

Section A - INSTRUCTIONS

To ensure a timely review of your request for coverage, please complete all of the questions below and attach a copy of the following with your completed application:

- Current Declarations Page
- Written procedures for claims handling and risk management
- A complete copy of current policy and endorsements
- Loss runs from all carriers for the previous 10 years or since the start of the practice, whichever is greater, if losses are noted in Section J
- Organizational chart
- Schedule of subsidiaries and/or affiliated entities with relationship to applicant
- Additional Supplements as indicated throughout the application

We will contact you to obtain any missing information; however, this may result in a delay in processing your application. Please provide as complete information as possible. If any question does not apply, please select No.

Section B - ENTITY APPLICANT INFORMATION

Name of Entity: _____

Contact Person/Insured's Representative: _____
First Middle Initial Last

Office Phone: _____ Fax: _____ Cell Phone: _____

Email Address: _____ Website: _____

Your email address will never be sold. It will be used to send you important messages.

Primary Practice Location: _____
Street City State Zip County ☐ Office ☐ Hospital

Mailing/Billing: ☐ Primary Practice Location
Address: ☐ Other: _____
Street City State Zip

Type of Entity: ☐ Solo Corporation ☐ Professional Corporation ☐ Partnership/LLC ☐ Joint Venture
☐ Shared: _____

IF MORE ROOM IS NEEDED FOR PRACTICE LOCATIONS, USE THE LAST PAGE OF THIS APPLICATION

Section C - COVERAGE INFORMATION

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

3. Please indicate limits of liability requested for coverage or a quote: (not all limits may be available in all states):

- | | | | |
|--|-----------|---|---|
| ☐ Shared with
Physician(s) limits | OR | ☐ \$100,000/\$300,000 | ☐ \$500,000/\$1,500,000
(available in MI, only option in KS) |
| | | ☐ \$200,000/\$600,000 | ☐ \$1,000,000/\$1,500,000
(available in MI only) |
| | | ☐ \$250,000/\$750,000 | ☐ \$1,000,000/\$3,000,000 |
| | | ☐ \$500,000/\$1,000,000 | ☐ \$2,000,000/\$4,000,000 |

4. Requested deductible(s) for coverage or a quote:

- | | | | |
|---|--|---|---|
| ☐ None | ☐ \$5,000/\$15,000 | ☐ \$10,000/\$30,000 | ☐ \$15,000/\$45,000 |
| ☐ \$25,000/\$75,000 | ☐ \$50,000/\$150,000 | ☐ \$100,000/\$300,000 | ☐ \$200,000/\$600,000 |

5. Will you be participating in a state-operated patient's compensation fund? ☐ Yes ☐ No

If yes, please indicate the state operating the fund: _____

What is the state of domicile? _____

ATTACH A COPY OF THE DECLARATIONS PAGE FOR THE CURRENT OR PREVIOUS PRIMARY INSURER.

Section D - RISK MANAGEMENT

1. Does your organization have a designated Risk Manager? ☐ Yes ☐ No

If yes, Risk Management contact: _____
First Middle Initial Last

Phone: _____ **Email Address:** _____

Your email address will never be sold. It will be used to send you important messages.

Does the Risk Manager have the authority to implement changes to policies and procedures? ☐ Yes ☐ No

2. Is there a written, formalized Risk Management plan? ☐ Yes ☐ No

If yes, please attach a copy.

Does the Risk Manager have the authority to implement changes to policies and procedures? ☐ Yes ☐ No

3. Is there an ongoing Quality Assessment or Improvement Plan? ☐ Yes ☐ No

If yes, please attach a copy.

Section E - OWNERSHIP AND OPERATIONS

Please note: a minimum of 50% of corporate owners and employed practitioners of the corporation must be insured with Professional Solutions Insurance Company to be eligible for this coverage.

1. Please list the names of all owners, stockholders and partners:
(If more room is needed, use the last page of this application.)

Name	Specialty	Current Insurer	Limit of Liability	Expiration Date

2. Are there other subsidiaries, DBAs or affiliated entities associated with this Entity? ☐ Yes ☐ No
If yes, please provide information below: (If more room is needed, use the last page of this application.)

