Kinsale Insurance Company
P. O. Box 17008
Richmond, VA 23226
(804) 289-1300
www.kinsaleins.com

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) SUPPLEMENTAL APPLICATION

COMPLETE IN FULL INCLUDING SIGNATURES AND DATING BY THE PROVIDER NOT EARLIER THAN 45 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OF COVERAGE.
ATTACH ADDITIONAL SHEETS AS NECESSARY.
ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

GENERAL INFORMATION

1)

Named Insured:	
Professional Designation(s):	Social Security Number:
US Citizen? Yes ☐ No ☐	Date of Birth:
Immigration status:	Entry date:
Brokerage/Broker:	Agency/Agent:
Renewal? Yes ☐ No ☐	Policy Number:
Effective Date:	
Website:	

2) Current/Most Recent Professional Liability Carrier Information:

Carrier:			
Limit of Insurance:			
Deductible:		Premium:	
Policy Term Dates:			
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐	Retroactive date:	

Please attach copies of the following:

a) Currently valued five year loss runs, including claim detail for all losses
b) Copy of your current Professional Liability insurance Declarations Page and Commercial General Liability insurance Declarations Page (claims made policies must reflect the retroactive date and limits for retro continuity)
c) A copy of all marketing materials, brochures, etc. if a website is not available
d) A copy of your business letterhead
e) A copy of all licenses and board certifications held by you
f) A copy of all reporting endorsements previously issued to you

3) Mailing Address: _____
City: _____ State: _____ Zip Code: _____

4) Practice Address 1 (primary): _____
City: _____ State: _____ Zip Code: _____
☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty

5) Practice Address 2: _____
City: _____ State: _____ Zip Code: _____
☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty

6) Practice Address 3: _____

City: _____ State: _____ Zip Code: _____

☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty

7) Practice Address 4: _____

City: _____ State: _____ Zip Code: _____

☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty

8) Are you a(n): ☐ Corporation ☐ Individual ☐ Partnership ☐ LLC
☐ Employed CRNA ☐ Contracted CRNA ☐ Contracted Locum Tenens ☐ Freelance Locum Tenens
☐ Other: _____

a. If you are employed or contracted, by whom? _____

9) Your practice is: ☐ Full-time ☐ Part-time ☐ "Moonlighting"

a. If you are moonlighting, who is your regular full-time employer? _____
b. What is their address? _____
c. What is your position title? _____
d. What are your normal weekly hours (not including on-call)? _____
e. Please attach a COI showing proof of Professional Liability insurance for your full-time practice.

10) What is the entity name of your practice? _____

a. What is your ownership percentage? _____ %
b. How many other professionals practice at this entity? _____
c. Are you seeking coverage for this entity? If yes please attach articles of incorporation. Yes ☐ No ☐

11) Please complete the following table for states in which you are licensed to practice:

State	% of Practice	License #	Status
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐

PRACTICE AND EDUCATION INFORMATION

12) Please complete the below table for all locations and dates of practice you have had in the last ten years:

Practice Name	City/State	Specialty	Beginning Date	End Date

13) Do you work for or accept work assignments or placements from a locum tenens company? Yes ☐ No ☐

a. If yes, please complete the following table:

Name	Address	Employee or Independent Contractor?	Average Hours Each Month	Professional Liability Insurance Provided?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

b. If any company(ies) are providing Professional Liability insurance to you, please attach a copy of the COI.

c. If any company(ies) are not providing Professional Liability insurance to you, are you requesting coverage for this activity? Yes ☐ No ☐

14) Do you own a locum tenens company? Yes ☐ No ☐

a. What is the entity name of this company? _____

b. What is your ownership percentage? _____ %

c. How many other CRNAs practice at this entity? _____

d. Are you seeking coverage for this entity? Yes ☐ No ☐

e. If yes please attach articles of incorporation, if no please attach COI showing this entity has Professional Liability coverage in place.

15) Please complete the following table for your education history:

	Institution	Location	Degree/Specialty	Completed?
Nursing School				Yes ☐ No ☐
Graduate School				Yes ☐ No ☐
Internship				Yes ☐ No ☐
Residency				Yes ☐ No ☐
Fellowship				Yes ☐ No ☐

16) What date did you begin practicing as a CRNA? _____

17) How many CE hours have you completed in the past 2 years? _____

18) Are you a member of any professional associations or societies? Yes ☐ No ☐

a. If yes, which one(s)? _____

_____

19) Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy act? Yes ☐ No ☐

a. If yes, have you implemented procedures to comply with the HIPPA Privacy Rule? Yes ☐ No ☐

b. Who is your Privacy Officer? _____

20) Are you a foreign nursing school graduate? Yes ☐ No ☐

a. What date did you begin practicing in the US? _____

SPECIFIC PRACTICE AND PROCEDURE INFORMATION

21) Please complete the following table for patients for which you are seeking coverage. Complete all that apply:

Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months	Procedure	Percentage of Practice Last 12 Months	Estimated Percentage of Practice Next 12 months
☐ Bariatric Surgery	%	%	☐ Dental/Oral Surgery	%	%
☐ Plastic/Cosmetic Surgery	%	%	☐ Pediatric	%	%
☐ Podiatric	%	%	☐ Obstetrical	%	%
☐ Ophthalmological	%	%	☐ Non-surgical Pain Management (_____)	%	%
☐ Research or Experimental (_____)	%	%	☐ Other Surgery or Experimental (_____)	%	%

