UNDERWRITERS DIRECT ACCESS

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INDIVIDUAL MEDICAL MALPRACTICE

General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: _____ Fax: _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____ Producer's Name: _____

Detailed description of business activities (specifically, and by location): _____

_____

Is this a new business? ☐ Yes ☐ No If no, how many years have you been in business? _____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other: _____

Annual Payroll: $ _____ Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? ☐ Yes ☐ No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: _____

Fax: _____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor or related person or entity ever had a claim? ☐ Yes ☐ No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? ☐ Yes ☐ No

If yes, please explain: _____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? ☐ Yes ☐ No

If the standard markets are declining placement, please explain why: _____

2. Desired Insurance

Per Act/Aggregate		OR	Per Person/Per Act/Aggregate
☐	$50,000/$100,000	☐	$25,000/$50,000/$100,000
☐	$150,000/$300,000	☐	$75,000/$150,000/$300,000
☐	$250,000/$1,000,000	☐	$100,000/$250,000/$1,000,000
☐	$500,000/$1,000,000	☐	$250,000/$500,000/$1,000,000
☐	Other: _____	☐	Other: _____

Self-Insured Retention (SIR): ☐ $1,000 (Minimum) ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

3. Business Activities

1. In what states is the Applicant registered and licensed to practice? _____
2. Please specify any professional societies or associations which you are a member. _____
3. Is the firm engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No
4. Is the firm owned by any physician? ☐ Yes ☐ No
5. Is the firm owned by any a hospital, or are any services hospital based? ☐ Yes ☐ No
6. Have there been any changes in ownership of the business since the entity was established? ☐ Yes ☐ No
7. Professional Activities and Specialty (Attach narrative description if necessary)
   Check all that apply:

☐ Acupuncturist/Naturopathic Medicine	☐ Medical Testing/Laboratory
☐ Alcohol/Drug/Psychiatric Rehabilitation	☐ Nurse Registry
☐ Ambulance Services	☐ Optometry
☐ Ambulatory Surgery Center	☐ Out-Patient Medical Clinic
☐ Diagnostic Imaging	☐ Out-Patient Mental Health Clinic
☐ Dialysis Center	☐ Pharmacy
☐ Health/Fitness Center	☐ Residential Facility
☐ Home Healthcare Agency	☐ Speech Therapy
☐ Hospice	☐ Other (Specify): _____

8. State approximate division of Applicant's patients among:

Alcoholics	(_____%)	Obstetrical	(_____%)
Counseling/Family Planning	(_____%)	Pediatric	(_____%)
Communicable	(_____%)	Prisoners	(_____%)
Dental	(_____%)	Psychiatric	(_____%)
Drug Addicts	(_____%)	Research or Experimental	(_____%)
General	(_____%)	Senile or Aged	(_____%)
Hemodialysis	(_____%)	Stress Testing	(_____%)
Holistic Medicine	(_____%)	Surgical	(_____%)
Medical	(_____%)	Tubercular	(_____%)
Mentally Handicapped	(_____%)	Other: (_____%)	_____

9. List the number and type of Applicant's employees and volunteers below. If none, state "N/A".

Number	Type of Profession	Number	Type of Profession
#_____.	Acupuncturist	#_____	Optometrists
#_____	Counselors	#_____	Paramedics
#_____	EMT's	#_____	Perfusionists
#_____	Home Health Aides	#_____	Pharmacists
#_____	Inhalation Therapists	#_____	Physician Assistants
#_____	Laboratory Technicians	#_____	Physicians – Minor Surgery
#_____	Massage Therapists	#_____	Physicians – No Surgery
#_____	Medical Directors	#_____	Physiotherapists
#_____	Nurse Anesthetists	#_____	Psychologist
#_____	Nurses, Licensed Practical	#_____	Social Workers
#_____	Nurse Practitioner	#_____	Speech Therapists
#_____	Nurses Registered	#_____	Other:_____
#_____	Opticians	#_____	Other:_____

10. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet, if necessary._____

_____

11. Are all of the individuals listed in the professions listed on page two, licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
    If "No," attach explanation.
12. Are all employed/contracted physicians board certified in their specialty? ☐ Yes ☐ No
13. Are criminal background checks conducted on all employees? ☐ Yes ☐ No
    If "No," attach explanation.
14. Does the Applicant conduct pre-employment screenings and any other necessary investigations prior to hiring all staff? ☐ Yes ☐ No
15. Has the Applicant or any of the individuals listed in the profession list on page two:
16. Ever been the subject or disciplinary or investigative proceedings or reprimand by any
17. governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
18. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
19. Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
20. Ever had any state professional license or license to prescribe or dispense narcotics
21. refused, suspended, revoked, renewal refused or accepted only on special terms or
22. ever voluntarily surrendered same? ☐ Yes ☐ No
23. Is there a written/formalized risk management/quality assurance program? ☐ Yes ☐ No
24. Does the Applicant have a written credentialing process for employees and staff? ☐ Yes ☐ No
25. Does the Applicant have written procedures for reporting all incidents? ☐ Yes ☐ No
    If "No" to any of the above, attach explanation.
26. State approximate division of services being provided among the following settings:

    Assisted Living Facilities (___ %) Nursing Homes (___ %)

    Clinics (___ %) Physician Offices (___ %)

    Emergency Rooms (___ %) Private Homes (___ %)

    Hospitals (___ %) Other: (___ %)

27. For AMBULANCE SERVICES, answer the following:

    Number of Ground Ambulances Number of Emergency Calls (per year) _____

    Number of Non-Emergency Calls (per year) _____

Number of Air Ambulances Number of Transport Calls (per year _____

Number of Body Transports (per year) _____

Radius of Services Is the Applicant part of a Fire Department? ☐ Yes ☐ No

28. For AMBULATORY SURGERTY CENTERS, answer the following:

Number of Surgical Procedures in the next 12 months _____

Percentage of procedures using general anesthesia _____

29. For DIALYSIS CENTERS, answer the following:

Number of hemodialysis treatments in the next 12 months _____

Number of peritoneal treatments in the next 12 months _____

Hours of service in the next 12 months for in home treatments _____

Number of stations _____

30. For ALCHOHOL/DRUG/PSYCHIATRIC REHABILITATION CENTERS, answer the following:

Number of total licensed beds _____

Are there off site counseling services? ☐ Yes ☐ No

Are all counselors licensed? ☐ Yes ☐ No

Are there interns counselors? ☐ Yes ☐ No

31. For HEALTH/FITNESS CENTERS, answer the following:

Is there a pool? ☐ Yes ☐ No

Are there tanning beds? ☐ Yes ☐ No

(Attach detailed explanation for any “Yes” answers to the following:)

32. Does the Applicant perform:

Acupuncture or acupuncture anesthesia? ☐ Yes ☐ No

Angiography/Arteriography/Venography? ☐ Yes ☐ No

Cardiac Catheterization? ☐ Yes ☐ No

Catheterization (other than cardiac, urinary or umbilical)? ☐ Yes ☐ No

Closed reduction of compound fractures? ☐ Yes ☐ No

Normal Deliveries? ☐ Yes ☐ No

Dermabrasion? ☐ Yes ☐ No

Injection of radioisotopes and/or use of irradiated substances? ☐ Yes ☐ No

IV/Infusion Therapy? ☐ Yes ☐ No

AIDS Therapy? ☐ Yes ☐ No

Radiation Therapy and/or Chemotherapy? ☐ Yes ☐ No

Psychiatric shock therapy? ☐ Yes ☐ No

Silicone Injections? ☐ Yes ☐ No

Spinal Anesthesia (other than saddle blocks or caudals)? ☐ Yes ☐ No

Botox Injections? ☐ Yes ☐ No

Chelaton Therapy? ☐ Yes ☐ No

DNA Testing? ☐ Yes ☐ No

Genetic Testing? ☐ Yes ☐ No

Environmental Testing? ☐ Yes ☐ No

Pharmaceutical Testing? ☐ Yes ☐ No

Testing of any weapons? ☐ Yes ☐ No

Blood Banking? ☐ Yes ☐ No

Clinical Trials or Research using animal or human test subjects? ☐ Yes ☐ No

Teleradiology? ☐ Yes ☐ No

Telemedicine? ☐ Yes ☐ No

(Attach detailed explanation for any "Yes" answers to the following:)

