NAS Insurance Services, inc.

Application For:

Miscellaneous Medical Malpractice Insurance

(Claims Made Basis)

1. Name of Applicant: _____

2. Mailing Address: _____ Phone: ( ) _____

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

   No. of Locations: _____ **(If multiple names and locations, please attach list)**

3. a) Date Established _____ Corporation ☐ Partnership ☐ Professional Assoc. ☐ Individual ☐
   For Profit ☐ Not for Profit ☐

   b) In what states is the Applicant registered and licensed to practice? _____

   _____

   c) Please specify any professional societies or associations which you are a member. _____

   _____

4. a) Is the firm engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No
   b) Is the firm owned by any physician? ☐ Yes ☐ No
   c) Is the firm owned by any a hospital, or are any services hospital based? ☐ Yes ☐ No
   d) Have there been any changes in ownership of the business since the date the entity was established? ☐ Yes ☐ No

   If "Yes" to any of the above, give details: _____

   _____

   _____

   _____

5. Professional Activities and Specialty **(Attach narrative description if necessary)**

   Check all that apply:

   _____ Acupuncturist/Naturopathic Medicine
   _____ Alcohol/Drug/Psychiatric Rehabilitation
   _____ Ambulance Services
   _____ Ambulatory Surgery Center
   _____ Diagnostic Imaging
   _____ Dialysis Center
   _____ Health/Fitness Center
   _____ Home Healthcare Agency
   _____ Hospice
   _____ Medical Testing/Laboratory
   _____ Nurse Registry
   _____ Optometry
   _____ Out-Patient Medical Clinic
   _____ Out-Patient Mental Health Clinic
   _____ Pharmacy
   _____ Residential Facility
   _____ Speech Therapy
   _____ Other (Specify): _____

6. State approximate division of Applicant's patients among:

a) Alcoholics	(%)	k)	Obstetrical	(	%)
b) Counseling/Family Planning	(%)	l)	Pediatric	(	%)
c) Communicable	(%)	m)	Prisoners	(	%)
d) Dental	(%)	n)	Psychiatric	(	%)
e) Drug Addicts	(%)	o)	Research or Experimental	(	%)
f) General	(%)	p)	Senile or Aged	(	%)
g) Hemodialysis	(%)	q)	Stress Testing	(	%)
h) Holistic Medicine	(%)	r)	Surgical	(	%)
i) Medical	(%)	s)	Tubercular	(	%)
j) Mentally Retarded	(%)	t)	Other: _____	(	%)

7. a. List the number and type of Applicant's employees and volunteers below: If "None," state None. _____

Number	Type of Profession		Number	Type of Profession
i) _____	Acupuncturist	xiv)	_____	Optometrists
ii) _____	Counselors	xv)	_____	Paramedics
iii) _____	EMT's	xvi)	_____	Perfusionists
iv) _____	Home Health Aides	xvii)	_____	Pharmacists
v) _____	Inhalation Therapists	xviii)	_____	Physician Assistants
vi) _____	Laboratory Technicians	xix)	_____	Physicians – Minor Surgery
vii) _____	Massage Therapists	xx)	_____	Physicians – No Surgery
viii) _____	Medical Directors	xxi)	_____	Physiotherapists
ix) _____	Nurse Anesthetists	xxii)	_____	Psychologist
x) _____	Nurses, Licensed Practical	xxiii)	_____	Social Workers
xi) _____	Nurse Practitioner	xxiv)	_____	Speech Therapists
xii) _____	Nurses Registered	xxv)	_____	Other: _____
xiii) _____	Opticians			

b. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet, if necessary.

_____

_____

_____

If "None," state None. _____

c. Are all of the individuals listed in question 7.a. and 7.b. licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

If "No," attach explanation.

d. Are all employed/contracted physicians board certified in their specialty? ☐ Yes ☐ No

(Attach detailed explanation for any "Yes" answers to the following:)

e. 1) Are criminal background checks conducted on all employees? ☐ Yes ☐ No

If "No," attach explanation.

2) Does the Applicant conduct preemployment screenings and any other necessary investigations prior to hiring all staff? ☐ Yes ☐ No

f. Has the Applicant or any of the individuals listed in question 7.a. and 7.b.:

i) Ever been the subject or disciplinary or investigative proceedings or reprimand by a governmental or administrative 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

ix) 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

8. a) Is there a written/formalized risk management/quality assurance program? ☐ Yes ☐ No

b) Does the Applicant have a written credentialing process for employees and staff? ☐ Yes ☐ No

c) Does the Applicant have written procedures for reporting all incidents? ☐ Yes ☐ No

If "No" to any of the above, attach explanation.

9. State approximate division of services being provided among the following settings:

a) Assisted Living Facilities	(%)		e) Nursing Homes	(%)	
b) Clinics	(%)		f) Physician Offices	(%)	
c) Emergency Rooms	(%)		g) Private Homes	(%)	
d) Hospitals	(%)		h) Other: _____	(%)	

10. For AMBULANCE SERVICES, answer the following:

Number of Ground Ambulances _____ Number of Emergency Calls (per year) _____
Number of Non-Emergency Calls (per year) _____

Number of Air Ambulances _____ Number of Transport Calls (per year _____
Number of Body Transports (per year) _____

Radius of Services _____ Is the Applicant part of a Fire Department? ☐ Yes ☐ No

11. For AMBULATORY SURGERTY CENTERS, answer the following:

Number of Surgical Procedures in the next 12 months _____
Percentage of procedures using general anesthesia _____

12. For DIALYSIS CENTERS, answer the following:

Number of hemodialysis treatments in the next 12 months _____
Number of peritoneal treatments in the next 12 months _____
Hours of service in the next 12 months for in home treatments _____
Number of stations _____

13. For ALCHOHOL/DRUG/PSYCHIATRIC REHABILITATION CENTERS, answer the following:

Number of total licensed beds _____
Are there off site counseling services? ☐ Yes ☐ No
Are all counselors licensed? ☐ Yes ☐ No
Are there interns counselors? ☐ Yes ☐ No

14. For HEALTH/FITNESS CENTERS, answer the following:

Is there a pool? ☐ Yes ☐ No
Are there tanning beds? ☐ Yes ☐ No

(Attach detailed explanation for any "Yes" answers to the following:)

15. Does the Applicant perform:

a.	Acupuncture or acupuncture anesthesia?	☐ Yes ☐ No
b.	Angiography/Arteriography/Venography?	☐ Yes ☐ No
c.	Cardiac Catheterization?	☐ Yes ☐ No
d.	Catheterization (other than cardiac, urinary or umbilical)?	☐ Yes ☐ No
e.	Closed reduction of compound fractures?	☐ Yes ☐ No
f.	Normal Deliveries?	☐ Yes ☐ No
g.	Dermabrasion?	☐ Yes ☐ No
h.	Injection of radioisotopes and/or use of irradiated substances?	☐ Yes ☐ No
i.	IV/Infusion Therapy?	☐ Yes ☐ No
j.	AIDS Therapy?	☐ Yes ☐ No
k.	Radiation Therapy and/or Chemotherapy?	☐ Yes ☐ No
l.	Psychiatric shock therapy?	☐ Yes ☐ No
m.	Silicone Injections?	☐ Yes ☐ No
n.	Spinal Anesthesia (other than saddle blocks or caudals)?	☐ Yes ☐ No
o.	Botox Injections?	☐ Yes ☐ No
p.	Chelaton Therapy?	☐ Yes ☐ No
q.	DNA Testing?	☐ Yes ☐ No
r.	Genetic Testing?	☐ Yes ☐ No
s.	Environmental Testing?	☐ Yes ☐ No
t.	Pharmaceutical Testing?	☐ Yes ☐ No
u.	Testing of any weapons?	☐ Yes ☐ No
v.	Blood Banking?	☐ Yes ☐ No
w.	Clinical Trials or Research using animal or human test subjects?	☐ Yes ☐ No
x.	Teleradiology?	☐ Yes ☐ No
y.	Telemedicine?	☐ Yes ☐ No

(Attach detailed explanation for any "Yes" answers to the following:)

16. Does the Applicant perform any:

a.	Surgery other than incision of superficial boils or suturing superficial fascia?	☐ Yes ☐ No
b.	Circumcisions?	☐ Yes ☐ No
c.	Dilation and curettage?	☐ Yes ☐ No
d.	Insertion of temporary pacemakers?	☐ Yes ☐ No
e.	Tonsillectomies and/or Adenoidectomies?	☐ Yes ☐ No
f.	Caesarean Sections?	☐ Yes ☐ No
g.	Cosmetic Plastic Surgery?	☐ Yes ☐ No
h.	Excision of large cysts and/or I&D of deep-seated boils or carbuncles?	☐ Yes ☐ No
i.	Hysterectomies?	☐ Yes ☐ No
j.	Open reduction of fractures?	☐ Yes ☐ No
k.	Surgery for weight reduction of patients?	☐ Yes ☐ No
l.	Abortions and/or Menstrual extractions? (If "Yes," include trimester, method and number of abortions performed per month in description.)	☐ Yes ☐ No
m.	Silicone Implants?	☐ Yes ☐ No
n.	Sterilization Procedures?	☐ Yes ☐ No
o.	Biopsies and/or Endoscopies?	☐ Yes ☐ No