22) Are you supervised by an anesthesiologist at each location for which coverage is requested? Yes ☐ No ☐

a. If yes, is 100% of your practice supervised by an anesthesiologist? Yes ☐ No ☐

b. If no, please clarify the percentage of your practice supervised by the following:

Supervisor	Percent	Supervisor	Percent
Another CRNA	%	Dentist/Oral Surgeon	%
Podiatrist	%	Anesthesiologist	%
Ophthalmologist	%	Bariatric Surgeon	%
Plastic/Cosmetic Surgeon	%	Other: _____	%
Other: _____	%	Other: _____	%

23) Please complete the following. For all "no" answers, please attach an explanation:

a. During administration of all anesthetics, do you use a pulse oximeter monitor? Yes ☐ No ☐

b. During all anesthetics, is an electrocardiogram continuously displayed? Yes ☐ No ☐

c. During all general anesthesia, do you use an end tidal CO2 monitor? Yes ☐ No ☐

d. During all general anesthesia using an anesthesia machine do you use an oxygen analyzer with a low concentration limit alarm? Yes ☐ No ☐

e. When ventilation is controlled by a mechanical ventilator, do you use a device equipped with a full set of safety alarms? Yes ☐ No ☐

f. Do you test proper functioning of all equipment alarms prior to each use? Yes ☐ No ☐

g. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? Yes ☐ No ☐

24) During all anesthetics, how often is arterial blood pressure determined and evaluated? _____

25) During all anesthetics, how often is heart rate determined and evaluated? _____

26) During all anesthetics, how is circulatory function evaluated? _____

_____

27) What are your average weekly practice hours for all jobs, not including on-call? _____

28) What are your average weekly practice hours for jobs for which coverage is requested, not including on-call? _____

29) How many weekly patient encounters do you have on average for all jobs? _____

30) How many weekly patient encounters do you have on average for jobs for which coverage is requested? _____

STAFF INFORMATION

31) Do you employ anyone? Yes ☐ No ☐

a. If yes, please complete the following for your staff:

	Number Employed		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full-Time	Part-Time	Full-Time	Part-Time		
CRNAs					Yes ☐ No ☐	Yes ☐ No ☐
RNs					Yes ☐ No ☐	Yes ☐ No ☐
LPNs					Yes ☐ No ☐	Yes ☐ No ☐
Physician Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Surgeon Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Other: _____					Yes ☐ No ☐	Yes ☐ No ☐

32) Are all of the individuals included in the table above licensed in accordance with applicable State and Federal regulations? Yes ☐ No ☐

a. Do you collect COIs for all employees? Yes ☐ No ☐

b. Do you collect COIs for all contractors? Yes ☐ No ☐

33) Do you supervise anyone other than your own employees? Yes ☐ No ☐

a. If yes, please attach a list of their profession(s), number supervised, and details on your supervisory duties.

34) Which of the following procedures do you use for hiring/screening professionals and paraprofessionals who provide patient care services in your operations other than surgeons and anesthesia providers? Check all that apply:

☐ Check of educational background
☐ Check of residency program
☐ Check of previous employers – In writing
☐ Check of previous employers – By telephone
☐ Criminal background check – State
☐ Criminal background check – Federal
☐ Driver's license verification
☐ MVR Check
☐ Drug screening
☐ Alcohol screening
☐ Abuse screening
☐ Reference verification
☐ Verification of license validity, suspensions, revocations, citations, or pending disciplinary actions
☐ Verification of any pending disciplinary actions by current or previous employers
☐ Verification of Professional Liability or other workplace related claims history against the applicant
☐ Other: _____

COVERAGE AND LOSS HISTORY

35) Has any licensing authority or professional association taken any action against you or any of your employees? **If yes, please attach an explanation and copies of all citations.** Yes ☐ No ☐

36) Have you or any of your employees ever had any professional license or license to prescribe and or dispense narcotic ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If yes, please attach an explanation.** Yes ☐ No ☐

37) Has your board certification or membership in any professional society or association been refused, suspended, revoked, or voluntarily surrendered? **If yes, please attach an explanation.** Yes ☐ No ☐

38) Have your hospital privileges been suspended, restricted, denied, placed in probation status, or revoked? **If yes, please attach an explanation.** Yes ☐ No ☐

39) Have you or any of your employees ever been charged with or convicted of a crime other than minor traffic violation(s)? **If yes, please attach an explanation.** Yes ☐ No ☐

40) Have you or any of your employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

41) During the past five years, has any insurer ever canceled or non-renewed similar insurance to any applicant or has your insurance been canceled for nonpayment of premium by any insurance or finance company. **If Yes, please attach an explanation.** Yes ☐ No ☐

42) Have you ever practiced without Professional Liability insurance in place? Yes ☐ No ☐

43) Do you have Professional Liability insurance in place for work you do elsewhere? **If yes, please attach a copy of the policy Declarations page(s).** Yes ☐ No ☐

44) Has any claim or suit for medical malpractice or professional liability ever been filed, or any claim otherwise been made against you or any other person proposed for this insurance, including any partnership or joint venture of which you have been a member or your company's predecessors in business? Yes ☐ No ☐

a. **If yes, please complete the Kinsale Health Care Claim Supplemental.**
b. How many malpractice or professional liability claims have you had? _____
c. Have these claims all been reported to your current or a prior insurer? Yes ☐ No ☐

45) Are you or anyone else proposed for this insurance aware of any occurrences, facts, circumstances, incidents, situations, act, error, omission or records request from a patient or their attorney which may result in a claim or suit? **If yes, please complete the Kinsale Health Care Claim Supplemental.** Yes ☐ No ☐

46) If your Professional Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim 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 and subjects the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.

Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____