CNA HEALTHPRO
MEDICAL PRACTITIONERS APPLICATION
CLAIMS-MADE COVERAGE

Carefully read this page and the questions posed in this application. In order for you to be considered for coverage, this application must be completed in full and submitted along with required attachments and/or supplementary information requested throughout the application. ***In order to expedite the underwriting process, please write legibly and ensure that all questions have been fully answered.*** Additional information may be required upon review of the application. If the application does not provide you with sufficient space to properly respond to a question, please write "*see attached*" and respond via separate attachment. Please be sure to sign and date the attachment.

- **The following required attachments must be submitted along with the fully completed application.**

  - ☐ Copy of current Insurance Policy declarations page.
  - ☐ Copy of the Extended Reporting Endorsement from your current/past carrier(s) if your current coverage is claims-made and you are **not** applying for prior acts coverage (aka retroactive or nose coverage).
  - ☐ Up-to-date Curriculum Vitae/Resume.
  - ☐ Copies of all current advertising materials such as Brochures, Yellow Pages, Newspaper, and/or Magazine advertisements. Also include copies of scripts for voice and/or film media.
  - ☐ Formal, up-to-date loss runs from all prior insurance companies for the past 10 years.
  - ☐ A ***CLAIM / INCIDENT / SUIT SUPPLEMENT*** form (last page of the application) must be completed for each claim, incident and/or suit you have ever been involved with either directly or indirectly. You must also complete this form for any precautionary report (aka incident report) you have ever submitted to your present or past professional liability insurance carrier(s).
  - ☐ Please attach a copy of your business letterhead.

- **Please contact your insurance agent if you have any questions concerning this application or the coverage for which this application applies.**

NOTE:

This is an application for insurance, not an insurance binder. Your application is subject to underwriting review and approval by the company. The effective date, prior acts date (aka retroactive date or nose coverage), and additional classification and/or rating aspects of this application are also subject to approval by the company. In no event can the requested coverage effective date be prior to the date this application is received by us. If the application is hand-carried or received by facsimile, the effective date of coverage will be no earlier than the following day. No offer of coverage exists unless and until this application is accepted/approved by the company, **and**, you have received written notification of said acceptance.

I PERSONAL/PROFESSIONAL DATA

Name (last, first, middle, designator)				Date of birth (MM/DD/YY)
Clinic name/Employer				
Maiden Name (if applicable)				Designation ☐ MD ☐ DO

Have you ever practiced under a name other than as it appears on your medical license? ☐ No ☐ Yes
If yes, under what name(s) have you practiced and attach a copy of the applicable legal documents:

____

____

Primary practice address	City	State	Zip Code	County
Residence address	City	State	Zip Code	County
Telephone - office	Fax number		Telephone – residence	
Number of years at current office location	If less than three years, list previous locations and dates			
Tax I.D. number			Social Security number	
Additional practice locations			Email Address	

Desired policy dates

Effective date: ____________________

Prior Acts date: ____________________

Desired coverages/limits

Professional liability: $ ____________________ each claim

$ ____________________ aggregate

1. If you are currently insured by a claims-made policy:

A. Are you obtaining Extended Reporting ("tail") coverage from your current insurance company? ☐ No ☐ Yes

B. Is Prior Acts coverage being requested? ☐ No ☐ Yes

If Yes, show Prior Acts effective date: __________________________

Note: **To prevent possible gaps in your claims-made coverage, either Extended Reporting or Prior Acts coverage must be purchased.**

2. **Have you <u>ever</u>** practiced without insurance or had a claims-made policy lapse without purchasing the Extended Reporting Period (aka "Tail") Endorsement? ☐ No ☐ Yes
<u>IF YES</u>, please explain circumstances (i.e. "why") and note date(s):

____

____

COMPANY/AGENCY USE ONLY

Territory	Dec ISO	PLD code	Policy number	Group	Producer number
Step	Rate ISO	Rate class	Account number	Producer's name	

II MEDICAL TRAINING AND HISTORY

Please answer all questions completely. If a question does not apply to you, mark "N/A" or "0."
Do not leave any questions unanswered. If space is inadequate, use the Comments section or attach a separate sheet.

