Professional SOLUTIONS | INSURANCE COMPANY

Corporation and Partnership Professional Liability Claims Made Application

A. AGENCY INFORMATION

Agency Name: _____ Agency License Number: _____

Soliciting Producer: _____
Last Name First Middle Initial

Address: _____
Street City State Zip

Office Phone: _____ Email Address: _____
Your email address will never be sold. It will be used to send you important messages.

B. ENTITY APPLICANT INFORMATION

Name of Entity: _____

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

Office Phone: _____ Office Fax: _____

Email Address: _____ Website Address: _____
Your email address will never be sold. It will be used to send you important messages.

Primary Office Address: _____
Street City State Zip County

Mailing Address: ☐ Primary Office Address
☐ Other: _____
Street City State Zip

Billing Address: ☐ Primary Office Address
☐ Mailing Address
☐ Other: _____
Street City State Zip

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

C. COVERAGE INFORMATION

1. Effective dates desired: From: _____ (MO/DAY/YR) To: _____ (MO/DAY/YR)
2. Retroactive date requested: _____ (MO/DAY/YR)

The retroactive date is the date first continuously insured under a Claims Made policy. Please contact your agent should you have any questions pertaining to Claims Made coverage or the need for Prior Acts coverage.

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
☐ $200,000/$600,000 *(only limit available in KS)*
☐ $250,000/$750,000
☐ $500,000/$1,000,000
☐ $500,000/$1,500,000 *(MI only)*
☐ $1,000,000/$1,500,000 *(MI only)*
☐ $1,000,000/$3,000,000
☐ $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

C. COVERAGE INFORMATION *(continued)*

5. Will the entity 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? _____

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

D. RISK MANAGEMENT

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

If yes, Risk Management Contact: _____
Last Name First Name

Phone: _____ *Email Address*: _____
Email addresses are never sold. They are used to send 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.

If yes, is this plan regularly reviewed for effectiveness and/or any necessary changes? ☐ Yes ☐ No

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

If yes, please attach a copy.

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	Limits 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 complete the 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.

F. MEDICAL PERSONNEL

1. Does the entity employ, or have as independent contractors, any physicians, surgeons or certified nurse midwives? ☐ Yes ☐ No

If yes, please complete 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					
Certified Nurse Midwives					

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, surgeons or midwives? ☐ Yes ☐ No

If yes, please complete and submit the following applications:
Physician and Surgeon Group Roster Addendum (PSIC-MDAPP-03)
Physician Group Member Professional Liability Application (PSIC-MDAPP-04) for each physician & surgeon

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

If yes, please complete 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
Nurse Anesthetists					
Nurse Practitioners					
Physician Assistant					
Surgical Assistant					
Other:					
Other:					

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

If yes, please complete and submit the following application:
Mid-Level Employee Roster Addendum (PSIC-MDAPP-06)

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

If yes, please complete the following:

Job Title/Specialty	# of Employees	Job Title/Specialty	# of Employees
RN		Other:	
LPN		Other:	
Medical Assistant			
Other:			

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.

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? _____

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, please explain.
7. 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?: _____ *%*
8. 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?: _____ *%*
9. 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?: _____ *%*
10. 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.
11. Does this entity use Locum Tenens Physicians? ☐Yes ☐No
    If yes, indicate number of days per year: _____ *days*

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

I. HISTORY

1. Please provide information on the entity's insurance/limits/claims 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
			☐ Occurrence ☐ Claims Made	☐ Yes ☐ No	☐ Yes ☐ No

ATTACH AN ENTIRE LOSS HISTORY, WHICH INCLUDES: POLICY NUMBER, CLAIM NUMBER, REPORT DATES, DESCRIPTION OF LOSS AND SETTLEMENT AMOUNT

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?..... ☐ Yes ☐ No
Missouri residents, skip this question.

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

J. LOSS INFORMATION

1. Has the entity been involved, directly or indirectly, in a **claim**, **potential claim**, or suit arising out of the rendering or failing to render professional services within the last 10 years?*..... ☐ Yes ☐ No
If yes, please indicate the number of each below:

Number of pending suits: _____ Number of closed claims: _____ Number of **potential claims**: _____

2. Have all **claims**, **potential claims**, suits and circumstances that might reasonably be expected to lead to a **claim** or suit been reported to your current or prior professional liability insurer? ..... ☐ Yes ☐ No
If no, please explain: _____

_____

* *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 or any professional corporation or partnership.*

*For the purpose of this section the word **potential claim** is defined as any circumstance that has been brought to your attention by a patient or patient's representative, in a manner that would indicate the possibility of a legal action against you or any professional corporation/partnership. (This may include, but is not limited to: a letter from an attorney or a patient requesting medical records or expressing dissatisfaction regarding your medical treatment, a patient or family member's dissatisfaction with the outcome of a procedure, treatment, or diagnosis, or any other circumstance that might reasonably lead to a claim or suit.)*

FOR EACH PENDING SUIT, CLOSED CLAIM, AND POTENTIAL CLAIM, PLEASE COMPLETE AND ATTACH A CLAIM INFORMATION FORM

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: _____

Email addresses never are sold. They are used to send important messages.

Please describe your claims handling/incident reporting procedures: _____

L. REQUIRED DOCUMENTS

Please remember to attach a copy of the following with the application:

- Current Declarations Page
- Brochures and marketing information
- Written procedures for claims handling and risk management
- If available, 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
- List of all past claims. Please complete Claim Information Forms as necessary
- Organizational chart
- Schedule of subsidiaries and/or affiliated entities with relationship to applicant

M. SIGNATURE REQUIRED

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

THE ABOVE STATEMENTS ARE, TO THE BEST OF MY KNOWLEDGE, THE TRUTH, AND I HAVE NOT KNOWINGLY SUPPRESSED, WITHHELD OR MISSTATED ANY MATERIAL FACT IN COMPLETING THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE.

The undersigned represents and acknowledges that all information provided including the application, its supplements, attachments and answers to any questions our underwriter asks will be relied upon by the Company in determining whether to insure and 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 Professional Solutions 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 Professional Solutions.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to Professional Solutions Insurance Company, 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 Professional Solutions 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 Professional Solutions 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 agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: 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.

X _____ **X** _____

SIGNATURE OF APPLICANT DATE

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 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.

N. DETAILS…

Section/Question	Comments

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE

