NAS Insurance Services, inc.

APPLICATION for:
Non-Standard Physicians & Surgeons Professional Liability Insurance

Applicant's Instructions:

1. If you have a Curriculum Vitae (C.V.), please attach to application and check here _____.
2. Please do not complete application earlier than 45 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT IN INK)

1. A. Name of Applicant _____ Degree _____

   B. Social Security No. _____

   C. Date of Birth _____ Place of Birth _____

   D. Are you a U.S. Citizen? ☐ Yes ☐ No
   If No, please indicate your status and date of entry into USA on separate sheet and attach.

2. A. Principal Office: _____
   No. Street City State Zip Country

   Phone: ( ) _____

   B. Are there other locations? ☐ Yes ☐ No
   If Yes, please attach a list with all addresses.

3. I practice as: ☐ Solo Practitioner (unincorporated) ☐ Solo Practitioner (incorporated)
   ☐ Professional Association ☐ Partnership
   ☐ Professional Corporation ☐ Employee of _____ (give name)

4. If you practice other than as an employee OR an unincorporated solo practitioner:
   A. List the names of ALL your partners, your employees, or members of your professional association or corporation who practice medicine:
   _____
   _____
   _____

   B. Give the formal corporate, association, partnership or business name:
   _____

   C. Attach a copy of your letterhead.

5. List state and license number where you practice:

State	License Number
_____	_____
_____	_____
_____	_____

6. A. List hospitals at which you are currently a staff member and show percentages of work at each hospital:

1. _____ _____%
2. _____ _____%
3. _____ _____%

B. Briefly describe type and extent of your hospital privileges: _____

_____

C. Are you Chief or Head of a hospital department? ☐ Yes ☐ No

7. Do you or the firm listed in Question 6. A. above 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, on a separate sheet give details including name, location, size and number of beds.

CURRENT PRACTICE

8. A. What is your medical or surgical specialty? _____

_____

B. Do you limit your practice to the above specialty? ☐ Yes ☐ No

C. Do you have a sub-specialty? ☐ Yes ☐ No

If Yes, describe: _____

9. Do you perform one or more of the following?

		YES	NO	Percentage of Practice:
A.	Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)? If Yes, describe below. _____ _____	A. ☐	☐	_____
B.	Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel)? Describe: _____ _____	B. ☐	☐	_____
C.	Arteriography/lymphangiography/myelography/phenmoencephalography?	C. ☐	☐	_____
D.	Interventional radiology – percutaneous transluminal angioplasty or embolization?	D. ☐	☐	_____
E.	Radiation therapy – deep (includes radium implants)?	E. ☐	☐	_____
F.	Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces?	F. ☐	☐	_____
G.	Mohs micrographic surgery? Describe: _____ _____	G. ☐	☐	_____
H.	Acupuncture (for analgesia) or Acupuncture anesthesia? Describe: _____ _____	H. ☐	☐	_____
I.	Prenatal care and normal deliveries? If Yes, Do you perform home deliveries? ☐ Yes ☐ No Do you only perform prenatal care? ☐ Yes ☐ No Do you supervise nurse midwives? ☐ Yes ☐ No	I. ☐	☐	_____

		YES	NO	Percentage of Practice
J.	Dilation and curettage?	J. ☐	☐	_____
K.	Needle biopsies? Describe: _____	K. ☐	☐	_____
L.	Electroshock therapy or hypnosis? Describe: _____	L. ☐	☐	_____
M.	Radial keratotomy? Indicate where performed: ☐ Hospital ☐ Office ☐ Surgicenter	M. ☐	☐	_____
N.	Hexagonal keratotomy? Indicate where performed: ☐ Hospital ☐ Office ☐ Surgicenter	N. ☐	☐	_____

10. Do you perform any one or more of the following?

A.	Surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia?	A. ☐	☐	_____
B.	Non-spontaneous, induced abortions? _____ 1st trimester (Not exceeding 14 weeks gestation) _____ 2nd trimester (Indicate where performed: ☐ Hospital ☐ Office ☐ Surgicenter)	B. ☐	☐	_____
C.	Sterilization procedures? Describe: _____	C. ☐	☐	_____
D.	Cosmetic plastic surgery, cosmetic body contouring (suction lipectomy), implantations, injections and/or blepharopigmentation? Describe: _____	D. ☐	☐	_____
E.	Spinal surgery? If you also perform chemonucleolysis, check here ☐	E. ☐	☐	_____
F.	Open reduction of fractures? Describe: _____	F. ☐	☐	_____
G.	Administration of general, spinal or caudal block anesthesia?	G. ☐	☐	_____
H.	Hysterectomies?	H. ☐	☐	_____
I.	Cholecystectomies? Do you perform laparoscopic cholecystectomies? Indicate number of laparoscopic cholecystectomies performed to date. _____	I. ☐	☐	_____
J.	Tonsillectomies and/or Adenoidectomies?	J. ☐	☐	_____
K.	Cesarean sections?	K. ☐	☐	_____
L.	Organ transplantations? Describe: _____	L. ☐	☐	_____
M.	Weight reduction surgery?	M. ☐	☐	_____
N.	Sex change operation? Describe: _____	N. ☐	☐	_____
O.	Experimental research or surgical research or experimental therapy in human patients? Describe: _____	O. ☐	☐	_____
P.	Other surgery? Describe: _____	P. ☐	☐	_____

11. A. Do you perform surgery in your office? ☐ Yes ☐ No
If Yes, list surgical procedures: _____

B. Do you perform surgery in other non-hospital facilities? ☐ Yes ☐ No
If Yes, list facilities and surgical procedures: _____

_____

12. A. Indicate number of hours per month devoted to hospital emergency room care: _____ hours per month
B. Is this emergency room care: 1. On your own patients only? ☐ Yes ☐ No
2. Required for staff privileges? ☐ Yes ☐ No
3. Other _____ ☐ Yes ☐ No

13. Do you assist in surgery: On your own patients? ☐ Yes ☐ No
Patients of other? ☐ Yes ☐ No

14. If your practice includes plastic surgery, specify percent of practice devoted to:
traumatic surgery _____% cosmetic surgery _____%

15. A. Do you practice weight reduction or control (other than by diet-exercise)? ☐ Yes ☐ No
If Yes, percent of patients exclusively weight control _____%

B. Do you dispense (as opposed to prescribe) any weight control drugs? ☐ Yes ☐ No
If Yes, list drugs dispensed. _____

C. Do you use injections for weight control? ☐ Yes ☐ No
If Yes, list drugs injected: _____

16. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? ☐ Yes ☐ No
If Yes, please attach detailed explanation of this activity.

17. A. List number and type of professional employees: IF NONE, STATE NONE. _____

_____ Physicians (other than yourself) _____ Surgeon's Assistants*
_____ Nurse Practitioners*/Physician's Assistants* _____ Nurse Anesthetists
_____ Other (describe) _____

* Describe duties in detail, including extent supervised, on separate sheet.

B. Are all of the above individuals licensed in accordance with applicable state and federal regulations? If No, attach explanation. ☐ Yes ☐ No

18. Have you or any of the above employees: (Attach detailed explanation for any Yes answers)

A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable.) ☐ Yes ☐ No

B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction? ☐ Yes ☐ No

D. 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

E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? ☐ Yes ☐ No

F. Ever failed any medical licensing or specialty organization examination? ☐ Yes ☐ No

G. Do you have any chronic illness or defect? ☐ Yes ☐ No

19. Do you supervise any individuals other than your own employees? ☐ Yes ☐ No
If Yes, attach detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-Ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

20. Are you in the employ of any individual, firm or corporation other than your own? ☐ Yes ☐ No
If Yes, attach explanation, including details of any responsibilities.

21. Are you under contract to any individual, firm or corporation other than your own? ☐ Yes ☐ No
If Yes, attach explanation including details of your responsibilities.
If this contract contains a hold-harmless agreement, a copy of contract must be attached to application.

22. Are you in the employ of or under contract to any government entity? ☐ Yes ☐ No
If Yes, attach explanation, including details of your responsibilities.

23. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? ☐ Yes ☐ No

24. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? ☐ Yes ☐ No
If Yes, submit copy of all the advertisements.

25. A. From what medical school did you graduate? _____
Degree: _____ Year: _____
Location of medical school: _____
(City) (State) (Country)

B. If a foreign medical student graduate, are you certified by the Educational Council for Medical School Graduates? ☐ Yes ☐ No
If Yes, state year and describe: _____
_____

C. Residency? ☐ Yes ☐ No
If Yes, complete the following for each residency served:
Location _____ From _____ To _____ Type _____
Location _____ From _____ To _____ Type _____

D. Additional Medical Training? ☐ Yes ☐ No
Location _____ From _____ To _____ Type _____

26. Are you American Board certified? ☐ Yes ☐ No
Medical Specialty _____ Date Certified ____/____/____ Recertified ____/____/____

27. Where have you practiced your profession since completion of training?
In _____ From _____ To _____
In _____ From _____ To _____
In _____ From _____ To _____

28. Indicate membership in professional societies: _____

_____

29. Have you participated in any continuing medical educational program within the past five years? ☐ Yes ☐ No
If Yes, describe separately.

30. Do you or the firm named in Question 6.B. above own or operate or provide professional services for or at any health care facility or business enterprise not already clearly described in this application? ☐ Yes ☐ No
If Yes, attach detailed explanation.

31. A. Has any claim or suit for alleged malpractice been brought against you? ☐ Yes ☐ No
If Yes, complete a Medical Claim Information Form for each claim or suit.

B. Has any claim or suit for alleged malpractice been brought against you that has NOT been reported to a prior insurer? ☐ Yes ☐ No
If Yes, complete a Medical Claim Information Form for each claim or suit.

C. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim, or suit being made or brought against you? ☐ Yes ☐ No
If Yes, complete a Medical Claim Information Form for each claim or suit.

32. Do you practice in a surgicenter, abortion clinic, drug control clinic, extended hr. walk-in clinic, birthing center, blood bank, emergency treatment facility, convalescent home, psychiatric hospital, industrial medical care facility, laboratory, nursing home, sanitorium, urgent care clinic, and x-ray or imaging facility? ☐ Yes ☐ No
If Yes, state location and describe:

_____

_____

33. A. Average patient load: _____ Patients Weekly _____ Total Patients Annually

B. Average number of hours practice time: _____ Hours weekly

34. Do you anticipate changes in your practice in the next 12 months? ☐ Yes ☐ No

If Yes, explain: _____

_____

35. Approximate your gross annual income from the practice (check one):

☐ Less than $50,000 ☐ $100,000 - $149,999 ☐ $200,000 or more (please estimate below)

☐ $50,000 - $99,999 ☐ $150,000 - $199,999 $ _____

36. List prior professional liability insurance carried to each of the past five years. If NONE, check here ☐.

	Insurance Company	Limits of Liability	Premium	Mo/Day/Yr Inception	Mo/Day/Yr Expiration	Mo/Day/Yr Retroactive	Was this a Claims Made policy form? YES	NO
1.							☐	☐
2.							☐	☐
3.							☐	☐
4.							☐	☐

ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR MOST RECENT COVERAGE.

37. Coverage desired:

Liability Limit _____ Each Claim

Liability Limit _____ Aggregate

Deductible Amount _____

Desired Effective Date (12:01am)_____

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Underwriters, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Underwriters to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the Underwriters of such changes, and the Underwriters may withdraw or modify and outstanding quotations and/or authorization or agreement to bind the insurance.

_____	_____	_____
Date	Signature of Applicant	Title

NAS Insurance Services, inc.

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MEDICAL CLAIM INFORMATION FORM

Name of Patient: Gender: Age:

1. Condition and Diagnosis of Patient prior to treatment and/or surgery:

2. Date(s) and type of treatment and/or surgery rendered by you:

3. Condition of patient subsequent to treatment and/or surgery by you:

4. Nature of Allegations:

5. Was a lawsuit ever filed against you? ☐ Yes ☐ No Case No.: _____

6. Was it served? ☐ Yes ☐ No Date: _____

7. Name of Insurer Claim reported to (if any): _____

8. Are you represented by an attorney? ☐ Yes ☐ No

   If Yes, name of attorney and law firm: _____

9. Present Status of Claim/Incident: Pending _____ Closed _____ In Suit _____

10. If Closed, Total Damages Paid: $ _____ Total Expenses Paid: $ _____

11. If Pending, is plaintiff demanding a settlement amount? ☐ Yes ☐ No

    How much? $ _____

    Have you offered a settlement amount? ☐ Yes ☐ No

    How much? $ _____

    Legal Expenses to Date: $ _____

12. Names of other doctors and hospitals involved, if any:

_____

13. Names of all defendants employed and/or supervised by you, if any:

_____

14. If case tried to a plaintiff verdict, give explanation, including amounts and dates:

_____

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, AND ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY. MAKE ADDITIONAL COPIES AS NECESSARY.

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