

INDIVIDUAL PRACTITIONERS
(Chiropractors, Counselors, Dieticians, Nurse Practitioners, PAs, RNs, Therapists, Vets)
PROFESSIONAL AND GENERAL LIABILITY INSURANCE
(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/healthcare.html

1. APPLICANT INFORMATION:

a. Complete name of applicant (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary)**: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Contact name: _____ Title: _____ Email address: _____

Phone: _____ Web site Address: _____ Fax: _____

List all other locations **(use an additional sheet of paper if necessary)**: _____

b. Professional degree: _____

c. Place of Birth: _____

d. Applicant is (check all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> U.S. Citizen (If not, provide status) | <input type="checkbox"/> Self-employed Individual (unincorporated) | <input type="checkbox"/> Self-employed Individual (incorporated) |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Professional Association | <input type="checkbox"/> Professional Corporation (for profit) |
| <input type="checkbox"/> Professional Corporation (non-profit) | <input type="checkbox"/> Employee of _____ (give name of employer) | <input type="checkbox"/> Other (Describe) _____ |

e. Please indicate your professional specialty:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Counselor | <input type="checkbox"/> Dietician |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Registered Nurse |
| <input type="checkbox"/> Therapist | <input type="checkbox"/> Veterinarian | <input type="checkbox"/> Other (Specify) _____ |

f. Date established: ____ / ____

g. Please state sources and amounts of total gross annual revenue:

Source of revenue	Amount last 12 months	Amount next 12 months
_____	_____	_____
_____	_____	_____

h. If you practice **other than** as an **employee** OR an **unincorporated solo practitioner**, specify:

- (i) Formal business, corporate or partnership name: _____
- (ii) List the names of all partners or members of your professional association/corporation who provide professional services: _____

Attach a copy of your letterhead.

- i. Are you associated with or do you work for a physician or surgeon? Yes No
If yes, please give the name and specialty of the physician: _____
- j. Are you employed by an individual other than that shown in Question 1 above? Yes No
If yes, please attach an explanation, including details of your responsibilities.
- k. Are you under contract to any individual or entity other than that shown in Question 1 above? Yes No
If yes, please attach an explanation, including details of your responsibilities. If this contract contains a hold-harmless agreement, please attach a copy of the contract.
- l. Are you employed by or under contract to any governmental entity? Yes No
If yes, please attach an explanation, including details of your responsibilities.
- m. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No
If yes, has the applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No
Provide the name and title of the applicant's Privacy Officer _____
- n. Provide the following information for all of the states in which you practice:
- | <u>State</u> | <u>License No.</u> | <u>Effective Date</u> | <u>Expiration Date</u> | <u>Active (Yes/No)</u> |
|--------------|--------------------|-----------------------|------------------------|------------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
- If NONE, please attach an explanation.
- o. Are you licensed in accordance with applicable state and federal regulations? Yes No
If no, please attach an explanation.
- p. Please describe Professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (C.V.).

2. EDUCATION:

- a. Describe your professional training:
- | <u>Institution (Name & Address)</u> | <u>Years of Training</u> | <u>Degree or Certification Attained</u> |
|---|--------------------------|---|
| _____ | From _____ To _____ | _____ |
| _____ | From _____ To _____ | _____ |
| _____ | From _____ To _____ | _____ |

3. EXPERIENCE:

Where have you practiced your profession during the last ten years:

- a. Prior Experience - From: _____ To: _____ Location: _____
Practice Activity: _____
- b. Prior Experience - From: _____ To: _____ Location: _____
Practice Activity: _____
- c. Prior Experience - From: _____ To: _____ Location: _____
Practice Activity: _____
- d. Have you ever failed any professional licensing or specialty organization examination? Yes No
If yes, please attach a detailed explanation, including dates and location.

4. YOUR PRACTICE:

- a. Please give the approximate percentages of time spent in the following work locations:
- | | |
|--|--|
| _____ % Administrative Office | _____ % Hospital Ward (specify) _____ |
| _____ % Ambulance | _____ % Operating Room _____ % Other (specify) |
| _____ % Classroom | _____ % Outpatient Clinic _____ % Laboratory |
| _____ % Nursing Home/Assisted Living | _____ % Patient's Home _____ % Surgery Center |
| _____ % Professional Office (specify profession) _____ | |
| _____ % Emergency Dept of hospital | |

b. Please indicate the approximate division of your patients or clients among:

Hemodialysis _____%	Bariatrics _____%	Ophthalmologic _____%
Holistic Medicine _____%	Obstetrical _____%	Cosmetic Surgery _____%
Dental _____%	Podiatric _____%	Disability Evaluation _____%
Stress Testing _____%	Pediatric _____%	Research or Experimental _____%
Communicable _____%	Pain _____%	(describe) _____%
Family Planning _____%	Management (describe) _____%	Surgical (describe) _____%
		100%

c. **Chiropractors – please complete the following:**

a. Are you licensed to practice any other health care practices? Yes No
 If Yes, please circle: MD DO DPM ND RN RPT LAC MIDWIFE Other: _____

