Private Practice/Misc. Medical Professional Liability Insurance Application

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1. APPLICANT INFORMATION:

a) Firm Name: _____

b) Owner (s): _____

Please indicate owner's practitioner certification below. Owners must be included in the staff count in the Professional Liability section of this application.

_____

c) Contact Person: _____

d) Doing Business as: _____

e) Address: _____

_____
(city) (state) (zip) (county)

f) Are all services provided from this location? ..... ☐ Yes ☐ No
If no, please attach separate sheet with addresses for additional locations.

g) Phone: _____

h) Email: _____

i) Total Annual Gross Receipts: _____

Total Annual Sales: _____

j) Date Established _____

k) Please provide your firm's web address if applicable:

_____

l) Type of Firm:

☐ Case Management	☐ Clinic	☐ Consulting
☐ Counseling	☐ Fitness	☐ Health Education
☐ Home Health	☐ Pharmacy	☐ Rehab Services
☐ Staffing	☐ Med Spa	☐ Other _____

m) My firm is:

☐ Sole Proprietor	☐ Corporation
☐ Limited Liability Company	☐ Limited Partnership
☐ Trust	☐ Other _____

n) Requested Effective Date of Policy _____
(Must be within 60 days following application date.)

2. HIRING/SCREENING AND EMPLOYMENT PROCEDURES – Skip to #3 if you do not have any Employees or Independent Contractors

a) Do you do criminal record background checks for all employees and contractors? ..... ☐ Yes ☐ No

b) Does your business maintain a quality assurance or risk management program? ..... ☐ Yes ☐ No

3. CLAIMS HISTORY:

a) Does any of the following apply to you or anyone who provides professional services for your firm:

Received a lawsuit for malpractice? ..... ☐ Yes ☐ No

Become aware of any incident that may result in a malpractice claim or lawsuit? ..... ☐ Yes ☐ No

Received complaints (or charges, disciplinary actions, investigations, inquiries, or document requests) from a trusted institution (e.g. Court, licensing board, government agency, regulatory agency) responsible for maintaining the professional standards ..... ☐ Yes ☐ No

4. RISK MANAGEMENT AND QUALITY ASSURANCE:

a) Does your business have all the following procedures in place:

Promotion of consistent and proper use of a prescription drug monitoring program, as required by regulations? ..... ☐ Yes ☐ No

Assistance with identifying potential drug misuse, diversion or excessive prescribing? ..... ☐ Yes ☐ No

Specify actions to identify and report theft or loss to the DEA and required agencies? ..... ☐ Yes ☐ No

Prevention of early refills? ..... ☐ Yes ☐ No

Annual review of the above policies and procedures with staff? ..... ☐ Yes ☐ No

b) Are all x-rays interpreted by a radiologist? ..... ☐ Yes ☐ No

c) Do you perform cosmetic procedures? ..... ☐ Yes ☐ No

d) Do you agree that all of the following procedures are excluded from this policy? ..... ☐ Yes ☐ No

- Basti
- Carboxytherapy
- Colonics
- Colon Hydrotherapy
- Emesis or Purgation
- Gas Injections, including carboxy & Radon Therapy
- Liposuction including laser liposuction
- Sclerotherapy if vein size exceeds 3mm
- Vamana
- Stripping
- Any procedures, treatments or services that are identified as beyond the scope of your state's practice act for that licensed practitioner
- Silicone Injections

e) Is IV Hydration/Vitamin Therapy more than more 20% of your services? ..... ☐ Yes ☐ No

Continued...

