

Corporation and Partnership Professional Liability Application

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

- Current Declarations Page
- 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, if losses are noted in Section I
- Organizational chart
- Schedule of subsidiaries and/or affiliated entities with relationship to applicant
- Additional Supplements as indicated throughout the application

A. ENTITY APPLICANT INFORMATION

Name of Entity: _____

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

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 Practice Location: _____
Street City State Zip County

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

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

B. COVERAGE INFORMATION

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

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

- | | | | |
|--|-----------|---|--|
| <input type="checkbox"/> Shared with Physician(s) limits | OR | <input type="checkbox"/> \$100,000/\$300,000 | <input type="checkbox"/> \$500,000/\$1,500,000
<small>(MI only)</small> |
| | | <input type="checkbox"/> \$200,000/\$600,000
<small>(only limit available in KS)</small> | <input type="checkbox"/> \$1,000,000/\$1,500,000
<small>(MI only)</small> |
| | | <input type="checkbox"/> \$250,000/\$750,000 | <input type="checkbox"/> \$1,000,000/\$3,000,000 |
| | | <input type="checkbox"/> \$500,000/\$1,000,000 | <input type="checkbox"/> \$2,000,000/\$4,000,000 |

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

<input type="checkbox"/> None	<input type="checkbox"/> \$5,000/\$15,000	<input type="checkbox"/> \$10,000/\$30,000	<input type="checkbox"/> \$15,000/\$45,000
<input type="checkbox"/> \$25,000/\$75,000	<input type="checkbox"/> \$50,000/\$150,000	<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$200,000/\$600,000

4. 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? _____

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

C. RISK MANAGEMENT

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

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

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.

D. 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.

E. 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 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
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 and submit the following application: **Roster for CRNA and app for NP, PA, CNS and CNM***

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.

F. 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

F. CREDENTIALING (continued)

- 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? _____

G. 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, PLEASE PROVIDE A DETAILED NARRATIVE TO THE ABOVE QUESTIONS ON THE LAST PAGE.

H. 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?
			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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, PLEASE PROVIDE DETAILS.

I. LOSS INFORMATION

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: _____

**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.*

***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, PROVIDE DETAILS ON A CLAIM INFORMATION FORM.

J. 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: _____

K. 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.

For residents of all states except Oklahoma:

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.

Oklahoma residents: 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 false, incomplete or misleading information is guilty of a felony.

Signature of Applicant

Date

Signature of Agent

Date

L. DETAILS

Section/Question	Comments

