KINSALE INSURANCE

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www.bsrins.com

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

PHYSICIANS & SURGEONS NEW BUSINESS APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.

If a question is not applicable, then state "N/A".

The following information must be submitted with the completed application:

- Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
- Copy of your Curriculum Vitae
- Copy of all licenses and board certifications
- Copy of your business letterhead
- Copy of all advertising that you use
- Copy of all reporting endorsements previously issued to you
- 5-year company loss runs, valued within the last 60 days

PERSONAL INFORMATION

Applicant's Name: _____ ☐ MD ☐ DO

Social Security Number: _____ - _____ - _____ Date of Birth _____ / _____ / _____

Practice Address: _____
STREET CITY COUNTY STATE ZIP

Mailing Address: _____
STREET CITY COUNTY STATE ZIP

Are you a U.S. Citizen? ☐ Yes ☐ No If no, indicated status and date of entry _____

Provide the following information for all states in which you are license to practice:

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

Federal DEA License Number: #_____ Status _____

PRACTICE SPECIALTY AND EDUCATION

1. List all locations and dates where you have practiced in the last 10 years.

Practice Name	City/State	Specialty	From	To

2. Current Practice Specialty _____ % of Practice: _____
   Subspecialty _____ % of Practice: _____

3. Board Certification:

   ☐ Board Certified Name of Board(s):_____
   _____
   ☐ Board Eligible Date of Exam: ____ / ____ / _____
   ☐ Board Qualified

   If Board Eligible for Over Five Years, But Not Board Certified, Then Please Explain:
   _____
   _____

4. Complete the following:

	Institution	Location	Degree/Specialty	Completed?
Medical School				☐ YES ☐ NO
Internship				☐ YES ☐ NO
Residency				☐ YES ☐ NO
Fellowship				☐ YES ☐ NO

5. Date you began practicing medicine _____

6. Indicate number of CME hours you have completed in past two years: _____

7. Are you ACLS certified? ☐ YES ☐ NO 8. Are you ATLS certified? ☐ YES ☐ NO

PRACTICE INFORMATION

8. Applicant is an:
   - ☐ Individual
   - ☐ Corporation
   - ☐ LLC
   - ☐ Partnership
   - ☐ Employed Physician: By Whom: _____
   - ☐ Contracted Physician: By Whom: _____

Practice is a: ☐ Solo Practice ☐ Group Practice

9. Entity Name:_____ Applicant's % Ownership: _____%

10. Risk Management Contact Name: _____

11. Risk Management Contact E-mail: _____

12. Are you requesting that the entity be named on your policy? ☐ YES ☐ NO
If yes, please forward articles of incorporation.

OFFICE STAFF

13. Do you employ, contract with, or supervise any physicians or surgeons? If yes, provide the names and attach certificate of insurance for each: ☐ YES ☐ NO

_____

_____

14. Do you share office space or have an expense sharing arrangement with any other physician or surgeon other than those named above? Please provide details on page 7. ☐ YES ☐ NO

15. Please complete the staff table.

TYPE	Number Employed	Coverage Desired?	Number Contracted	Insured Elsewhere?
Midwife*		☐ YES ☐ NO		☐ YES ☐ NO
CRNA*		☐ YES ☐ NO		☐ YES ☐ NO
Nurse Practitioner		☐ YES ☐ NO		☐ YES ☐ NO
Physician Assistant		☐ YES ☐ NO		☐ YES ☐ NO
Surgeon Assistant		☐ YES ☐ NO		☐ YES ☐ NO
Optometrist		☐ YES ☐ NO		☐ YES ☐ NO
Lab Technician		☐ YES ☐ NO		☐ YES ☐ NO
Pharmacists		☐ YES ☐ NO		☐ YES ☐ NO
Nurse (RN or LPN)		☐ YES ☐ NO		☐ YES ☐ NO
X-Ray Technician		☐ YES ☐ NO		☐ YES ☐ NO
Physical Therapist		☐ YES ☐ NO		☐ YES ☐ NO
Other:		☐ YES ☐ NO		☐ YES ☐ NO
Other:		☐ YES ☐ NO		☐ YES ☐ NO
* Separate application must be submitted				

SPECIFICS OF PRACTICE/PROCEDURES

16. Average Weekly Practice Hours: _____

17. Average Weekly Patient Encounters: _____

18. Percentage of Locum Tenens Work: _____%

19. Do you work for any Locum Tenens companies as an employee or independent contractor? ☐ YES ☐ NO
If yes, indicate number of hours worked each month:____ AND does the Locum Tenens company provide you with Professional Liability insurance? No: ☐ Yes: ☐ If yes, provide copy of the COI.

20. Have there been any changes in your specialty or practice activities within the past 10 years? ☐ YES ☐ NO
If yes, explain: _____

_____

21. Do you perform any procedure not routinely performed by others practicing in your specialty or subspecialty? If yes, explain: ☐ YES ☐ NO

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

22. Provide the following information for all hospitals and surgery-centers where you are currently on staff:
(If no hospital privileges, attach protocol for patient admission)

Name of Facility	City	State	% of Work	Type of Privileges

23. Are you currently or ever been a hospital chief of staff or head of any hospital department? ☐ YES ☐ NO
If yes, explain:_____

24. Do you or any entity named in this application own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center. If yes, explain on page 7. ☐ YES ☐ NO

25. Do you serve as a medical director of a nursing home, clinic, commercial enterprise, or any other organization? If yes, explain on page 7 and attach a copy of any contract or agreement describing the position. ☐ YES ☐ NO

26. Do you work in an Emergency Room, other than to maintain privileges? ☐ YES ☐ NO
(If yes, provide the average number of ER hours worked per month) _____

27. Are you employed full-time or part-time by the federal, state, or local government, or are you on active military duty? If yes, please explain: _____ ☐ YES ☐ NO
_____

28. Do you treat patients in a nursing home, correctional facility or similar care facility? ☐ YES ☐ NO
If yes, percentage of practice _____%
Name(s) of Facilities:
_____
_____
_____

29. Are you a sports team physician or health care provider? ☐ YES ☐ NO
If yes: ☐ High school ☐ College ☐ Professional ☐ Other_____

30. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? If yes please explain on page 7. ☐ YES ☐ NO

31. Do you practice any forms of Alternative Medicine including but not limited to Ayurvedic Medicine, Chinese Medicine, Homeopathic Medicine, Chiropractic Medicine, Holistic Medicine, or Naturopathic Medicine? If yes please explain on page 7. ☐ YES ☐ NO

32. Are you engaged in any moonlighting activities? (If yes, are you requesting coverage for these activities? ☐ NO ☐ YES and describe)_____ ☐ YES ☐ NO
_____

33. If you are not a radiologist, do you read your own x-rays? ☐ YES ☐ NO
(If yes, indicate how many hours before they are subsequently read by a radiologist) _____

34. Do you read or interpret films, slides, or specimens of patients who reside in states other than your indicated practice states? If yes, please explain on page 7 indicating which states and how much each represented as a % of your practice. ☐ YES ☐ NO

35. Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering medical services? If yes please explain on page 7. ☐ YES ☐ NO

36. Do you prescribe drugs or provide diagnosis via the internet? If yes please explain on page 7. ☐ YES ☐ NO

37. Do you perform surgery, other than incision of boils and superficial abscesses or suturing and superficial fascia? ☐ YES ☐ NO

38. Do you perform surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? ☐ YES ☐ NO

39. Do you perform surgical procedures at a same-day surgery center other than your own office? ☐ YES ☐ NO

40. Do you perform surgery in your office or private suite using anesthesia other than local or topical? If yes, please complete the following: ☐ YES ☐ NO

Procedures	Anesthetic or Parenteral Sedation	Emergency Equipment and/or Procedures in Place

41. Check all Procedures/Treatments that you perform:

- ☐ Abortions
- ☐ Acupuncture
- ☐ Adenoidectomy
- ☐ Amputations
- ☐ Anesthesia (circle: OB or non-OB)
- ☐ Angiography
- ☐ Angioplasty
- ☐ Assist in Surgery (circle: own or other patients)
- ☐ Arterial Catheterization
- ☐ Arteriography
- ☐ Bariatric Surgeries: (Supplement Required)
- ☐ Cardiac Catheterization
- ☐ Intensive Care for Adults
- ☐ Joint Replacement Surgery
- ☐ Laparoscopy
- ☐ Mastoidectomy
- ☐ MOHS Micrographic Surgery
- ☐ Needle Biopsy
- ☐ Office Gynecology

Obstetrics

- ☐ Prenatal Care
  - ☐ 1st Trimester
  - ☐ 2nd Trimester
  - ☐ 3rd Trimester

- ☐ Cervical Biopsy
- ☐ Chelation Therapy (circle: **cardiac care** or **heavy metal**)
- ☐ Chemonucleolysis
- ☐ Chemotherapy
- ☐ Clinical Trials
- ☐ Closed Reduction Fractures
- ☐ Cholecystectomies
- ☐ Colonoscopy
- ☐ Complex Flaps and Grafts

Cosmetic Procedures

- ☐ Breast Implants/Augmentations/Reductions
- ☐ Botox Injection
- ☐ Chemical Peels
- ☐ Chemobrasion
- ☐ Collagen Injection
- ☐ Dermabrasion
- ☐ Fat Transfer
- ☐ Hair Transplant
- ☐ Liposuction
- ☐ Lipodissolve
- ☐ Facial Plastic Surgery (circle **Elective** or **Reconstructive**)
- ☐ Mesotherapy
- ☐ Microdermabrasion
- ☐ Sclerotherapy
- ☐ Silicone Injection
- ☐ Laser Hair Removal
- ☐ Rhinoplasty
- ☐ Other Laser Procedure (specify:_____)
- ☐ Other Cosmetic Procedure