33. Does the Applicant perform any:

Surgery other than incision of superficial boils or suturing superficial fascia? ☐ Yes ☐ No

Circumcisions? ☐ Yes ☐ No

Dilation and curettage? ☐ Yes ☐ No

Insertion of temporary pacemakers? ☐ Yes ☐ No

Tonsillectomies and/or Adenoidectomies? ☐ Yes ☐ No

Caesarean Sections? ☐ Yes ☐ No

Cosmetic Plastic Surgery? ☐ Yes ☐ No

Excision of large cysts and/or I&D of deep-seated boils or carbuncles? ☐ Yes ☐ No

Hysterectomies? ☐ Yes ☐ No

Open reduction of fractures? ☐ Yes ☐ No

Surgery for weight reduction of patients? ☐ Yes ☐ No

Abortions and/or Menstrual extractions? ☐ Yes ☐ No

34. If "Yes," include trimester, method and number of abortions performed per month in description.

Silicone Implants? ☐ Yes ☐ No

Sterilization Procedures? ☐ Yes ☐ No

Biopsies and/or Endoscopies? ☐ Yes ☐ No

Therapeutic Optometry (implantation of prosthetic ocular devices)? ☐ Yes ☐ No

Sex change operations? (If "Yes," advise the number performed per year.) ☐ Yes ☐ No

Other surgery ☐ Yes ☐ No

Does the Applicant perform hospital emergency room care?

For its own patients? ☐ Yes ☐ No

For patients not its own? ☐ Yes ☐ No

35. 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.

36. Does the applicant use drugs for weight reduction for patients? ☐ Yes ☐ No
If "Yes," 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: _____

_____

37. Does the Applicant administer any methadone treatment? ☐ Yes ☐ No

38. If "Yes," please contact underwriting for the methadone supplementary application.

39. Is anesthesia (other than topical or by means of local infiltration) administered by either Applicant or others? ☐ Yes ☐ No

If "Yes," attach detailed explanation.

40. Does the Applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No
If "Yes," number of licensed beds by location: _____

41. State the number of x-ray machines owned or operated and whether they are used for diagnosis or treatment or both: _____

42. State by whom treatment is given and number of procedures: _____

43. Does the Applicant own (wholly or in part), operate, or administer any hospital, nursing

44. home or other institution where medical services are customarily rendered? ☐ Yes ☐ No
If "Yes," give details, including name, location, size and number of beds: _____

45. Does the Applicant sell or lease any equipment for use by any other persons or entities? ☐ Yes ☐ No
If "Yes," give details, including name, location, size and number of beds: _____

46. State sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
Charitable Contributions	$	$
Government Funding	$	$
Fee for Services	$	$
Other:	$	$
Other:	$	$
TOTAL GROSS REVENUE	$	$

47. For PHARMACIES, state sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
Prescription Sales	$	$
Non-Prescription Sales	$	$
Other:	$	$

48. Are all drugs dispensed approved by the FDA? ☐ Yes ☐ No

If "No," attach explanation.

49. Number of estimated patient encounters last 12 months and/or patient tests carried out.

(Note: "patient encounters" refers to number of visits – not number of patients)

Patient encounters _____

Patient Tests _____

50. Number of estimated patient encounters and patient tests in the next 12 months:

(Note: "patient encounters" refers to number of visits – not number of patients.)

Patient encounters _____

Patient Tests _____

51. Describe Professional Liability coverage for last five years for the firm:

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

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

52. If the expiring policy is claims made, what is the retroactive date?_____

53. Has any insurer cancelled or refused to renew any similar insurance during thepast five years? ?
☐ Yes ☐ No

If "Yes," please describe: _____

_____

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

If "Yes," please give details:

Insurance Company Type of Coverage Limits Bl Limits PD From To

_____ _____ _____ _____ _____ ____.

55. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners even been declined or has the insurance ever been cancelled or renewal refused? ☐ Yes ☐ No
If "Yes," please describe: _____

_____

56. Has any claim ever been made against the fi rm 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.

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 the previous question

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name