p. Therapeutic Optometry (implantation of prosthetic ocular devices)? ☐ Yes ☐ No

q Sex change operations? (If "Yes," advise the number performed per year.) ☐ Yes ☐ No

r. Other surgery ☐ Yes ☐ No

17. Does the Applicant perform hospital emergency room care?

a. For its own patients? ☐ Yes ☐ No

b. For patients not its own? ☐ Yes ☐ No

c. If answer to (b) is "Yes," please specify: the percentage of its time devoted to this work = _____%, the number of hours per month devoted to this work = _____hrs.

18. Does the applicant use drugs for weight reduction for patients? ☐ Yes ☐ No
If "Yes," list drugs used and advise: Percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by Applicant:

_____

_____

19. Does the Applicant administer any methadone treatment? ☐ Yes ☐ No
If "Yes," please complete the methadone supplementary application.

20. Is anesthesia (other than topical or by means of local infiltration) administered by either Applicant or others? ☐ Yes ☐ No
If "Yes," attach detailed explanation.

21. Does the Applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No
If "Yes," number of licensed beds by location: _____

_____

_____

22. State number of x-ray machines owned or operated and whether they are used for diagnosis or treatment or both:

_____

_____

State by whom treatment is given and number of procedures: _____

_____

23. Does the Applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? ☐ Yes ☐ No
If "Yes," give details, including name, location, size and number of beds: _____

_____

_____

24. Does the Applicant sell or lease any equipment for use by any other persons or entities? ☐ Yes ☐ No
If "Yes," give details, including name, location, size and number of beds: _____

_____

_____

25. a) State sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
A. Charitable Contributions	$ _____	$ _____
B. Government Funding	$ _____	$ _____
C. Fee for Services	$ _____	$ _____
D. Other: _____	$ _____	$ _____
E. Other: _____	$ _____	$ _____
TOTAL GROSS REVENUE	$ _____	$ _____

b) For PHARMACIES, state sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
A. Prescription Sales	$ _____	$ _____
B. Non-Prescription Sales	$ _____	$ _____
C. Other: _____	$ _____	$ _____

c) Are all drugs dispensed approved by the FDA? ☐ Yes ☐ No

If "No," attach explanation.

26. Number of estimated patient encounters last 12 months _____ and/or patient tests carried out _____. (Note: "patient encounters" refers to number of visits – not number of patients)

27. Number of estimated patient encounters and patient tests in the next 12 months:
(Note: "patient encounters" refers to number of visits – not number of patients.)

Patient encounters _____

Patient Tests _____

28. Describe Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

If the expiring policy is claims made, what is the retroactive date? _____

29. Has any insurer cancelled or refused to renew any similar insurance during the past five years? ☐ Yes ☐ No

If "Yes," please describe: _____

30. Is the Applicant currently insured under a Commercial General Liability Policy? ☐ Yes ☐ No

If "Yes," please give details:

Insurance Company	Type of Coverage	Limits Bl	Limits PD	From	To

31. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners even been declined or has the insurance ever been cancelled or renewal refused? ☐ Yes ☐ No

If "Yes," please describe: _____

_____

Please answer Questions 31 and 32 below if the Applicant does not currently have Miscellaneous Medical Professional/General Liability through NAS Insurance Services, Inc.

32. Has any claim ever been made against the firm or any of its employees? ☐ Yes ☐ No
If "Yes," please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

33. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? ☐ Yes ☐ No

If "Yes," please give full details on the same basis as item 31.

34. Please answer this question if the Applicant currently has Miscellaneous Medical Professional/General Liability through NAS Insurance Servcies, Inc.
Has the applicant notified NAS Insurance Services of all litigation, administrative proceedings, demand letters, formal or informal governmental investigations or inquiries which have occurred in the past 12 months? ☐ Yes ☐ No ☐ None to Report

If "Yes," please indicate number of event in the last 12 months. _____
If "No," please forward notice to NAS Insurance Services, Inc., on behalf of Underwriters, immediately.

35. Limits of Liability requested _____ Deductible _____

36. Desired term of policy: From _____ To _____

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein proper to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

For Kentucky residents:
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 commits a fraudulent insurance act, which is a crime.

Name of Applicant: _____
Please Print Title Date

Signature: _____
Name Date