3. Medical specialty: ____________________ Percentage of practice: __________ **%**

Sub-specialty: ____________________ Percentage of practice: __________ **%**

A. Do you limit your practice to the above Specialty and/or Sub-specialty? ☐ No ☐ Yes
IF NO, please explain: ______________________________

____

B. Will you or have you provided professional services outside of the United States? ☐ No ☐ Yes

C. Have you added or discontinued procedures which are considered to be outside of, or not usual to the above practice specialty, or are experimental in nature? ☐ No ☐ Yes
IF YES, please list procedures/services and note dates of change(s):

____

____

D. Have you changed your medical specialty? ☐ No ☐ Yes
IF YES, please provide complete details and note dates of change(s):

____

____

4. Medical education

	Specialty	State	From	To	Completed?
A. Medical school: Institution		State	From	To	Completed? ☐ No ☐ Yes
B. Internship: Institution		State	From	To	Completed? ☐ No ☐ Yes
C. Residency: Institution	Specialty	State	From	To	Completed? ☐ No ☐ Yes
D. Residency: Institution	Specialty	State	From	To	Completed? ☐ No ☐ Yes
E. Fellowship: Institution	Specialty	State	From	To	Completed? ☐ No ☐ Yes

5. If you are a graduate of a foreign medical school:
- are you certified by the Education Council for Foreign Medical Graduates? ☐ No ☐ Yes Date completed: _______
- have you passed the CFMG? ☐ No ☐ Yes

6. Number of hours continuing education completed within the past two years: _______ hrs.

II MEDICAL TRAINING AND HISTORY (continued)

7. Date and location you began practicing: ____________________ ____________________

Date City,State

8. Medical license information

Please list all of your medical licenses including all active and inactive licenses:

State	License number	Expiration date	Status

9. **ABMS** (American Board of Medical Specialties) and/or **AOA** (American Osteopathic Association) Certification Information

b. How many times have you taken the exam(s) for certification? Orals: _______ Written: _______

c. If you are **not** **ABMS** or **AOA** certified, do you intend to pursue certification? Please check appropriate box below and respond accordingly:

☐ **N/A** ⇔ **IF N/A**, (i.e. you are already certified) please skip the rest of this question.

☐ **YES** ⇔ **IF YES,** please use space below to outline your plans for pursuing certification.

☐ **NO** ⇔ **IF NO,** please use space below to explain why you do not intend to pursue certification and/or why you are not certified. If additional space is needed, please write "*see attached*" and respond via separate attachment.

____

____

____

10. Board certification information

Name of board: ______________________________ ☐ Certified ☐ Qualified

Name of board: ______________________________ ☐ Certified ☐ Qualified

Name of board: ______________________________ ☐ Certified ☐ Qualified

11. **List locations where you have practiced since** completion of Residency and/or Fellowship program(s) to date and explain any gaps in your practice history. If provided in Curriculum Vitae or Resume, no need to complete.

Type of practice or position (e.g., group or private practice, hospital employee, medical director, independent contractor, etc.)	**Physical** street address	City	State	Dates (Month/Year) Start	End

II MEDICAL TRAINING AND HISTORY (continued)

12. In regard to your Medical License:

- **a.** Has any State/Medical Board ever refused you a medical license? ☐ No ☐ Yes
- **b.** Has any State/Medical Board ever restricted, suspended or revoked your medical license? ☐ No ☐ Yes
- **c.** Has any State/Medical Board ever imposed a fine or any other obligation? ☐ No ☐ Yes
- **d.** Has any State/Medical Board ever issued a letter of guidance? ☐ No ☐ Yes
- **e.** Have you ever voluntarily surrendered a medical license? ☐ No ☐ Yes
- **f.** Has any State/Medical Board ever placed you on probation or restricted your practice? ☐ No ☐ Yes
- **g.** Is your medical license currently under investigation for any reason? ☐ No ☐ Yes
- **h.** **IF YES** to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents:

____

____

____

13. Narcotics/DEA license number: ______________________ Status: ______________

14. Has your Narcotics/DEA license ever been surrendered/refused/suspended/revoked, voluntarily or otherwise? ☐ No ☐ Yes
IF YES, describe circumstances, outcome, dates, and attach copies of any relevant documents:

____

____

15. Have you ever been evaluated, treated or recommended for treatment of alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? ☐ No ☐ Yes
IF YES, describe circumstances, outcome, dates, and attach copies of any relevant documents:

____

____

16. Have you ever been diagnosed with, or treated for, a chronic physical illness and/or disability? ☐ No ☐ Yes
IF YES, provide complete details including dates and attach copies of any relevant documents:

____

____

17. Are you aware of any physical illness, mental illness and/or disability which affects, or could affect, your ability to practice medicine now or anytime in the future? ☐ No ☐ Yes
IF YES:

- **a.** Provide complete details including diagnosis/prognosis/dates and attach copies of any relevant documents:

____

____

- **b.** Attach letter from your treating physician addressing your state of health and whether any condition exists which could adversely affect your ability to practice medicine.

18. Has any professional conduct or fee complaint ever been filed against you with any Specialty, National, State or County Medical Society or other Professional Association? ☐ No ☐ Yes
IF Yes, describe circumstances, outcome and dates and attach copies of any relevant documents:

____

____

19. Has any professional conduct or fee complaint ever been filed against you with any licensing or regulatory authority? (e.g., AHCA/DPR/Board of Medicine or Health; Medicare/Medicaid; OSHA; EEOC; etc.) ☐ No ☐ Yes
IF YES, describe circumstances, outcome and dates:

____

____

II MEDICAL TRAINING AND HISTORY (continued)

20. **Have you ever** been charged with or convicted of a felony or misdemeanor for **other than** a minor traffic violation? ☐ No ☐ Yes

IF YES, describe circumstances, outcome, dates, and attach any relevant documents:

____

____

III INSURANCE HISTORY

21. Provide complete insurance history for past 10 (ten) years beginning with your current insurance carrier. If there is an uninsured period, please write "uninsured" or "bare". Please be sure to explain any gaps in your coverage.

Name of Insurance Carrier	Policy Number	Prior Acts Date	Policy Limits	Deductible or SIR?	Period of Coverage (Month/Day/Year)		Claims Trigger
				☐ No ☐ Yes	From:	To:	☐ Incident Driven ☐ Written Demand
				☐ No ☐ Yes	From:	To:	☐ Incident Driven ☐ Written Demand
				☐ No ☐ Yes	From:	To:	☐ Incident Driven ☐ Written Demand
				☐ No ☐ Yes	From:	To:	☐ Incident Driven ☐ Written Demand
				☐ No ☐ Yes	From:	To:	☐ Incident Driven ☐ Written Demand
				☐ No ☐ Yes	From:	To:	☐ Incident Driven ☐ Written Demand

22. Has your insurance for medical malpractice ever been canceled, suspended, non-renewed or declined?

☐ No ☐ Yes — Explain: ______________________________

23. Have you ever had professional liability insurance provided by CNA? ☐ No ☐ Yes

24. Do you have any medically related duties that are insured by another company or for which you do not desire CNA Coverage?

☐ No ☐ Yes — Explain: ______________________________

IV CURRENT MEDICAL PRACTICE

25. **Are you practicing in a part-time, semi-retired,** or limited capacity? ☐ No ☐ Yes

IF YES:

a. Provide date you began part-time practice: _______/_______/_______
MONTH DAY YEAR

b. Provide total number of ***hours per week*** you devote to the following aspects of your practice:

i. _______ Actual patient care
ii. _______ Patient record keeping
iii. _______ Administrative duties for your practice
iv. _______ After hours emergency care
v. _______ Hospital rounds
vi. _______ Returning patients' calls (including after hours)

c. Provide ***reason(s)*** why you are no longer engaged in a full-time practice **and** describe ***activities*** you are involved in, business related or otherwise, outside of your part-time practice.
{e.g., ***Reason(s)***: health/medical reasons; enables you to travel; spend more time with the family, etc. ***Activities***: teaching/faculty appointment; involved in other than a medical related business (describe business); study for boards; work part-time elsewhere; etc.}

____

____

26. Percentage of your practice outside of your primary state? _______ %

List States: ____

27. Percentage of your practice devoted to practicing as a locum tenens: _______ %

28. Practice structure / ownership information (please check all that apply):
You are a/an:

a.

