Application professional liability insurance miscellaneous medical

Claims made form

1. Name of applicant

   (If other than parent firm, supply full details of ownership entity)

2. Mailing address

   City, state, and zip code Phone No.

   (If multiple names and locations, please attach list)

   Square feet of total office space (all locations)

3. Date established Corp Partnership Proof. Assoc. Individual

   In what state is the applicant registered and licensed to practice

4. Is the firm engaged in, owned by, associated with or controlled by any other business?

   If yes, give detials

5. Professional activities and specialty (Attach narrative description if necessary) Check One:

   Health maintenance organization

   Home healthcare agency

   Medical/testing laboratory

   Nurse's registry

   Out-patient clinic

   Residential healthcare facility

   Other (specify)

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

a. Alcoholics	%	b. Obstetrical	%
c. Counseling/Family Planning	%	d. Pediatric	%
e. Communicable	%	f. Psychiatric	%
g. Dental	%	h. Research or Experimental	%
i. Drug addicts	%	j. Senile or Aged	%
k. General	%	l. Stress Testing	%
m. Hemodialysis	%	n. Surgical	%
o. Holistic medicine	%	p. Tubercular	%
q. Medical	%	r. Other:	%
s. 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
b.	Inhalation Therapists	c.	Nurse Practitioner
d.	Laboratory Technicians	e.	Nurses Registered
f.	Nurse Anesthetists	g.	Opticians
h.	Nurses, License Practical	i.	Optometrists
Number	**Type of profession**	**Number**	**Type of profession**
j.	Perfusionists	k.	Physiotherapists
l.	Pharmacists	m.	Social Workers
n.	Physicians-minor surgery	o.	Speech Therapists
p.	Physicians-no surgery	q.	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

		Yes	No
a.	Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b.	Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c.	Ever been treated for alcoholism or drug addiction?		
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?		
8.	Does the applicant perform:	Yes	No
a.	Acupuncture or acupuncture anesthesia? Explain:		
b.	Angiography/Arteriography/Venography? Describe:		
c.	Catheterization (other than urinary or umbilical)? Describe procedure:		
d.	Closed reduction of compound fractures and/or Normal Deliveries and/or Dermabrasion?		
e.	Injection of radioisotopes and/or use of irradiated substances? Describe:		
f.	Radiation Therapy and/or Chemotherapy? Describe:		
g.	Psychiatric shock therapy?		
h.	Silicone Injections? Describe:		
i.	Spinal Anesthesia (other than saddle blocks or caudals)?		
j.	Laser treatment? Describe:		
9.	Does the applicant perform any:	Yes	No
a.	Surgery other than incision of superficial boils or suturing superficial fascia?		
b.	Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers?		
c.	Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections?		
d.	Cosmetic Plastic Surgery? Describe:		
e.	Excision of large cysts and/or I&D of deep-seated boils or carbuncles?		
f.	Hysterectomies?		
g.	Open reduction of fractures? Describe:		
h.	Surgery for weight reduction of patients?		
i.	Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month)		
j.	Cryosyrgery (other than use on benign or pre-malignant dermatological lesions)? Describe:		
k.	Silicone Implants? Describe:		
l.	Sterilization Procedures? Describe:		

m. Biopsies and/or endoscopies? List types performed:

n. Sex change operations? Describe and advise the number performed:

o. Other Surgery? Describe:

10. Does the applicant perform hospital emergency room care?

a. for its own regular patients? Yes No b. for patients not its 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 the 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 prescriptions for weight reduction drugs, and quantity dispensed by applicant.

12. Does the applicant administer any methadone treatments? Yes No If yes, describe treatment and controls used and 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:

Source	Amount last policy year	Est. amount this policy year
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 if *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:

Specify profession max. for which students are being trained	No. of students per session	No. of sessions per year	% of time involved in clinical setting	Number of students	Qualifications of facility (eg. MD,RN,PHD)

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

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

If expiring insurance is a claims made policy, what is the retroactive date?

22. Is the Applicant currently insured under a Commercial General Liability Policy? Yes No

If ye, please give details:

		Limits		Effective	
Insurance company	Type of coverage	BI	PD	From	To

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

If yes, please give details:

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**	