

## Miscellaneous Medical Professional Liability Application (Claims Made Form)

1. Full Name of Applicant (Including all dba's and subsidiaries seeking coverage under the policy for which you are applying):

2. Mailing and Location Address: (If multiple addresses include an attachment with a complete schedule of all locations)

3. Internet Address:

4. Date Established:

5. Type of Entity:

Corporation

Partnership

Individual

Other :

6. Is this entity owned by, associated with or controlled by any other entity?

YES

NO

If Yes, please give details:

7. Professional Activities and Specialty:

Ambulance Service  Ground  Air

Cosmetic Aesthetics Clinic (Medi-Spa)

Dental Practice

Drug and Alcohol Treatment

Home Healthcare Agency

Kidney Dialysis Center

Laser Vision Correction Center

Medical Clinic

Medical Staffing

Methadone Clinic

Mental Health Services

Nurses Registry

Pharmacy

Radiology (Teleradiology  YES  NO)

Residential Care Facility

Social Services

Surgery Center

Other (Please Provide Details)

8. State the approximate division of patients :

<input type="text"/> %	Substance Abuse - Drug or Alcohol	<input type="text"/> %	Developmentally Disabled
<input type="text"/> %	Cosmetic or Elective	<input type="text"/> %	Obstetric
<input type="text"/> %	Counseling	<input type="text"/> %	Pediatric
<input type="text"/> %	Communicable Diseases	<input type="text"/> %	Psychiatric
<input type="text"/> %	Dental	<input type="text"/> %	Research or Experimental
<input type="text"/> %	Dialysis	<input type="text"/> %	Geriatric
<input type="text"/> %	Family Planning	<input type="text"/> %	Surgical
<input type="text"/> %	Holistic or Alternative Medicine	<input type="text"/> %	Other (Please provide details):
<input type="text"/> %	General Medical	<input type="text"/>	

9. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

	<u>Employees or Volunteer</u>	<u>Independent Contractors</u>	<u>Insured On Own Med Mal Policy</u>		<u>Employees or Volunteer</u>	<u>Independent Contractors</u>	<u>Insured On Own Med Mal Policy</u>
Physicians (no surgery)	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Occupational Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Physicians (surgical)	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Physical Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Physician Assistants	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Speech Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Surgical Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Other <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Certified Nurse Anesthetists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Total Staff:	<input type="text"/>		
Nurse Practitioners	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<b>** Please attach copies of declarations pages on all individuals that carry their own medical malpractice.</b>			
Registered Nurses	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	If you have a Medical Director, provide name, speciality and C.V.:			
LPN's or Nurse Aides	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>			
X-Ray Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	a) Are Medical Director's duties administrative only?			
Medical Assistants	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO			
Optometrists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	b) Does Medical Director provide direct patient care?			
Opticians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO			
Pharmacists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	c) What medical malpractice limits is Medical Director required to carry?			
Pharmacy Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>			
Chiropractors	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Massage Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Laboratory Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Paramedics	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
EMT's	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Social Workers	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Aestheticians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Perfusionists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				

10. Are all of the above individuals licensed in accordance with applicable state and federal regulations?  YES  NO  
 If No, Please attach a detailed explanation.

11. Has the applicant or any of the above employees and/or independent contractors:

Please attach explanation for any of the questions below answered "YES":

- a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association?  YES  NO
- b) Ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense?  YES  NO
- c) Ever been treated for alcoholism or drug addiction?  YES  NO
- d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  YES  NO

12. Does the applicant perform any of the following non-surgical procedures or treatment?

- a) Acid or chemical peels  YES  NO  
 Solution Strength  If over 30%, is this done by licensed MD  YES  NO
- b) Acupuncture  YES  NO
- c) Angiography, Arteriography, Venography  YES  NO
- d) Botox Injections  YES  NO
- e) Catheterization (other than urinary or umbilical)  YES  NO
- f) Closed reduction of compound fractures  YES  NO
- g) Collagen injections  YES  NO
- h) Electrolysis  YES  NO
- i) Laser Treatments (non-surgical) If Yes, which of the following:  YES  NO
  - Hair Removal
  - Skin Resurfacing
  - Tatoo Removal
 Other:

- j) Lipodissolve  YES  NO
- k) Mesotherapy  YES  NO
- l) Microdermabrasion  YES  NO
- m) Pain management (non-surgical)  YES  NO
- n) Permanent Makeup Application  YES  NO

- o) Psychiatric shock therapy
 YES
 NO
- p) Radiation Therapy and/or Chemotherapy
 YES
 NO
- q) Sclerotherapy
 YES
 NO
- r) Silicone Injections
 YES
 NO

13. Does the applicant perform any of the following surgical procedures?

- a) Abortions If Yes, please answer the following:
 YES
 NO
- What is the maximum trimester
- What methods
- How many per month
- b) Bariatric Surgery If Yes, attach a list of types performed
 YES
 NO
- c) Biopsies
 YES
 NO
- d) Circumcisions
 YES
 NO
- e) Colonoscopies or Endoscopies
 YES
 NO
- f) Cosmetic Plastic Surgery If Yes, what percentage of Practice?