- ☐ Dilaton and Curettage
- ☐ Echocardiography
- ☐ Electroshock Therapy
- ☐ Endoscopic Procedures
- ☐ Hernioplasty
- ☐ Hemorrhoidectomies
- ☐ Hyperberic Chamber Treatments
- ☐ Interphalangeal Joint Surgery
- ☐ Intensive Care for Newborns
- ☐ Normal Deliveries (indicate # annually____)
- ☐ VBAC Deliveries (indicate # annually____)
- ☐ High risk patient (indicate # annually____)
- ☐ Open Reduction of Fractures
- ☐ Organ Transplants
- ☐ Orthopedic Surgery Excluding Spine
- ☐ Orthopedic Surgery Including Spine
- ☐ Osteopathic Manipulative Medicine

Pain Management

- ☐ Medication Only
- ☐ Procedures: (Supplement Required)

- ☐ Pedicle Screw Insertion
- ☐ Penile Augmentation
- ☐ Penile Prosthetic Implants
- ☐ Pericardiocentesis
- ☐ Permanent Pacemaker Insertion
- ☐ Pneumoencephalography
- ☐ Prolotherapy
- ☐ Prostatectomy
- ☐ Radial Keratotomy
- ☐ Radiopaque Dye Injections
- ☐ Refractive Surgery (circle LASIK, PRK, PTK, AK, ICR)
- ☐ Thoracic Surgery
- ☐ Transgender Surgery or Hormonal Gender Coversion
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Vertebroplasty

Other:_____

Other:_____

☐ None of the above procedures apply to my practice.
Please initial _____

PRIOR POLICY AND LOSS INFORMATION – Questions 42-56 PROVIDE DETAILS FOR ALL "YES" ANSWERS

42. Has your medical or narcotics license ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ YES ☐ NO
43. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ YES ☐ NO
44. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? ☐ YES ☐ NO
45. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ YES ☐ NO
46. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? ☐ YES ☐ NO
47. Has any fee or professional relations complaints been registered against you with your medical association, hospital, or a state licensing authority? ☐ YES ☐ NO

48. Provide the following information pertaining to your past 5 years of professional liability insurance coverage:

Carrier	Policy Period	Policy Limits	Deductible	Claims Made or Occurrence	Retro Date

49. Have you ever practiced without professional liability insurance? ☐ YES ☐ NO

50. Do you have professional liability insurance for work you do elsewhere? ☐ YES ☐ NO
If yes, please explain on page 7.

51. Have you ever had any insurance company decline, cancel, rescind, or non-renew any professional liability insurance policy? ☐ YES ☐ NO

52. Have you ever been involved in any professional liability claim or suit, either directly or indirectly? ☐ YES ☐ NO

53. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ YES ☐ NO

54. Are you aware of any request for medical records by a patient or his/her attorney which might result in a claim? ☐ YES ☐ NO

55. Are you aware of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission, or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result notice, or attorney contact? ☐ YES ☐ NO

56. Have all circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit, been reported to your current or prior professional liability company? ☐ YES ☐ NO ☐ N/A
Indicate N/A if you are not aware of any such circumstances . If yes, how many? ____
Please complete a supplemental claims form for each.

Provide details for all "yes" answers to questions 42-56 on page 7 or attach additional pages as needed

REQUESTED COVERAGE

(NOTE: The Company may not offer or quote requested coverage)

Requested Effective Date:_____

Requested Retroactive Date:_____

Requested Limits of Liability

- ☐ $100,000/$300,000
- ☐ $200,000/$600,000
- ☐ $250,000/$750,000
- ☐ $500,000/$1,500,000
- ☐ $1,000,000/$3,000,000

Requested Deductible

- ☐ $5,000
- ☐ $7,500
- ☐ $10,000
- ☐ $25,000
- ☐ $50,000

☐ $2,000,000/ $6,000,000 (VA only) ☐ Other $_____

SUPPLEMENTAL INFORMATION

Use this page to as needed to address questions referenced within the application or to provide information you deem pertinent to our review of your application

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

- I have no known losses or claims that have not been reported to my prior insurance carrier or any other source from which payment might be made;
- I have no knowledge of acts, omissions or circumstances that relate to a professional service which could reasonably result in a claim, that has not been reported to a prior insurance carrier;
- I have no knowledge of any request for medical records by a patient or their attorney which might result in a claim;
- I have no knowledge or information relating to service or services on a Board which might result in a claim; and
- I have no knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result, or attorney contact.

MY SIGNATURE ON PAGE 9 CONFIRMS THE ABOVE STATEMENTS UNLESS OTHERWISE NOTED

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: _____

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, then please photocopy this form and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: _____ Age:_____ Sex:_____

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient? _____

_____

Status of Claim

___Suit threatened, no action taken
___Suit filed but dropped by claimant
___Summary judgment in your favor

___Suit settled out of court
a. Date claim paid:_____
b. Amount paid:$_____
c. Did you want to settle? Yes ☐ No ☐

Court outcome in your favor:
___Jury verdict
___Directed verdict

Court outcome in favor of plaintiff:
___Jury verdict
___Directed verdict
Amount of loss payment: $_____

Unresolved/Open
___Awaiting mediation
___Awaiting court action

Reserve amount:
$_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? Yes ☐ No ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim: _____

_____

_____

_____

Signature: _____ Date: _____

Printed Name: _____

Return to **Submit@bsrins.com**