KINSALE INSURANCE

BSR
(T) 800-768-7475 · (F) 615-264-3980
www.bsrins.com

Kinsale Insurance Company
P.O. Box 17008
Richmond, VA 23236
(804) 289-1300
www.kinsaleins.com

ALLIED HEALTHCARE PROFESSIONALS 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 applicant, 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/Resume
- Copy of all licenses and board certifications
- Copy of your business letterhead, if you own your practice
- 5-year company loss runs, valued within the last 60 days

PERSONAL INFORMATION

Applicant's Name and Degree designation(s): _____

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

Mailing Address: _____
STREET CITY COUNTY STATE ZIP

Practice Address: _____
STREET CITY COUNTY STATE ZIP

E-Mail Address: _____ Website Address: _____

SPECIFICS OF PRACTICE/PROCEDURES

1. Principal practice location for which coverage is requested:

_____
(Practice Name) (Street)

_____
(City) (State) (Zip)

a. Provide the number of weekly hours for your principal practice location (exclude on-call hours): _____

b. Your principal practice location is a(n):

☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty ☐ Other _____

2. Secondary practice location for which coverage is requested (If none, check here ☐)

_____
(Practice Name) (Street)

_____
(City) (State) (Zip)

a. Provide the number of weekly hours for your secondary practice location (exclude on-call hours): _____

b. Your principal practice location is a(n):

☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty ☐ Other _____

3. Please indicate your professional specialty: _____

4. Do you render professional services directly to patients? ..... ☐ YES ☐ NO
If yes, please describe these services in detail and indicate whether you are supervised and by whom.

Detailed Description of Professional Services	**% Supervised**	**Name of Supervising/Collaborating Physician**
_____	_____%	_____
_____	_____%	_____
_____	_____%	_____

5. Do you render professional services that do not involve contact with a patient? ..... ☐ YES ☐ NO
If yes, please describe these services in detail _____

_____

6. Do you perform or assist in any surgical procedures?..... ☐ YES ☐ NO
If yes, please answer (i) below.

i. Please list all surgical procedures performed (including minor surgery): _____

_____

ii. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? *If yes, please attach a detailed explanation.* ☐ YES ☐ NO

iii. Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? *If yes, please attach a detailed explanation* ☐ YES ☐ NO

7. Do you perform radiation therapy?..... ☐ YES ☐ NO

8. Do you perform psychiatric shock therapy?..... ☐ YES ☐ NO

9. Do you prescribe or dispense any drugs without the countersignature of a physician?
If yes, please provide a detailed explanation below.

_____

_____

10. Please indicate the approximate percentages of your patients for which coverage is requested:

_____% Hemodialysis	_____% Psychiatric	_____% Pediatric
_____% Holistic Medicine	_____% Substance Abuse	_____% Bariatrics
_____% Surgical	_____% Obstetrical	_____% Physical Rehabilitation
_____% Stress Testing	_____% Gynecology	_____% Disability Evaluation
_____% Communicable	_____% Dental	_____% Research or Experimental
_____% Family Planning	_____% Family/General Practice	_____% Other _____

11. Please give the approximate percentages of time spent in the following work locations:

_____% Administrative Office	_____% Nursing Home	_____% Patient's Home
_____% Ambulance	_____% Laboratory	_____% Hospital Ward
_____% Classroom	_____% Operating Room	_____% Professional Office
_____% Emergency Dept. of Hospital	_____% Outpatient Clinic	_____% Other _____

12. Provide the following:

	Weekly	**Annually**
a. Average number of patients you saw during the last 12 months for all jobs	_____	_____
b. Estimated number of patients you will see during the next 12 months for all jobs	_____	_____
c. Estimated number of patients you will see during the next 12 months for all jobs for which coverage is requested	_____	_____

13. If you are the owner of the practice, indicate your sources and amounts of actual and projected total revenue:

Source	**Amount This Fiscal Year**	**Amount Next Fiscal Year**
Charitable Contributions:	$ _____	$ _____
Government Funding:	$ _____	$ _____
Fee for Services:	$ _____	$ _____
Other: _____	$ _____	$ _____

PRACTICE SPECIALTY AND EDUCATION

14. Provide the following information for all of the states in which you practice:

State	License #	Effective Date	Expiration Date	Active (Yes/No)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

15. Describe your professional training:

Name of Institution	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

16. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy? If yes,

a. Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ☐ YES ☐ NO

b. Provide the name and title of the Applicant's Privacy Officer: _____

17. Are you a member of any professional societies? *If yes, list memberships below* ☐ YES ☐ NO

_____

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

Practice Name	City/State	From	To

PRACTICE INFORMATION

19. Type of practice for which coverage is requested:

☐ Solo practitioner (unincorporated)
☐ Solo practitioner (incorporated)*
☐ Partnership
* Name of Entity: _____
☐ Professional Association
☐ Professional Corporation (for profit)
☐ Employee of _____
☐ Professional Corporation (not for profit)
☐ Other _____

20. Do you own or operate any business other than that shown above? ☐ YES ☐ NO
If yes, please give details on a separate sheet.

21. Are you employed or contracted by any individual or entity other than your principal practice location(s)? *If yes, please attach a description of your responsibilities.* ☐ YES ☐ NO

22. Are you employed by or under contract to any government entity? ☐ YES ☐ NO
If yes, please attach a description of your responsibilities.

23. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? *If yes, attach a copy of all of your advertisements.* ☐ YES ☐ NO

24. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? *If yes, please attach a detailed explanation and copy of all advertisements.* ☐ YES ☐ NO

PRIOR POLICY AND LOSS INFORMATION – Questions 25-40 provide details for all "YES" answers

25. Has your medical or narcotics license ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ YES ☐ NO

26. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ YES ☐ NO

27. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? ☐ YES ☐ NO

28. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ YES ☐ NO

29. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? ☐ YES ☐ NO

30. Has any fee or professional relations complaints been registered against you with your medical association, hospital, or a state licensing authority? ☐ YES ☐ NO

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

Carrier	Policy Period	Policy Limits	Deductible	Claims Made? (Y/N)	Retro Date

32. Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? If yes, identify _____ ☐ YES ☐ NO

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

34. Do you have professional liability insurance for work you do elsewhere? If yes, please explain on page 6. ☐ YES ☐ NO

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

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

37. 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

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

39. 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

40. 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? **Indicate N/A if you are not aware of any such circumstances**. If yes, how many? ____ please complete a supplemental claims form for each. ☐ YES ☐ NO ☐ N/A

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 ☐ $2,000,000/ $6,000,000 (VA only)

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 8 below 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 fact.

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: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____

SUPPLEMENTAL CLAIM/ INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy 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:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

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
Date claim paid: _____
Amount paid: $_____
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**