 YES
 NO
- g) Cryosurgery
 YES
 NO
- h) Deliveries
 YES
 NO
If Yes, C Sections?
 YES
 NO
- i) Dilation and curettage
 YES
 NO
- j) Hysterectomies
 YES
 NO
- k) Minor surgical procedures only
 YES
 NO
- l) Major surgical procedures
 YES
 NO
- m) Mastectomies or lumpectomies
 YES
 NO
- n) Neurosurgery
 YES
 NO
- o) Organ transplant surgery
 YES
 NO
- p) Orthopedic surgery other than spinal
 YES
 NO
- q) Penile lengthening or enhancement surgery
 YES
 NO
- r) Sex change operations or sexual reassignment surgery
 YES
 NO
- s) Spinal surgery
 YES
 NO
- t) Surgical podiatry
 YES
 NO
- u) Vasectomies
 YES
 NO
- v) Other

14. Does the applicant administer methadone treatment?  YES  NO  
 If yes, how many slots?

15. Does the applicant administer detoxification treatment?  YES  NO  
 How many patients annually?

16. Does the applicant maintain any beds for overnight occupancy?  YES  NO  
 If Yes, what is the total number of beds?

17. Does the applicant provide services to Nursing Homes or Assisted Living Centers?  YES  NO  
 If Yes, please provide description of the services, and the percentage (%) of total revenue derived from these services:

18. Is anesthesia (other than topical or by means of local infiltration) administered at the applicant's facility?  YES  NO  
 If Yes, what percentage of procedures require general anesthesia?

19. Does the applicant sell any products?  YES  NO  
 If Yes, please include product brochures.  
 a) What kind of products?   
 b) Do any of these products require a physicians prescription?  YES  NO  
 c) Do you re-label these products in your own name?  YES  NO

	<u>Last 12 months</u>	<u>Estimate for next 12 months</u>
Charitable Contributions	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Government Funding	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Fee for service	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Other income: <input style="width: 350px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Total Gross Revenues	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

	<u>Last 12 months</u>	<u>Estimate for next 12 months</u>
Outpatient Visits (Non-Surgical)	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Surgical Procedures (not included in above)	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>
Other <input style="width: 360px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

22. If the applicant has or is a training school, please provide the following: (attach separate sheet if more room needed)

Profession for which students are being trained.	Max # students per session.	# of sessions per year	% of time in clinical settings	Qualifications of Facility (MD, RN,PHD)
<input style="width: 260px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 240px;" type="text"/>
<input style="width: 260px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 50px;" type="text"/>	<input style="width: 240px;" type="text"/>

23. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If None, state NONE)

Carrier	Limit	Deductible	Premium	Policy Term
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

24. What is the retroactive date on your current policy?

25. Is the applicant currently insured under a Commercial General Liability policy?  YES  NO

If Yes, please attach copies of declaration page.

26. Does the applicant own, operate or manage any business other than the one (s) described in this application for which you are applying for coverage?  YES  NO

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

27. Has any application for professional liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed?  YES  NO

If Yes, please provide details including name of carrier and dates.

28. Has any claim ever been made against the Applicant or any of its employees?  YES  NO

If Yes, please complete the Supplemental Claim Information Form with your submission of this application. [Form Link](#)

29. Is the applicant aware of any circumstances which may result in any claim against them or their employees?  YES  NO

If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.

30. Does the Applicant have a Risk Management and Risk Control Program in place?  YES  NO

a. Who is responsible for that Program?

Title:  Contact E-mail:

Phone Number

I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:   Current Date

Title

**If you prefer not to return application with an electronic signature, please print and sign below:**

Signature of Applicant or Authorized Representative  Current Date:

Title

**Please attach the following documents to this application:**

- \* Resumes or CV's on principals and partners
- \* Copies of brochures, marketing or advertising materials
- \* Five years of currently valued company loss runs.
- \* Information on disciplinary actions, license revocations, etc.
- \* Copy of most current declarations page