

**MISCELLANEOUS MEDICAL**

**PROFESSIONAL LIABILITY INSURANCE APPLICATION**

**(CLAIMS-MADE FORM)**

1. NAME OF APPLICANT: \_\_\_\_\_  
(If other than parent firm, supply full details of ownership entity)
2. MAILING ADDRESS: \_\_\_\_\_  
(If multiple name & locations, please attach list)  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_ WEBSITE ADDRESS: \_\_\_\_\_
3. a) DATE ESTABLISHED \_\_\_\_\_ Corp. \_\_\_\_\_ Partnership \_\_\_\_\_ Prof. Assoc. \_\_\_\_\_ Individual \_\_\_\_\_  
b) In what states is the applicant registered and licensed to practice? \_\_\_\_\_
4. Is the firm engaged in, owned by, associated with or controlled by any other business? \_\_\_\_ YES \_\_\_\_ NO  
If yes, give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. PROFESSIONAL ACTIVITIES AND SPECIALTY ( Attach narrative description if necessary) Check One:

- |                                       |                             |
|---------------------------------------|-----------------------------|
| _____ Health Maintenance Organization | _____ Residential Health    |
| _____ Home Healthcare Agency          | _____ Other (Specify) _____ |
| _____ Medical / Testing Laboratory    | _____                       |
| _____ Nurse's Registry                | _____                       |
| _____ Out-Patient Clinic              |                             |

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

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

7. a. List the number and type of applicant's employees and volunteers: If None, State None.

- | NUMBER    | Type of Profession         | NUMBER    | Type of Profession |
|-----------|----------------------------|-----------|--------------------|
| (a) _____ | Inhalation Therapists      | (e) _____ | Nurse Practitioner |
| (b) _____ | Laboratory Technicians     | (f) _____ | Nurses Registered  |
| (c) _____ | Nurse Anesthetists         | (g) _____ | Opticians          |
| (d) _____ | Nurses, Licensed Practical | (h) _____ | Optometrists       |
| NUMBER    | Type of Profession         | NUMBER    | Type of Profession |
| (i) _____ | Perfusionists              | (m) _____ | Physiotherapists   |
| (j) _____ | Pharmacists                | (n) _____ | Social Workers     |
| (k) _____ | Physicians-minor surgery   | (o) _____ | Speech Therapists  |
| (l) _____ | Physicians-no surgery      | (p) _____ | Other              |

b. List the number and type of independent contractors who provide professional services on behalf of the applicant.  
If NONE, STATE NONE. \_\_\_\_\_

c. Are all the above individuals licensed in accordance with applicable state and federal regulations?  YES  NO  
If no, attach explanation.

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the employees:

- a) Ever been the subject of disciplinary or investigative proceedings or reprimand 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 traffic offenses?  YES  NO
- c) Ever been treated for alcoholism or drug addiction?  YES  NO
- d) Ever had any state professional license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  YES  NO

8. Does the applicant perform:

- A. Acupuncture or acupuncture anesthesia? Explain: \_\_\_\_\_  YES  NO
- B. Angiography/Arteriography/Venography? Describe: \_\_\_\_\_  YES  NO
- C. Catheterization (other than urinary or umbilical)? Describe procedure: \_\_\_\_\_  YES  NO
- D. Closed reduction of compound fractures and / or Normal Deliveries and / or Dermabrasion?  YES  NO
- E. Injection of radioisotopes and / or use of irradiated substances? Describe: \_\_\_\_\_  YES  NO
- F. Radiation Therapy and / or Chemotherapy? Describe: \_\_\_\_\_  YES  NO
- G. Psychiatric shock therapy?  YES  NO
- H. Silicone Injections? Describe: \_\_\_\_\_  YES  NO
- I. Spinal Anesthesia (other than saddle blocks or caudals)?  YES  NO
- J. Laser treatment? Describe: \_\_\_\_\_  YES  NO

9. Does the applicant perform any:

- A. Surgery other than incision of superficial boils or suturing superficial fascia?  YES  NO
- B. Circumcisions and / or dilation and curettage and / or insertion of temporary pacemakers?  YES  NO
- C. Tonsillectomies and / or Adenoidectomies and / or Caesarean Sections?  YES  NO
- D. Cosmetic Plastic Surgery? Describe: \_\_\_\_\_  YES  NO
- E. Excision of large cysts and / or I&D of deep-seated boils or carbuncles?  YES  NO
- F. Hysterectomies?  YES  NO
- G. Open reduction of fractures? Describe: \_\_\_\_\_  YES  NO
- H. Surgery for weight reduction of patients?  YES  NO
- I. Abortions and / or menstrual extractions? Describe (including trimester, method & number of Abortions performed per month): \_\_\_\_\_  YES  NO
- J. Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: \_\_\_\_\_  YES  NO
- K. Silicone Implants? Describe: \_\_\_\_\_  YES  NO
- L. Sterilization Procedures? Describe: \_\_\_\_\_  YES  NO
- M. Biopsies and / or endoscopies? List types performed: \_\_\_\_\_  YES  NO
- N. Sex change operations? Describe and advise the number performed per year: \_\_\_\_\_  YES  NO
- O. Other Surgery? Describe: \_\_\_\_\_  YES  NO

10. Does the applicant perform hospital emergency room care?

- a) for its own regular patients?  YES  NO      b) for patients not it's own?  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 = \_\_\_\_\_ hrs.

11. Does this applicant use drugs for weight reduction of patients?  YES  NO If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescription for weight reduction drugs, and quantity dispensed by applicant.

12. Does the applicant administer any methadone treatment? \_\_\_ YES \_\_\_ NO If yes, describe treatment and controls used to indicate number of treatments during last 12 months \_\_\_\_\_ Next 12 months \_\_\_\_\_
13. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? \_\_\_ YES \_\_\_ NO If yes, attach detailed explanation.
14. Does the applicant maintain any beds for overnight occupancy? \_\_\_ YES \_\_\_ NO If yes, total number: \_\_\_\_\_
15. State number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by Whom treatment is given and number of procedures: \_\_\_\_\_  
\_\_\_\_\_
16. 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: \_\_\_\_\_  
\_\_\_\_\_
17. State sources and amounts of total revenue:

<u>Sources</u>	<u>Amount Last Policy Year</u>	<u>Est. Amount This Year Policy</u>
A. Charitable Contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee For Service	\$ _____	\$ _____
D. _____	\$ _____	\$ _____
E. _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

18. Number of patient encounters last 12 months \_\_\_\_\_ and / or patient tests carried out \_\_\_\_\_  
(NOTE: "Patient encounters" refers to number of visits – not number of patients.)
19. Number of estimated patient encounters next 12 months \_\_\_\_\_ and / or patient tests carried out \_\_\_\_\_  
(NOTE: "Patient encounters" refers to number of visits – not number of patients.)
20. If applicant has a training school, complete the following.

<b>Specify profession for which students are being trained</b>	<b>Max. No. of students per session</b>	<b>No. of sessions per year</b>	<b>% of Time involved in clinical setting</b>	<b>Number of students</b>	<b>Qualifications of faculty (eg. MD, RN, PHD)</b>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

21. Give Professional Liability coverage for the last five years for the firm:

<b>Carrier</b>	<b>Limit</b>	<b>Deductible</b>	<b>Premium</b>	<b>Expiration (Mo/Day/Yr)</b>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claim made policy, what is retroactive date? \_\_\_\_\_

22. Is the Applicant currently insured under a Commercial General Liability Policy? \_\_\_ YES \_\_\_ NO If yes, please Give details:

<b>Insurance Company</b>	<b>Type of Coverage</b>	<b>BI</b>	<b>Limits PD</b>	<b>Effective From</b>	<b>To</b>
_____	_____	_____	_____	_____	_____

23. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? \_\_\_ YES \_\_\_ NO
24. Has any claim ever been made against the firm 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.
25. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in Business, or any of the present or past Partners or Officers? \_\_\_ YES \_\_\_ NO If yes, please give full details on the Same basis as item #23.
26. Has any insurer cancelled or refused to renew any similar insurance during the past five years? \_\_\_\_\_
27. Limits of Liability requested \_\_\_\_\_ Deductible \_\_\_\_\_
28. Desired term of policy: From \_\_\_\_\_ To \_\_\_\_\_
29. The applicant declares that the above statements and representations are true and correct and that no facts have been Suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to Purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations Made in this application and this application will be made part of the policy.

The applicant understands that any subsequent contract issued by the company will be issued on a **CLAIMS MADE FORM**.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Title

\_\_\_\_\_  
Producer