Professional SOLUTIONS

Midlevel Provider Supplemental Questionnaire

Section A – APPLICANT INFORMATION

Name: _____ (First) (Middle Initial) (Last)

Specialty License Number: _____ Designation: _____ *(CRNA, OD, RN, etc.)*

Social Security No. (last 4 digits): _____ Date of Birth: _____

Name of supervising or collaborating physician: _____ (First) (Middle Initial) (Last) Date Employed: _____ (MO/YR)

Facility/School where training completed: _____ (Name) (City) (State)

Training completed from: _____ (MO/YR) to _____ (MO/YR)

Average number of direct patient care* hours per week: _____

If practicing part-time, how many years have you practiced less than 21 hours per week in direct patient care*? ____

**For the purposes of this section, direct patient care is defined as medical professional services rendered that could form the basis of a claim by a patient against the insured. This includes but is not limited to: performing medical professional services on a patient; consulting or making a diagnosis of a patient's medical condition; prescribing medicine or medical treatment; updating, dictating or reviewing a patient's medical records and supervising or consulting with healthcare staff regarding a patient.*

Section B – COVERAGE INFORMATION

1. Desired effective date: _____ (MO/DAY/YR) *(policy issued annually)* 2. Desired retroactive date: _____

3. Select requested coverage: ○ Shared Limits ○ Separate Limits

4. Choose Limits of Coverage (exception states are in bold below):

○ $100,000/$300,000	○ $200,000/$600,000	○ $250,000/$750,000
○ $500,000/$1 Million	○ $1 Million/$3 Million	○ $2 Million/$4 Million

<u>Additional</u> limits available in Michigan:	○ $500,000/$1.5 Million	○ $1 Million/$1.5 Million
The <u>only</u> limits available in Kansas:	○ $500,000/$1.5 Million	

5. Requested deductible:

○ None	○ $5,000/$15,000
○ $10,000/$30,000	○ $15,000/$45,000

6. Do you provide medical or other practice activities that are insured elsewhere for which you do not desire coverage? ..... ○ Yes ○ No
If Yes, please include proof of coverage, a description of these activities and the practice name and location.

7. Will you be participating in a state-operated patient's compensation fund? ..... ○ Yes ○ No
Are you a resident of the compensation fund state? ..... ○ Yes ○ No
If Yes, please indicate the state operating the fund: _____

Section C – PRACTICE ACTIVITIES

1. Primary medical specialty: _____ Percent of practice: ___%

2. Do you have a secondary medical specialty? ..... ○ Yes ○ No
If Yes, please list: _____ Percent of practice: ___%

3. Please list all states in which you currently hold or have held a license: (All locations must total 100%)

State: _____ License No.: _____ ___ % of Practice

Status of License: ○ Active ○ Inactive ○ Temporary ○ Pending

State: _____ License No.: _____ ___ % of Practice

Status of License: ○ Active ○ Inactive ○ Temporary ○ Pending

State: _____ License No.: _____ ___ % of Practice

Status of License: ○ Active ○ Inactive ○ Temporary ○ Pending

4. Please list any Healthcare Professional Societies or Associations you belong to: _____

_____

5. Will you be scheduled to work at a separate location from your supervising physician? ..... ○ Yes ○ No
If Yes, please provide details on the last page.

6. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? ..... ○ Yes ○ No

7. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? ○ Yes ○ No

8. Do you order or perform diagnostic tests? ..... ○ Yes ○ No

9. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referrals and consultations when needed? ..... ○ Yes ○ No

10. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? ..... ○ Yes ○ No

11. Do you perform a physical examination? ..... ○ Yes ○ No
If Yes, briefly describe techniques and instruments used: _____

_____

12. Do you conduct informed consent discussions? ..... ○ Yes ○ No

13. Describe any other procedures, treatments, or duties you perform: _____

_____

14. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice: _____

_____

_____

IF MORE SPACE IS NEEDED FOR EXPLANATIONS, USE THE LAST PAGE OF THIS APPLICATION

Section D – HISTORY

1. Please provide information on each professional liability insurer you have had for the last 10 years.
Please provide this information in chronological order.