No	Yes		No	Yes	
☐	☐	Solo Practitioner	☐	☐	Shareholder or Stockholder of a **multi-member** corporation
☐	☐	Solo Corporation	☐	☐	Limited Liability Partnership
☐	☐	Solo Professional Association	☐	☐	Medical Partnership, be it legal or "implied"
☐	☐	Hospital Employee	☐	☐	Using an assumed or fictitious name (i.e. a "DBA")
☐	☐	Hospitalist	☐	☐	**Employed by** another individual or corporate entity
☐	☐	Independent Contractor	☐	☐	**Employer of** other physicians
☐	☐	Other: ⇔ Describe: ____________			

b. For other than a Solo Practitioner or Solo Corporation/Professional Association, explain your relationship and provide complete, detailed information in regard to any items checked above.
For example:

- If a Hospitalist, Hospital employee or Independent Contractor, provide name of organization you are contracted with and/or employed by and explain scope of duties;
- If employed by, or contracted by, another individual or corporate entity, provide complete name of employer and/or entity with whom you are contracted by and explain scope of duties;
- If using an assumed or fictitious name (i.e. a "DBA"), provide complete "DBA" name;
- If employer of other physicians, provide complete/detailed list of employed physicians including their name, medical specialty and relationship to you.

Provide any additional information you feel will help clarify, or explain, items checked above. If additional space is needed, please write "*see attached*" and respond via separate attachment.

____
____
____
____
____
____
____
____

29. Are you in a space-sharing arrangement or agreement with another, or other, physician(s)? ☐ No ☐ Yes
IF YES, provide:

a. Name(s) of other physician(s) with whom you are space sharing:

____
____

b. How, **exactly**, does the sign to the entrance of the practice (i.e. the front door) read?

____
____

c. Do you share receptionist? ☐ No ☐ Yes

d. Do you share employees that provide medical care? ☐ No ☐ Yes

e. Do you have a common waiting room? ☐ No ☐ Yes

f. Are there common examination rooms? ☐ No ☐ Yes

g. Are patient charts for all space sharing physicians kept or retrieved from the same area? ☐ No ☐ Yes

h. Are there various letterheads being used by the physicians with whom you are space sharing? ☐ No ☐ Yes

IF YES, attach a copy of all letterheads being used by the physicians with whom you are space sharing.

IV CURRENT MEDICAL PRACTICE (continued)

i. Provide any additional information you feel will better help the company understand your space-sharing arrangement: If additional space is needed, please write "*see attached*" and respond via separate attachment.

____

____

30. Are you under contract (other than PPO, HMO, IPA or anything listed in Question 7) in any capacity involving the practice of medicine?

☐ No ☐ Yes — Explain: ______________________________

31. Do you have hospital privileges? ☐ No* ☐ Yes

Hospital Name	City, County, State	Type of privilege
		☐ Full ☐ Courtesy ☐ Restricted ☐ Other*
		☐ Full ☐ Courtesy ☐ Restricted ☐ Other*
		☐ Full ☐ Courtesy ☐ Restricted ☐ Other*

*** If No, Restricted or Other, please explain on your letterhead and explain your referral process.**

32. a. Are you professionally associated with (either directly or indirectly), and/or do you provide professional services on behalf of (either directly or indirectly), and/or do you have a financial interest in, any of following. Please answer all.