Name	Description of Operations	County	Date Acquired	% of Ownership

3. Is the entity providing services at more than one location? ☐ Yes ☐ No
If yes, please provide information below: (If more room is needed, use the last page of this application.)

Name of Facility	Address	County	% of Practice

4. Does your organization currently, or plan to, provide or operate any of the following services? ☐ Yes ☐ No
If yes, please select the services below:

- | | | | | |
|--|---|-------------------------------------|---|--|
| ☐ Abortion Clinic | ☐ Dialysis | ☐ Home Care | ☐ Medical Spa | ☐ Radiology |
| ☐ Birthing Center | ☐ Diagnostic Imaging | ☐ Laboratory | ☐ Office Based Surgery | ☐ Substance Abuse |
| | | | ☐ Pharmacy | ☐ Surgical Center |

For any that are checked, does the state require that you be licensed to provide these services? ... ☐ Yes ☐ No
If yes, please provide a copy of these licenses.

Section F - MEDICAL PERSONNEL

1. Does the entity employ, or have as independent contractors, any physicians or surgeons? ☐ Yes ☐ No
If yes, please provide the following:

Designation	# of Employees or Ind. Contractors Current Year	# of Employees or Ind. Contractors 1 Year Ago	# of Employees or Ind. Contractors 2 Years Ago	# of Employees or Ind. Contractors 3 Years Ago	# of Employees or Ind. Contractors 4 Years Ago
Physicians					
Surgeons					

2. Has the license of any employed/contracted physician or surgeon been restricted or suspended in the last two years? ☐ Yes ☐ No

If yes, please provide the name of the individual(s): _____

3. Have the privileges of any employed/contracted physician or surgeon been restricted or suspended in the last two years? ☐ Yes ☐ No

If yes, please provide the name of the individual(s): _____

4. Is coverage desired for the entity's employed or contracted physicians or surgeons? ☐ Yes ☐ No

If yes, please complete and submit the following application for each physician and surgeon:

Physicians and Surgeons Professional Liability Application

5. Does the entity employ, or have as independent contractors, any mid-level providers (PA, NP, CRNA, CNM, CNS, etc.)? ☐ Yes ☐ No

If yes, please complete the following:

Designation	# of Employees or Independent Contractors Current Year	# of Employees or Independent Contractors 1 Year Ago	# of Employees or Independent Contractors 2 Years Ago	# of Employees or Independent Contractors 3 Years Ago	# of Employees or Independent Contractors 4 Years Ago
Clinical Nurse Specialist					
Certified Nurse-Midwife					
Nurse Anesthetist					
Nurse Practitioner					
Physician Assistant					
Surgical Assistant					

6. Is coverage desired for the individual(s) listed above? ☐ Yes ☐ No

If yes, please complete the Midlevel Provider Supplemental Questionnaire.

If no, please provide proof of other coverage.

7. Does the entity employ any ancillary healthcare providers (RN, LPN, Medical Assistant, etc.)? ☐ Yes ☐ No

8. Does the entity maintain current certificates of insurance on file for all employed or contracted practitioners and non-physician employees? ☐ Yes ☐ No

9. Have any practitioners performed any new procedures in the last five years? ☐ Yes ☐ No

If yes, please provide a detailed explanation on the last page of this application.

Section G - CREDENTIALING

Complete the questions below on the hiring and screening procedures for employees who provide patient care.

1. Is license renewal and credentialing verification conducted for the professional staff? ☐ Yes ☐ No

If yes, how often: _____

2. Are educational backgrounds and/or residency programs checked when applicable? ☐ Yes ☐ No

3. Are previous employers and/or personal references checked either in writing or by telephone? ☐ Yes ☐ No

4. Does the entity verify and research any pending or previous license suspensions, revocations or disciplinary actions by any hospital, healthcare facility or state agency? ☐ Yes ☐ No
If yes, what role does this information play in the hiring process? _____
5. Is information required on any professional liability or work-related claim that has previously been made against any individual? ☐ Yes ☐ No
If yes, what role does this information play in the hiring process? _____