Dates	Insurer	Practicing Specialty	Limits of Liability	Coverage Type	Tail Coverage Purchased?	Any Claims?
				○ Occurrence ○ Claims Made	○ Yes ○ No	○ Yes ○ No
				○ Occurrence ○ Claims Made	○ Yes ○ No	○ Yes ○ No
				○ Occurrence ○ Claims Made	○ Yes ○ No	○ Yes ○ No

2. Are you now, or have you ever, practiced without professional liability insurance? ..... ○ Yes ○ No

3. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled your professional liability policy? *Missouri residents, skip this question* ..... ○ Yes ○ No

4. Has your medical license ever been investigated, denied, restricted, suspended, voluntarily surrendered or revoked in any state? ..... ○ Yes ○ No

5. Regarding your DEA certification, has it ever been restricted/put on probation, suspended or voluntarily suspended? ..... ○ Yes ○ No

6. Have any complaints or actions been brought against you by any hospital? (This includes restriction, suspension, revocation of privileges or probation.) ..... ○ Yes ○ No

7. Have you ever been the subject of or are you aware of any future involvement in an investigation by a regulatory or peer review board? ..... ○ Yes ○ No

8. Have any complaints or claims been brought against you for sexual misconduct? ..... ○ Yes ○ No

9. Have you ever been accused of or been found to have altered health care records? ..... ○ Yes ○ No

10. Have you ever had a chronic physical limitation or mental/emotional illness or disorder which impairs or adversely impacts your practice of medicine? ..... ○ Yes ○ No

11. Are you currently or have you ever been evaluated, treated or hospitalized for alcohol, narcotics, or any other substance abuse? ..... ○ Yes ○ No

12. Have you ever been charged, indicted or convicted; received a deferred prosecution or a deferred judgment and sentence; entered a guilty plea or a plea of nolo contendere; or been placed on adult diversion for any violation of any law? ..... ○ Yes ○ No

Note: You must answer "Yes" even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report traffic offenses that do <u>not</u> involve alcohol or drugs.

13. Have you ever been subjected to a criminal or civil monetary penalty under the Medicare or Medicaid program and/or been suspended from participation in Medicare or Medicaid or has participation status ever been modified? ..... ○ Yes ○ No

Section E – LOSS INFORMATION

For the purposes of this section, the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.

1. In the past 10 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services? ..... ○ Yes ○ No
   If Yes, please indicate the number of each: Number of pending suits: _____ Number of closed claims: _____

2. Other than the situations indicated in Question 1 above, are you aware of any of the following:
   - Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient? ..... ○ Yes ○ No
   - A letter from an attorney regarding your treatment of a patient? ..... ○ Yes ○ No
   - A patient, family member or a patient representative's dissatisfaction with the outcome of a procedure, treatment or diagnosis? ..... ○ Yes ○ No
   - Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? ..... ○ Yes ○ No

3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier? ..... ○ N/A* ○ Yes ○ No

   If Yes, please attach a current loss run for each carrier, as appropriate.
   If No, please explain why these circumstances were not reported: _____

   _____

**N/A means that you are aware of no circumstances that might reasonably lead to a claim or suit.*

IF YOU ANSWERED "YES" TO ANY QUESTIONS IN SECTIONS D & E, PLEASE PROVIDE DETAILS ON THE LAST PAGE.

Section F – SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC. In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or argument related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the Company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

Residents of Kansas: Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

Residents of Ohio: Any person who, with the intent to defraud or knowing that he 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.

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

Residents of all other 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 conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

X _____ **Date** _____
Signature

X _____ **Date** _____
Agent Signature

Section G - DETAILS

Section/Question	Comments
IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE	

Professional SOLUTIONS

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