No	Yes	Loc. Code #	Location Type	No	Yes	Loc. Code #	Location Type
☐	☐	01	Abortion Clinic	☐	☐	23	Industrial Firm Medical Care Facility
☐	☐	02	Administrative Position	☐	☐	24	Inpatient (bed/board) type Facility
☐	☐	03	Adult Congregate Living Facility	☐	☐	25	Massage Parlor/Establishment
☐	☐	04	Adult Day Care type Facility	☐	☐	26	Medical Laboratory
☐	☐	05	Ambulatory Surgery Center or Surgi-Center	☐	☐	27	Military Service (active or reserve)
☐	☐	06	Birthing Center	☐	☐	28	Nursing Home
☐	☐	07	Chemotherapy or Infusion Center	☐	☐	29	Occupational or Orthopaedic Rehab Center
☐	☐	08	College/University Sports (team or individual)	☐	☐	30	Palliative Care
☐	☐	09	Cruise Ship	☐	☐	31	Paramedical Services
☐	☐	10	Day Spa	☐	☐	32	Pharmacy
☐	☐	11	Developmentally Disabled Facility	☐	☐	33	Private Practice
☐	☐	12	Dialysis Center	☐	☐	34	Psychiatric Facility
☐	☐	13	Educational Institution	☐	☐	35	Radiology and/or Imaging Center
☐	☐	14	Facial Salon	☐	☐	36	Rehabilitation Facility
☐	☐	15	Fitness Center	☐	☐	37	Sanatorium
☐	☐	16	Governmental Entity	☐	☐	38	Semi or Professional Sports (team or individual)
☐	☐	17	Grade or High School Sports (team or individual)	☐	☐	39	Tattoo Parlor/Establishment
☐	☐	18	Hair Restoration or Laser Hair Removal Clinic	☐	☐	40	Urgent Care or E-Care type facility
☐	☐	19	Home Health Care Services	☐	☐	41	Vein Clinic
☐	☐	20	Hospital-Based Practice	☐	☐	42	Walk-In Clinic
☐	☐	21	Hotel	☐	☐	43	Weight Loss Center
☐	☐	22	Other(s) ⇔ please explain:				

b. Please use this space to explain your professional and/or financial relationship with each of the above. If additional space is needed, please write "*see attached*" and respond via separate attachment.

____

____

____

____

____

33. **Are you a Medical Director** or have you accepted similar type responsibilities for or on behalf of a medical office, hospital, nursing home, sanitarium, any other in or out-patient type facility or an entity providing patient / medical related services? ☐ No ☐ Yes

34. **Do you currently, or do you intend to,** carry (or be provided with) any other medical professional liability insurance in addition to the coverage for which you are applying? ☐ No ☐ Yes

IF YES:

a. Provide complete details:

____

____

b. Provide proof of coverage from the other company or explain why you do not have coverage for these activities:

____

____

35. **Please complete the following**

a. Do you employ, supervise or contract with individual(s), physicians or otherwise, who:

i. perform patient manipulation of skeletal structure? ☐ No ☐ Yes

ii. hold a U.S. or foreign MD license/designation and practice as a non-MD healthcare provider? ☐ No ☐ Yes

iii. hold a foreign MD license/designation and practice as an MD with a restricted or limited medical license? ☐ No ☐ Yes

b. Do you employ, supervise or contract with any of the following?

NOTE: For the "**Status**" column, please indicate as follows:

‘**E**’ = Employee
‘**S**’ = Supervise only (i.e. not your employee)
‘**I/C**’ = Independent Contractor

No	Yes		Status: 'E', 'S' or 'I/C'	How many?	No	Yes		Status: 'E', 'S' or 'I/C'	How many?
☐	☐	Aesthetician			☐	☐	Optometrist and/or Optician		
☐	☐	Anesthesiology Assistants			☐	☐	Paramedic		
☐	☐	Chiropractor			☐	☐	Pharmacist		
☐	☐	Electrologist			☐	☐	Physical Therapist		
☐	☐	H/L Perfusionist			☐	☐	Physician Assistant		
☐	☐	Lay Midwife			☐	☐	Podiatrist		
☐	☐	Massage Therapist			☐	☐	Psychologist		
☐	☐	Naturopath			☐	☐	Scrub Nurse (in OR)		
☐	☐	Nurse Anesthetist			☐	☐	Sex Therapist		
☐	☐	Nurse Midwife			☐	☐	Surgeon Assistant		
☐	☐	Nurse Practitioner			☐	☐	Tattoo Artist		
☐	☐	Other: ↔ Description:							

36. **Telemedicine, E-Commerce Medicine, Internet Medicine and/or Internet Prescribing**

a. Do you perform/provide consultations, diagnose and/or treat, provide medical advice and/or opinions, review slides or specimens, prescribe medications, sell any products (as a distributor or for products you make, produce and/or manufacture), or sell any type of services via telecommunications, video, electronic information systems or the Internet? ☐ No ☐ Yes