5. PROFESSIONAL LIABILITY SECTION

a) PLEASE INDICATE ALL OWNERS, EMPLOYEES AND INDEPENDENT CONTRACTORS BELOW

Profession	# Full-Time	# Part-Time	Annual Hrs.	Payroll	Profession	# Full-Time	# Part-Time	Annual Hrs.	Payroll
Acupuncture					**Nurses:**				
Art Therapist					RN				
Athletic Trainer					RN Case Manager				
Audiologist					Home Health Aide				
Case/Care Manager not otherwise healthcare licensed/certified					LPN/LVN				
					Nurses Aide				
Certified Lab Tech.					Nursing Asst.				
Clinical Lab Tech.					Geriatric Nursing Asst.				
Counseling Professionals:					Aesthetician				
Psychotherapist					CRNA				
Psychologist					**Nurse Practitioners:**				
Clinical Counselor					Geriatric/Adult/NP/Family Planning NP				
Alcohol/Drug Counselor					Psychiatric NP				
Marriage/Family Counselor					Pediatric/Family Practice/Neonatal/Acute Care				
School Counselor					OB/GYN/Acute Care OB				
Pastoral Counselor					Nutritionist				
Bodywork Counselor					**OT:**				
Genetic Counselor					Occupational Therapist				
Life Coach Counselor					Occupational Therapist Assistant				
Psychological Counselor					Certified Occupational Therapist Assistant				
Licensed Prof. Counselor					Personal Trainer				
Vocational Counselor					Phlebotomist				
Counselor Educator					Physical Therapist				
Forensics Counselor					Physical Therapist Assistant				
Rehabilitation Counselor					Physical Therapy/Case Manager				
Mental Health Counselor					Radiologic Tech.				
Counselor Aide					Recreation Therapist				
CRNA					Registered Nurse/Case Manager				
Diagnostic Medical Sonographer					Rehabilitation Assistant				
Dietitian					Rehabilitation Therapist				
EEG Tech.					Respiratory Therapist				
EKG Tech.					Respiratory Therapist Tech.				
EMS:					Social Worker/Case Manager				
Paramedic / Instructor					Social Worker, Clinical				
Basic / Intermediate					Speech Hearing Therapist				
Emergency Medical Tech.					Speech Language Pathologist				
Exercise Physiologist					Sports Medicine Instructor				
Health Educator					Sports Medicine Therapist				
Hearing Aide Dispenser					Surgical Tech.				
Kinesiologist / Kinesiotherapist					X-Ray Machine Operator				
Massage Therapist					Other Healthcare Aide				
Medical Assistant					**Other Professions**				
Medical Esthetician					**(List Professions/Job Titles)**				
Medical Lab Tech.									
Medical Tech.									
Medical Tech. Assistant					**Total**				

Coverage is not available for Certified Nurse Anesthetist or Midwives. If you are a RN and NP, you must list your area of practice as a NP.
For additional professions not listed, please attach a separate sheet.

b) Are more than 50% of services provided to a nursing home? ..... ☐ **Yes** ☐ **No**

c) Do you provide high tech/critical care/trach/vent? ..... ☐ **Yes** ☐ **No**

d) Limits of Professional Liability Requested: ☐ **$1,000,000 per claim/$3,000,000 aggregate**
☐ **Other (specify)** _____ *(May be subject to state specific guidelines)*

e) Do you agree that your business does not provide overnight healthcare services at its own premise/location? ..... ☐ **Yes** ☐ **No**

f) Do guardian or power of attorney represent more than 20% of your business? ..... ☐ **Yes** ☐ **No**

Name of Firm: _____

Continued...

6. MEDICAL DIRECTOR SECTION

a. Do you have a Medical Director? ☐ Yes ☐ No

b. Do you agree that only the following services are covered for a Medical Director? ☐ Yes ☐ No

- Support of the administrative functions that directly impact the medical service of the practice
- Collaboration with the management team to assure delivery of quality services to all patients

This policy does not provide direct coverage for physicians.

7. ADDITIONAL INSURED REQUESTS

Do you want to add an Additional Insured? ☐ Yes ☐ No

Name: _____ Address: _____

Insurance Agent: Michael J. Loughran, Iowa License# IA241616; Florida License# A158896; California License# 0B58418; Pennsylvania License# 363656

I have answered these questions truthfully, accurately, and completely. I have not withheld any information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued. I agree that the statements in the application shall be deemed material to the acceptance of the risk assumed by the Insurance Company under the policy and Certificate of Insurance, if issued, and that this application shall be on file with the Company or Program Administrator and shall be deemed to be attached to and made part of the policy and Certificate of Insurance, if issued, as if physically attached thereto. I understand that any misrepresentation in the application will render the Certificate of Insurance, if issued, void from inception and agree that the Insurance Company will not defend or pay any amounts or claim expense for any claim based on, arising out of, or in any way involving such incidents, circumstances or allegations asked about previously in this application, whether disclosed or not.

FRAUD NOTICE – Where Applicable Under The Law of Your State

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties (For District of Columbia residents only: 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.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: 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.) (For Maine residents only: 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 a denial of insurance benefits.) (For Maryland residents only: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.) (For New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Oklahoma residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) (For Pennsylvania residents only: 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 conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.) (For Tennessee and Washington residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.)

Name of Principal or Officer: (please print) _____

Signature of Principal or Officer: _____ Date: _____

Agent/Broker Information:

Agency Name: _____ Contact Name: _____

Address: _____
(street) (city) (state) (zip)

Telephone: _____ Fax: _____ Email: _____