapy?	☐ Yes	☐ No
l.	Psychiatric shock therapy?	☐ Yes	☐ No
m.	Silicone injections?	☐ Yes	☐ No
n.	Spinal anesthesia (other than saddle blocks or caudals)?	☐ Yes	☐ No
o.	Botox injections?	☐ Yes	☐ No
p.	Chelaton therapy?	☐ Yes	☐ No
q.	DNA testing?	☐ Yes	☐ No
r.	Genetic testing?	☐ Yes	☐ No
s.	Environmental testing?	☐ Yes	☐ No
t.	Pharmaceutical testing?	☐ Yes	☐ No
u.	Testing of any weapons?	☐ Yes	☐ No
v.	Blood banking?	☐ Yes	☐ No
w.	Clinical trials or research using animal or human test subjects?	☐ Yes	☐ No
x.	Teleradiology?	☐ Yes	☐ No
y.	Telemedicine?	☐ Yes	☐ No

17. Does the Applicant perform any: **(Attach detailed explanation for any "Yes" answers to the following)**

a.	Surgery other than incision of superficial boils or suturing superficial fascia?	☐ Yes	☐ No
b.	Circumcisions?	☐ Yes	☐ No
c.	Dilation and curettage?	☐ Yes	☐ No
d.	Insertion of temporary pacemakers?	☐ Yes	☐ No
e.	Tonsillectomies and/or adenoidectomies?	☐ Yes	☐ No
f.	Caesarean sections?	☐ Yes	☐ No
g.	Cosmetic plastic Surgery?	☐ Yes	☐ No
h.	Excision of large cysts and/or I&D of deep-seated boils or carbuncles?	☐ Yes	☐ No
i.	Hysterectomies?	☐ Yes	☐ No
j.	Open reduction of fractures?	☐ Yes	☐ No
k.	Surgery for weight reduction of patients?	☐ Yes	☐ No
l.	Abortions and/or menstrual extractions? (If "Yes", include trimester, method and number of abortions performed per month in description.)	☐ Yes	☐ No

m. Silicone implants? ☐ Yes ☐ No

n. Sterilization procedures? ☐ Yes ☐ No

o. Biopsies and/or endoscopies? ☐ Yes ☐ No

p. Therapeutic optometry (implantation of prosthetic ocular devices)? ☐ Yes ☐ No

q. Sex change operations? (If "Yes", please advise the number performed per year.) ☐ Yes ☐ No

r. Other surgery: _____ ☐ Yes ☐ No

18. Does the Applicant perform hospital emergency room care:

a. For its own patients? ☐ Yes ☐ No

b. For patients of other providers? ☐ Yes ☐ No

c. If answer to (b) is "Yes", please specify: the percentage of its time devoted to this work = _____%, the number of hours per month devoted to this work = _____ hours.

19. Does the Applicant prescribe or dispense weight reduction drugs? ☐ Yes ☐ No

If "Yes", list drugs used and indicate the percentage of the Applicant's practice devoted to weight reduction; the frequency and duration of prescriptions for weight reduction drugs; and quantity dispensed by the Applicant:

_____

_____

20. Does the Applicant administer any methadone treatments? ☐ Yes ☐ No

21. Is anesthesia (other than topical or by means of local infiltration) administered by either the Applicant or others working on behalf of the Applicant? ☐ Yes ☐ No
If "Yes", attach detailed explanation.

22. Does the Applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No

If "Yes", provide number of licensed beds by location: _____

_____

_____

23. State number of x-ray machines owned or operated by the Applicant and indicate whether they are used for diagnosis or treatment or both: _____

_____

_____

State by whom treatment is given and number of procedures: _____

_____

24. Does the Applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? ☐ Yes ☐ No

If "Yes", give details, including name, location, size and number of beds: _____

_____

_____

25. Does the Applicant sell or lease any equipment for use by any other persons or entities? ☐ Yes ☐ No

If "Yes", give details, including name, location, size and number of beds: _____

_____

_____

26. a) State sources and amounts of the Applicant's total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
1. Charitable Contributions:	$_____	$_____
2. Government Funding:	$_____	$_____
3. Fee for Services:	$_____	$_____
4. Product Sales: (attach a list of products)	$_____	$_____
5. Other: _____	$_____	$_____
TOTAL GROSS REVENUE	$_____	$_____

b) For PHARMACIES, state sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
1. Prescription Sales:	$_____	$_____
2. Non-Prescription Sales:	$_____	$_____
3. Other: _____	$_____	$_____

c) Are all drugs dispensed by the Applicant approved by the FDA? ☐ Yes ☐ No
If "No", attach explanation.

27. Number of estimated patient encounters in the last 12 months _____ and/or patient tests carried out _____ (Note: "patient encounters" refers to number of visits – not number of patients.)

28. Number of estimated patient encounters and patient tests in the next 12 months:
(Note: "patient encounters" refers to number of visits – not number of patients.)

Patient encounters _____

Patient Tests _____

29. Describe the Applicant's Professional Liability coverage for the last five years:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

If the expiring policy is claims-made, what is the retroactive date?_____

30. Has any insurer cancelled or refused to renew any similar insurance during the past five years? ☐ Yes ☐ No

If "Yes", please describe: _____

_____

31. Is the Applicant currently insured under a Commercial General Liability Policy? ☐ Yes ☐ No
If "Yes", please give details:

Insurance Company	Type of Coverage	Limits BI	Limits PD	From	To

32. Has any application for Professional Liability or General Liability Insurance made on behalf of the Applicant, any predecessors in business, or present partners ever been declined, or has such insurance ever been cancelled or renewal refused? ☐ Yes ☐ No

If "Yes", please describe: _____

_____

33. Has any claim ever been made against the Applicant or any of its employees? ☐ Yes ☐ No

If "Yes", please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

34. Is the Applicant aware of any circumstances which may result in any claim against the Applicant, predecessors in business, or any present or past partners and officers? ☐ Yes ☐ No
If "Yes", please give full details on the same basis as question 33.

Please answer, question 35 if the Applicant <u>currently has</u> Miscellaneous Medical Professional/General Liability through Cluett Commercial insurance Agency, Inc.

35. Has the Applicant notified NAS Insurance Services of all litigation, administrative proceedings, demand letters or formal or informal governmental investigations or inquiries which have occurred in the past 12 months?
☐Yes ☐No ☐None to Report

If "Yes", please indicate number of events in the last 12 months: _____
If "No", please forward notice to Cluett Commercial insurance Agency, Inc., on behalf of Underwriters.

36. Limits of Liability requested _____ Deductible _____

37. Desired term of policy: From _____ To _____

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENT A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISION.

The undersigned declares that the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached to and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on file by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

For Kentucky residents:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Name of Applicant: _____
Please print Title Date

Signature: _____
Name Date