IF YES:

i. Explain/describe services in detail (if additional space is needed, please write "*see attached*" and respond via separate attachment):

____

ii. List states services in which services are provided:

iii. Do you adhere to standards relating to telemedicine set forth by professional organizations such as the American College of Radiology, Standard for Teleradiology, the American Telemedicine Association, including licensor? ☐ No ☐ Yes

Explain: ______

b. Have you agreed, via contract or otherwise, to be the prescribing physician for an Internet site/service not directly associated with your private practice? ☐ No ☐ Yes
IF YES, please respond to the following:
- i. Do you prescribe drugs based solely on an electronic medical questionnaire? ☐ No ☐ Yes
- ii. Do you do this for more than one Internet site? ☐ No ☐ Yes
- iii. Provide all applicable web page/internet address(es): ☐ No ☐ Yes

____

____

c. Do you practice telemedicine services described above across international lines? ☐ No ☐ Yes
If yes, please list countries:

____

____

37. **Do you now**, **OR have you ever**, provided professional services on behalf of a **jail, prison, correctional facility, detention center, halfway house** or similar type facility for adults and/or juveniles? ☐ No ☐ Yes
IF YES:

a. Do you **currently** provide services on behalf the above described facilities? ☐ No ☐ Yes
- i. **IF YES**, provide total number of hours per month: ________
- ii. Complete details including "duties/services/when/where":

____

____

b. Have you **in the past** provided services on behalf of above described facilities? ☐ No ☐ Yes
- i. Complete details including "duties/services/when/where":

____

____

38. **Approved and non-approved FDA drugs / devices / procedures**
If additional space is needed, please write "*see attached*" and respond via separate attachment.

a. Do you perform any procedures/surgeries considered to be experimental in nature **and/or** not currently approved by the FDA? ☐ No ☐ Yes
IF YES, please provide complete details:

____

b. Are you involved/associated with any devices, including implants, considered to be experimental **and/or** not currently approved by the FDA? ☐ No ☐ Yes
IF YES, please provide complete details:

____

____

39. **Are you associated with (directly or indirectly), or do you participate in, TV reality shows** whose primary focus is to physically alter the looks of individuals who have either won a place on the show or who have been selected to be a participant in the show? ☐ No ☐ Yes

40. Have your hospital privileges ever been suspended, denied, revoked, restricted or otherwise sanctioned?
☐ No ☐ Yes — Explain: ______________________________

41. Do you work in the emergency department other than to fulfill requirements for you hospital privileges?
☐ No ☐ Yes — List number of hours per week: ______________________________

42. Office Surgery and Anesthesia

a. Do you follow/adhere/comply with all guidelines and standards for office space surgery as defined by the American Association of Anesthesiologists and the American College of Surgeons: ☐ No ☐ Yes

b. Do you (or will you) perform, or assist with, any **Level II and/or Level III** surgical procedure at **other than** a Hospital? ☐ No ☐ Yes

c. Do you (or will you) administer anesthesia (and/or supervise anyone administering anesthesia) for any **Level II and/or Level III** surgical procedure performed at **other than** a Hospital? ☐ No ☐ Yes

d. Do you maintain any overnight facilities in your office? ☐ No ☐ Yes

e. **IF YES to 'b' and/or 'c' above**, complete the following:

i. Do you have privileges at a local hospital for **all** procedure(s) performed and/or anesthesia administered (administering anesthesia includes the supervising of anyone administering anesthesia)? ☐ No ☐ Yes

IF NO, please explain:

____

____

ii. Anesthesia is administered by whom (e.g., yourself, Anesthesiologist, CRNA, contracted, etc.):

____

____

iii. Do you maintain a full emergency/crash cart? ☐ No ☐ Yes

IF YES, is a protocol in place for checking the cart on a regular basis? ☐ No ☐ Yes

iv. Name of, and distance to, nearest hospital with emergency services:

____

____

43. If you perform surgery, which of the following describes your practice?

☐ **No Surgery** — perform neither surgery nor obstetrical procedures. Incising of boils and superficial fascia, suturing or minor lacerations, removal of superficial skin lesions by other than surgical excision and assisting in surgery are not considered surgery.