b. Please indicate those procedures or devices used in your practice:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
(i) General merric adjusting	<input type="checkbox"/>	<input type="checkbox"/>	(XVI) Messages	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Upper cervical specific	<input type="checkbox"/>	<input type="checkbox"/>	(xvii) Short wave diathermy	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Instrumental adjusting	<input type="checkbox"/>	<input type="checkbox"/>	(xviii) Knesiology	<input type="checkbox"/>	<input type="checkbox"/>
(iv) Gonstead/diversified	<input type="checkbox"/>	<input type="checkbox"/>	(xx) Whirlpool	<input type="checkbox"/>	<input type="checkbox"/>
(v) Direct non-force	<input type="checkbox"/>	<input type="checkbox"/>	(xxi) Stressology	<input type="checkbox"/>	<input type="checkbox"/>
(vi) Sacro-occipital	<input type="checkbox"/>	<input type="checkbox"/>	(xxii) Internal cocoyx adjustment	<input type="checkbox"/>	<input type="checkbox"/>
(vii) Hydroculator/heat packs	<input type="checkbox"/>	<input type="checkbox"/>	(xxiii) Gemstone therapy	<input type="checkbox"/>	<input type="checkbox"/>
(viii) Electrical stimulation	<input type="checkbox"/>	<input type="checkbox"/>	(xxiv) Toftness devise	<input type="checkbox"/>	<input type="checkbox"/>
(ix) Ice-cryotherapy	<input type="checkbox"/>	<input type="checkbox"/>	(xxv) Treat cancer	<input type="checkbox"/>	<input type="checkbox"/>
(x) Trigger point	<input type="checkbox"/>	<input type="checkbox"/>	(xxvi) Treat epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
(xi) Cold laser	<input type="checkbox"/>	<input type="checkbox"/>	(xxviii) Manipulation under anesthesia	<input type="checkbox"/>	<input type="checkbox"/>
(xii) Activator	<input type="checkbox"/>	<input type="checkbox"/>	(xxx) Prenatal care & normal deliveries	<input type="checkbox"/>	<input type="checkbox"/>
(xiii) Galvanic	<input type="checkbox"/>	<input type="checkbox"/>			
(xiv) Ultraviolet	<input type="checkbox"/>	<input type="checkbox"/>			
(xv) Ultrasound	<input type="checkbox"/>	<input type="checkbox"/>			

d. If the answer to any of the questions below is No, please attach details. Do you:

- (i) Use the Georges test, the Vertebral Artery Ischemia Test or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six months? Yes No
 If No, please describe how you assess vascular flow.
 If an unusual finding results, do you refer the patient to the appropriate medical practitioner? Yes No
- (ii) Make a differential diagnosis? Yes No
- (iii) Always record the patient’s account of his/her progress? Yes No
- (iv) Always record objective findings? Yes No
- (v) Always record details of treatment procedures? Yes No

e. The practice for which coverage is requested is:

full-time part-time “moonlighting”

If the practice for which coverage is requested is part-time or “moonlighting” answer the following:

(i) Provide the name and address of your full-time position and number of weekly hours not including on-call.

(ii) Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice.

f. Do you work for and/or accept work assignments or placements from any locum tenens company? Yes No

If Yes, complete the following for each company:

<u>Name of Company</u>	<u>Address</u>	<u>Employee or</u> <u>Independent Contractor</u>	<u>No. of Hrs.</u> <u>Each Month</u>	<u>Is Prof. Liab. Insurance</u> <u>Provided to You? (Yes/No)*</u>
_____	_____	_____	_____	_____

* If Yes, attach a copy of your Certificate of Insurance.

If No, are you requesting coverage for this activity? Yes No

g. Are you a free-lance locum tenens not placed by or associated with any locum tenens company? Yes No

- h. Are you currently in active military service? Yes No
- i. Do you render professional services directly to patients? Yes No

If yes, please describe these services in detail and indicate whether you are supervised and by whom.

<u>Detailed Description of Professional Services</u>	<u>Percent of time Supervised</u>	<u>Qualifications of Supervisor</u>
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____

- j. Do you render professional services that do not involve contact with a patient? Yes No
If yes, please describe these services in detail. _____

- k. Do you administer any anesthesia? Yes No
If yes, please explain and indicate whether you are supervised and by whom. _____

- l. (i) Do you perform or assist in any surgical procedure(s)? Yes No
If yes, please answer (ii) below.

(ii) Please list ALL surgical procedures performed (including minor surgery): _____

- (iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? Yes No
If yes, please attach a detailed explanation.

- (iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? Yes No
If yes, please attach a detailed explanation.

- m. (i) Do you perform radiation therapy? Yes No
- (ii) Psychiatric shock therapy? Yes No

- n. Do you prescribe or dispense any drugs without the countersignature of a physician? Yes No
If yes, please provide a detailed explanation.

- o. Do you:
 - (i) Use acupuncture? Yes No
If Yes, do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique? Yes No
If No, do you use disposable needles? Yes No
If No, please attach details.
 - (ii) Dispense or prescribe: Drugs? Yes No
 - (iii) Use x-ray or imaging in treatment determination? Yes No
 - (iv) Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? Yes No
 - (v) Perform investigational or experimental research or therapy on human patients? Yes No

5. APPLICANT HISTORY (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS)

- a. Have you:
 - (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No
 - (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
 - (iii) Ever been treated for alcoholism or drug addiction? Yes No
 - (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No
 - (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? Yes No

- 6. Do you currently carry the following insurance:

a. **Professional Liability Insurance?**

Yes No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

b. **Commercial General Liability Insurance?**

Yes No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy? _____

7. CLAIMS HISTORY:

- a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? Yes No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS
IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT**

- b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No
If yes, provide full details. _____
- c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? Yes No
If yes, fully describe the circumstances and follow up action taken: _____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, 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.

*Notice applicable in most 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____/_____
Applicant's Signature **Title** **Date**