APPLICATION FOR INDIVIDUAL (NON-PHYSICIAN) MEDICAL PRACTITIONERS PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If more space needed, attach a separate sheet. If not applicable, please state "N/A".
2. Application must be signed and dated.

(PLEASE TYPE OR PRINT IN INK)

Desired Effective Date: ____________________

1. APPLICANT INFORMATION

a. Full name of applicant (including professional degree): ____________________

b. Principal business premise address: ____________________
(Street)

____
(City) (State) (Zip) (County)

Phone No. ____________________ Email Address: ____________________

c. ☐Individual ☐ Corporation ☐ Employee of (specify): ____________________.
☐ Independent Contractor of (specify): ____________________.

d. Date business established/began practicing profession: ____________________.

e. Number of your employees: Full time ________ Part time ________ Total ________

f. Do you own or operate any business other than that shown above? .... ☐Yes ☐No
If Yes, please provide details: ____________________

g. Date of Birth:____________________ Place of Birth: ____________________
Are you a U.S. citizen?.................... ☐Yes ☐No
If No, your status and date of entry into U.S.A.: ____________________

h. Educational Institutions that you have attended:

Name and City, State	Years of Training	Degree or Certification Attained
____________________	From ________ To ________	____________________
____________________	From ________ To ________	____________________
____________________	From ________ To ________	____________________

i. Experience: where have you practiced your profession during the last ten years?

Facility: ____________________ Location: ____________________ From: _________ To: _________
Facility: ____________________ Location: ____________________ From: _________ To: _________
Facility: ____________________ Location: ____________________ From: _________ To: _________

j. Have you ever failed any professional licensing or specialty organization examination? .... ☐Yes ☐No
If Yes, please provide details: ____________________

2. APPLICANT PRACTICE

a. Please indicate your professional specialty:

☐ Chiropractor*
☐ Counselor (describe): ______________________________
☐ Dental Hygienist
☐ Dietician
☐ Healthcare Consultant**
☐ Laboratory Technician
☐ Massage Therapist
☐ Medical Director**
☐ Nurse, Licensed Practical
☐ Nurse, Registered
☐ Nurse Anesthetist***
☐ Nurse Practitioner
☐ Occupational Therapist
☐ Optometrist
☐ Pharmacist
☐ Physical Therapist
☐ Physician Assistant
☐ Psychologist
☐ Respiratory Therapist
☐ Social/Case Worker
☐ Speech Therapist
☐ X-ray Technician
☐ Other (specify): ___________________________

b. Please describe in detail the professional services you render: ____

____

. Please describe the extent to which you are supervised and the qualifications of your supervisor: ________________________

____

d. Are you:

(i) Licensed and certified as required by state and/or federal law? .... ☐Yes ☐No

(ii) A member of a state or national association? .... ☐Yes ☐No

If Yes, please identify: ____

____

(iii) Affiliated or contracted with any HMO/PPO or Managed Care System?.. ☐Yes ☐No

If Yes, please describe: ____

____

e. Please list all states and any foreign countries where you provide service: ____

____

f. Are you associated with or do you work for a physician or surgeon? .... ☐Yes ☐No

If Yes, please provide name and specialty of physician: ____

g. Are you entered into any written indemnification agreements holding any other party harmless? .... ☐Yes ☐No

h. Are you under contract to any government entity? .... ☐Yes ☐No

If Yes, please provide details: ____

i. Do you advertise your professional services in any manner (other than simply a listing in a telephone directory)? .... ☐Yes ☐No

If Yes, attach a copy of ALL of your advertisements.

j. Annual Gross Revenues: (include all sources)	Last 12 months	Estimated next 12 months
	____________________	____________________
k. Annual Number of Client Visits:	Last 12 months	Estimated next 12 months
	____________________	____________________

l. Do you provide any internet services?.. ☐Yes ☐No

If Yes, please explain: ____

m. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? .... ☐Yes ☐No

If Yes, has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?........................ ☐Yes ☐No

n. Do you anticipate any changes in your practice in the next year? .... ☐Yes ☐No

If Yes, please explain: ____

3. SERVICES

a. Please give the approximate percentage of total service time spent in the following locations:

_____% Patient's Home _____ % Outpatient Clinic _____ % Hospital Ward (specify): ________________________
_____ % Assisted Living Facility _____ % Surgery Center
_____ % Nursing Home _____ % Operating Room _____ % Physician Office (specify specialty): ________________________
_____ % Laboratory _____ % Emergency Dept. of Hospital
_____ % Other (specify): ________________________

b. Please indicate the approximate division of your patients or clients among:

_____ % Dental _____ % Surgical _____ % Physical Rehabilitation
_____ % Stress Testing _____ % Obstetrical _____ % Addiction Rehabilitation
_____ % Communicable _____ % Hemodialysis _____ % Psychiatric
_____ % Family Planning _____ % Diagnostic Imaging _____ % Other (specify): ________________________
_____ % Other (specify): ________________________

c. Please indicate the approximate percentage of your patients or clients by age group: _______ Under 18 _______ 18 - 35 _______ 36 – 50 _______ 51 - 65 _______ Over 65

d. Do you perform radiation therapy? .... ☐Yes ☐No

e. Do you perform psychiatric shock therapy? .... ☐Yes ☐No

f. Do you perform or assist in any surgical procedures?.. ☐Yes ☐No
If Yes, please list all types of such procedures and your involvement: ________________________
____

g. Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action? ....☐Yes ☐No
If Yes, please provide details: ________________________

4. STAFF

a. For each classification listed below, show the number of your employees and/or independent contractors.

	Full Time		Part Time		Annual Hours Worked	
	Employees	Contracted	Employees	Contracted	Employees	Contracted
Registered Nurses						
Licensed Practical Nurses						
Certified Nurse Assistants						
Nurse Aides						
Medical Assistants						
Dental Assistants						
Pharmacy Technicians						
Counselors						
Social/Case Workers						
Therapist Assistants						
Technician Assistants						
Opticians						
Dieticians						
Other (describe):						
Total Number of Employees/ Independent Contractors						

b. Are all of the professionals licensed in accordance with applicable state and federal regulations? .... ☐Yes ☐No
If No, please provide details: ______________________________

c. Do all contracted professionals carry their own malpractice coverage? .... ☐Yes ☐No
At what limits of liability? ______________________________

5. CLAIMS/HISTORY

If "Yes" to any of the questions below, attach a detailed explanation.

a. Have you been the subject of investigatory or disciplinary proceedings or reprimand by an administrative or governmental agency or professional association? .... ☐Yes ☐No

b. Have you been the subject of any license suspension or revocation or been placed under probation? ..... ☐Yes ☐No

c. Has any insurance company ever canceled, non-renewed or declined to accept your professional or general liability insurance? .... ☐Yes ☐No

d. Have you been convicted for an act committed in violation of any law or ordinance other than traffic offenses? .... ☐Yes ☐No

e. Have you been treated for alcoholism or drug addiction or undergone personal psychiatric treatment? ☐Yes ☐No

f. Has any professional liability claim or suit been brought against you and/or any of your employees? ☐Yes ☐No
If Yes, please provide all dates and details of any incidents or payments: ______________________________

____

g. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you and/or any of your employees? .... ☐Yes ☐No
If Yes, attach an explanation.

h. List prior professional liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	

i. Does current policy cover sexual misconduct? .... ☐Yes ☐No
If Yes, please state sub-limits, if applicable: ______________________________

GENERAL LIABILITY (OPTIONAL)

1. PREMISES INFO

Complete the following for any owned or leased premises:

Location Address	Occupancy	Square Footage
	☐ Owned ☐ Leased	
	☐ Owned ☐ Leased	
	☐ Owned ☐ Leased	

2. PRODUCTS

a. Do you sell, lease or supply any medical supplies or equipment to patients or clients? .... ☐Yes ☐No

If Yes, please complete the following:

Category I	Expendable Items – intended for one time use and then disposed	Annual Sales:	$
Category II	Non-Expendable Items – including hospital beds, bathroom safety bars, portable toilets, lifts or hoists, ambulatory aids (excludes diagnostic or treatment devices)	Annual Sales and/or Rental Receipts:	$
Category III	Diagnostic or Treatment Devices – including oxygen and other medical gasses used in conjunction with respiratory therapy (excluding ventilators)	Annual Sales and/or Rental Receipts:	$
Category IV	Life Sustaining or Critical Monitoring Equipment or Devises – including dialysis or heart/lung machines, all monitors	Annual Sales/ Rental Receipts:	$

b. Do you install, service or demonstrate products or equipment?... ☐Yes ☐No

3. CLAIMS/HISTORY

a. Has any general liability claim or suit been brought against you? .... ☐Yes ☐No

If Yes, please provide all dates and details of any incidents or payments: ____

____

b. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you? .... ☐Yes ☐No

If Yes, attach an explanation.

c. Please list general liability insurance carried for each of the past five years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	

* CHIROPRACTORS ADDITIONAL QUESTIONS

a. Are you licensed to practice any other health care practices?... ☐Yes ☐No

If Yes, please circle: MD DO DPM ND RN RPT LAC Midwife Other (specify): ____________________

b. Please indicate those procedures or devices used in your practice:

		Yes	No			Yes	No
i.	General merric adjusting	☐	☐	xvi.	Massages	☐	☐
ii.	Upper cervical specific	☐	☐	xvii.	Short wave diathermy	☐	☐
iii.	Instrumental adjusting	☐	☐	xviii.	Kinesiology	☐	☐
iv.	Gonstead/diversified	☐	☐	xix.	Mechanical traction	☐	☐
v.	Direct non-force	☐	☐	xx.	Whirlpool	☐	☐
vi.	Sacro-occipital	☐	☐	xxi.	Stressology	☐	☐
vii.	Hydroculator/heat packs	☐	☐	xxii.	Internal coccyx adjustment	☐	☐
viii.	Electrical stimulation	☐	☐	xxiii.	Gemstone therapy	☐	☐
ix.	Ice-cryotherapy	☐	☐	xxiv.	Toftness device	☐	☐
x.	Trigger point	☐	☐	xxv.	Colonic irrigations	☐	☐
xi.	Cold laser	☐	☐	xxvi.	Treat cancer	☐	☐

xii.	Activator	☐	☐		xxvii.	Treat epilepsy	☐	☐
xiii.	Galvanic	☐	☐		xxviii.	Manipulation under anesthesia	☐	☐
xiv.	Ultraviolet	☐	☐		xxix.	Prenatal care & normal deliveries	☐	☐
xv.	Ultrasound	☐	☐					

c. If "No" to any of the questions below, attach a detailed explanation. Do you:

i. Use the Georges test, the Vertebral Artery Ischemia Test or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six months? .... ☐Yes ☐No

If No, please describe how you assess vascular flow.

If an unusual finding results, do you refer the patient to the appropriate medical practitioner? .... ☐Yes ☐No

ii. Make a differential diagnosis? .... ☐Yes ☐No

iii. Always record the patient's account of his/her progress? .... ☐Yes ☐No

iv. Always record objective findings? .... ☐Yes ☐No

v. Always record details of treatment procedures?.. ☐Yes ☐No

d. If "Yes" to any of the questions below, attach a detailed explanation. Do you:

i. Use acupuncture?.. ☐Yes ☐No

If Yes, do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique? .... ☐Yes ☐No

Date last NCCA exam taken and passed: ___________________________

If No, do you use disposable needles? .... ☐Yes ☐No

If No, please attach details.

ii. Dispense or prescribe: Drugs?.. ☐Yes ☐No
Vitamins? ☐Yes ☐No

iii. Use x-ray or imaging in treatment determination? .... ☐Yes ☐No

iv. Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? .... ☐Yes ☐No

v. Perform investigational or experimental research or therapy on human patients? .... ☐Yes ☐No

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** **HEALTHCARE CONSULTANTS/MEDICAL DIRECTORS ADDITIONAL QUESTIONS**

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a. Please identify the professional services for which coverage is desired and the approximate percentage of total service time spent in the following areas:

_____ % Case management _____ % Disease management _____ % Drafting practice guidelines/critical pathways
_____ % Telephone triage or counseling _____ % Physician practice/office management services
_____ % Billing/coding/reimbursement consulting _____ % Credentialing or peer review of health care providers
_____ % Other (describe in detail): ____

b. Has the Applicant ever acted, or will the Applicant act, in any capacity in which it has the ability to exercise decision-making authority for a client or an assignment? .... ☐Yes ☐No

If Yes, please explain: ____

c. Does the Applicant assist in negotiating or have any authority to alter or enter into contractual relationships on any client's behalf? .... ☐Yes ☐No

If Yes, please explain: ____

*** **NURSE ANSTHETISTS ADDITIONAL QUESTIONS**

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a. Are you always supervised by an Anesthesiologist?.. ☐Yes ☐No

If No, what percentage of your practice is supervised by the following: _____% Another CRNA _____% Dentist
_____% Podiatrist _____% Ophthalmologist _____% Physician/Surgeon [specify specialty(s)]: ______________________

b. During administration of all anesthetics, do you use a pulse oximeter monitor?.................................... ☐Yes ☐No
If No, please explain: ____

c. During all anesthetics:

i. Is an electrocardiogram continuously displayed?.. ☐Yes ☐No
If No, please explain: ____

ii. How often is arterial blood pressure determined and evaluated? ______________________

iii. How often is heart rate determined and evaluated? ______________________

iv. How is circulatory function evaluated? ______________________

d. During all general anesthesia, do you use an end tidal CO2 monitor? .... ☐Yes ☐No
If No, please explain: ____

ADDITIONAL ATTACHMENTS

1. Currently-valued Professional and General Liability loss experience for past five years.
2. Copies of contracts utilized for your services.
3. Copy of your resume.
4. List of additional insureds, description of their operations and relationship to you.

*NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I authorize the release of claim information from any prior insurer to XS/Group, Inc.**

____
Name of Applicant

______________________________ ______________________________
Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued. If the information in this application and any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify XS/Group, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.