☐ **Minor Surgery** — applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following medical techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive), tonsillectomies, and adenoidectomies.

Please list types of procedures routinely performed: ______________________________

____

____

☐ **Major Surgery** — includes operations in or upon any body cavity including, but not limited to, the carnium, throax, abdomen, pelvis or any other operation which because of the condition of the patient or length of the circumstances of the operation presents a distance hazard to life. It also includes: removal of tumors, open bone fractures, amputations, termination of pregnancy, the removal of any gland or organ (excluding tonsillectomies and adenoidectomies), plastic surgery and any operation done using general anesthesia.

Number per year: _______

Please list types of procedures routinely performed: ______________________________

____

____

☐ **Bariatric Surgery**

IV CURRENT MEDICAL PRACTICE (continued)

44. Please answer the following. If you answer yes to any question with asterisks(**), please explain fully on your letterhead.

Do you perform the following procedures?

A.	Elective cosmetic surgery	☐ No ☐ Yes —	percentage of practice: _______ %
B.	Itinerant surgery	☐ No ☐ Yes **	
C.	Vaginal deliveries	☐ No ☐ Yes —	number per year: _______
D.	Cesarean sections	☐ No ☐ Yes —	number per year: _______
E.	Deliveries outside the hospital	☐ No ☐ Yes **	
F.	Abortions	☐ No ☐ Yes —	percentage of practice: _______ %
G.	Neonatology	☐ No ☐ Yes —	percentage of practice: _______ %
H.	Professional sports medicine	☐ No ☐ Yes **	
I.	Angiography/arteriography/ cardiac catheterization	☐ No ☐ Yes	
J.	Experimental procedures	☐ No ☐ Yes **	
K.	Weight control surgery/drugs	☐ No ☐ Yes **	percentage of practice: _______ %

L. If you are a primary care physician, do you automatically receive the results of tests and consultation/exam reports ordered by the physician/surgeon to whom your patient was referred?

☐ No
☐ Yes — How quickly do receive them?

45.
- **a. Average number** of patients seen per **week**: _______
- **b. Do you accept "walk-in"** patients? ☐ No ☐ Yes
- **c.** Percentage of practice of **"walk-in"** patients: _______

46. Average number of hours practiced per **week**. The number of hours practiced per week should include **all** aspects of your practice and not limited to the number of hours you spend "one on one" with a patient.
NOTE: **"All aspects of your practice"** should include time spent on: patient record keeping; administrative duties for your practice; after hours emergency care; hospital rounds; returning patients' calls; etc. _______

47. Provide approximate percentage of your patient clientele makeup in the following categories. **Show "0" or "N/A" if "none".**

- **a.** _______ % Auto Insurance (e.g., auto accident victims)
- **b.** _______ % Medicare/Medicaid patients
- **c.** _______ % Work Comp
- **d.** _______ % Other: ⇔ Describe _______________________
- **e.** _______ % Disability and/or Independent Medical Evaluations
- **f.** _______ % Direct pay by patient and/or fee for service
- **g.** _______ % Managed Care HMO/IPA/PPO patients

48. Advertising methods

a. Please check all methods of advertising used:

No	Yes		No	Yes	
☐	☐	Brochures	☐	☐	Magazines
☐	☐	Direct Mail	☐	☐	Newspapers (local and/or other)
☐	☐	Flyers	☐	☐	Radio
☐	☐	Handouts	☐	☐	Television
☐	☐	Internet ⇔ Web Address: _______	☐	☐	Yellow Pages
☐	☐	Other, please explain: _______________________			

b. **Attach copy of materials for all checked above** including copies of scripts for voice and/or film media.