Section H - CURRENT PRACTICE

1. Does this entity or any subsidiary advertise? ☐ Yes ☐ No
If yes, please provide a copy of the advertising materials or explain in detail.
2. Does the entity provide services by contract to other entities? ☐ Yes ☐ No
If yes, have you agreed to indemnify these entities? ☐ Yes ☐ No
If yes, please include a copy of the contract(s).
3. Is this entity equipped to handle emergency procedures (e.g. cardiac arrests)? ☐ Yes ☐ No
4. Are there protocols in place for transfer to a hospital in case of emergencies? ☐ Yes ☐ No
If yes, please provide details.
5. Is office-based surgery performed? ☐ Yes ☐ No
If yes, please explain and answer the following:
What type of anesthesia is administered? ☐ None ☐ General ☐ Regional
Who is anesthesia administered by? (Check one or both) ☐ Board certified anesthesiologist ☐ CRNA
If CRNA, are CRNAs always supervised by a board certified anesthesiologist? ☐ Yes ☐ No
If no, please explain.
6. Does this entity or any subsidiary or affiliated entity provide telemedicine activities in a state other than your Primary Office Location? (Includes, but is not limited to, the prescribing of drugs or providing diagnosis via the internet.) ☐ Yes ☐ No
If yes, complete Telemedicine/Telehealth Supplemental Application (NFL 9734).
7. Do you engage in retainer medicine, such as concierge, direct primary care, etc.? ☐ Yes ☐ No
If yes, please complete and submit the Retainer Practices Supplemental Application (NFL 9707).
8. Are you employed full-time by the federal government or are you serving in the military? ☐ Yes ☐ No
9. Does this entity, any subsidiary or employee review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
If yes, what percentage of services are devoted to these activities? _____ %
10. Does this entity, any subsidiary or employee provide clinical or administrative services to any nursing home, skilled nursing facility, assisted living center, hospice or similar facility? ☐ Yes ☐ No
If yes, what percentage of services are devoted to these activities? _____ %
11. Does this entity, any subsidiary or employee provide professional services or review treatment of any professional athletes? ☐ Yes ☐ No
If yes, what percentage of services are devoted to these activities? _____ %
12. Does this entity, any subsidiary or employee participate in any medical research, clinical trials or off-labeled use of drugs or devices? ☐ Yes ☐ No
If yes, please include copies of any protocols or informed consent documents.
13. Does this entity use Locum Tenens Physicians? ☐ Yes ☐ No
If yes, what percentage of services are devoted to these activities? _____ %

IF APPLICABLE, PROVIDE A DETAILED NARRATIVE TO THE ABOVE QUESTIONS ON THE LAST PAGE.

Section I - 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	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. Is this entity currently, or has it ever been, without professional liability insurance? ☐ Yes ☐ No

3. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled the professional liability policy associated with this entity or any subsidiary? (*Missouri residents, skip this question.*) ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO EITHER OF THE ABOVE QUESTIONS, PROVIDE DETAILS.

Section J - 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 or any of your healthcare providers 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: Pending suits: _____ Closed claims: _____

2. Other than the situations indicated in Question 1 above, are you aware of any of the following related to the entity or any healthcare provider:

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: _____

** For purposes of this question, "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 OF THE ABOVE QUESTIONS IN SECTION J, PROVIDE DETAILS ON A CLAIM INFORMATION FORM.

Section K - CLAIM MANAGEMENT AND INCIDENT REPORTING PROCEDURES

Please complete the following for the person responsible for handling claims and reporting incidents.

Name: _____ Title: _____

Telephone: _____ Email Address: _____

Your email address will never be sold. It will be used to send you important messages.

Please describe your claims handling/incident reporting procedures: _____

Section L - 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 changes 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 agreement 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

Signature

Date _____

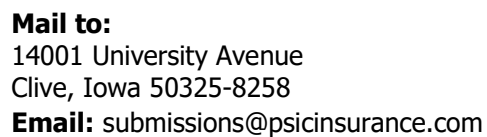
X

Agent Signature

Date _____

[illegible]

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE.



Email: submissions@psicinsurance.com