V CLAIMS HISTORY

Claim, Incident and/or Suit Information

NOTE:
- If you are requesting Prior Acts Coverage (aka retroactive or nose coverage), you must report all potential claims, suits, and/or incidents to your current insurance carrier before the underwriting process can continue. Some of the questions below have been designed to help you recall these types of circumstances / incidents.
- Please read the following questions (and sub-questions) carefully. Questions "**a**" and "**b**" are self-explanatory. Questions "**c**" and "**d**", while similar sounding, pose two distinctly different questions.

a. **Has your present or any past insurance carrier(s) ever refused or declined to accept your report of a claim or threat of a claim, adverse result, request for patient records, attorney contact, medical incident, suit, notice of intent to litigate, or any other similar type report?** ☐ No ☐ Yes

IF YES, please complete the following:

i. How many such reports have there been (note: the "count" should be 1 per refused or declined report)? _______
ii. A Claim / Incident / Suit Supplement Form (see last page of the application) must be completed for **each**.
iii. Attach copy of the original report(s) as well as a copy of the correspondence received from the carrier for **each**.

b. **Has any claim or suit for alleged malpractice ever been brought/filed against you or are you presently involved in malpractice litigation either directly or indirectly?** ☐ No ☐ Yes

IF YES, a Claim / Incident / Suit Supplement Form (see last page of the application) must be completed for **each**.

c. **Have all circumstances / incidents which you feel might reasonably lead to a claim or suit, even if you have not been made aware of possible litigation and/or believe the circumstance would be without merit, been reported to your present or past insurance carrier(s)? Please select the appropriate response from below:**

☐ **N/A** ⇔ A response of "**N/A**" means that you are not aware of any circumstances / incidents which might reasonably lead to a claim or suit being brought against you.

☐ **Yes** ⇔ **IF Yes**:
i. How many such circumstances / incidents are there? _______
ii. A Claim / Incident / Suit Supplement Form (last page of the application) must be completed for **each** circumstance.
iii. Copies/documentation of these circumstances / incidents having been reported to your present or past insurance carrier(s) must be attached.

☐ **No** ⇔ **IF No**:
i. How many such circumstances / incidents are there? _______
ii. These **must** be reported to your current carrier **immediately** with documentation of same provided before the underwriting process can continue.
iii. A Claim / Incident / Suit Supplement Form (see last page of the application) must be completed for **each** circumstance / incident.

d. i. **As of this date, have you received or are you aware of any of the following circumstances?**

A. Request for records from a patient and/or attorney due to an adverse medical outcome: ☐ No ☐ Yes
B. Letter from a patient and/or attorney regarding your medical treatment of a patient: ☐ No ☐ Yes
C. Complications resulting in death, paralysis, or other significant disabilities: ☐ No ☐ Yes
D. Patient dissatisfaction with the outcome of a procedure, treatment or diagnosis: ☐ No ☐ Yes
E. Conduct of any nature by you, your employees, Independent Contractors, partners, business associates, or individuals for whom you are legally responsible, which could reasonably be expected to result in a claim or complaint? ☐ No ☐ Yes

ii. **IF YES to any of "a" through "e" above, have these all been reported to your current carrier?** ☐ No ☐ Yes

A. **IF NO**, these **must** all be reported to your current carrier with documentation of same provided before the underwriting process can continue.
B. **IF YES**, a copy of the report sent to your carrier must be provided **and** a Claim / Incident / Suit Supplement Form (see last page of the application) must be completed for **each** circumstance / incident.

V CLAIMS HISTORY (continued)

Has any claim or suit for alleged malpractice ever been brought against you or are you aware of any circumstances that might lead to such a claim or suit?

☐ No ☐ Yes — Complete the following. If you need more space, use the comments section or attach an additional sheet.

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence

Allegations

☐ Claim closed. Date claim closed:	Amount paid on your behalf $
☐ Claim open. Date claim reported:	Amount reserved on your behalf $

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence

Allegations

☐ Claim closed. Date claim closed:	Amount paid on your behalf $
☐ Claim open. Date claim reported:	Amount reserved on your behalf $

COMMENTS SECTION

Question number	Comments

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

***For FL, KY, MN, NJ, NY, OH and PA residents only*: Any person who knowingly and with intent to defraud any Insurance Company or other person who 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, commits a fraudulent insurance act, which is a crime. *For NY residents only*: And shall also be subject to a civil penalty not to exceed five thousand ($5,000) dollars and the stated value of the claim for each such violation.**

______________________________ ______________
Signature in Full **Date**

____
Name - Please print

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

This program is underwritten by and Application is made to one of the CNA Insurance Companies. CNA is a registered service mark of the CNA Financial Corporation.