PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIAN EXTENDERS & ALLIED HEALTHCARE PROFESSIONALS

Aspen

APPLICATION

CLAIMS-MADE DISCLOSURE NOTICE: THIS IS AN APPLICATION FOR CLAIMS-MADE AND REPORTED INSURANCE PROVIDED THROUGH ASPEN SPECIALTY INSURANCE COMPANY (THE "COMPANY"). IT IS IMPORTANT THAT THE APPLICANT REPORT ANY CURRENTLY KNOWN CLAIMS OR CIRCUMSTANCES THAT COULD RESULT IN A CLAIM TO THE APPLICANT'S CURRENT INSURER OR PURCHASE AN EXTENDED REPORTING PERIOD TO COVER SUCH CLAIMS OR INCIDENTS. THE COMPANY WILL NOT PROVIDE COVERAGE FOR CLAIMS OR INCIDENTS WHICH THE APPLICANT IS AWARE OF PRIOR TO THE INCEPTION DATE OF ANY COVERAGE THAT IS OFFERED AND ACCEPTED.

You agree that any coverage issued will be contingent upon the truth of the information provided in this application. If a policy is issued, this application will become a part of the policy, as if physically attached thereto.

Please fully complete this application as an incomplete application cannot be evaluated. Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply. Provide any supporting information on a separate sheet and reference the applicable question number. This application must be completed, dated and signed by an authorized representative of the applicant.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the policy, if and when issued.

GENERAL INFORMATION

1. Full Name of Individual Applicant: _____

   Professional/Specialty Designation/Degree:

   ☐ Nurse Practitioner ☐ Physician Assistant ☐ Nurse Anesthetist
   ☐ Surgical Assistant ☐ Other, *specify*: _____

2. Date of Birth: _____
3. Birthplace: _____
4. Last four digits of your SSN: _____
5. States where you are certified and/or licensed to practice: _____
6. Please list any membership(s) in professional societies or associations: _____

   _____

7. Do you currently participate in or plan to participate in a state patient fund, health care stabilization fund or similar other governmentally established malpractice liability? ☐ Yes ☐ No
8. Are you currently in any branch of Military Service? ☐ Yes ☐ No

   If yes, specify capacity: _____
9. **Principal Practice Information** (% of Practice_____)

   Address: _____

   _____

   Office Telephone: _____ Office Fax: _____

   Web Site: _____ E-Mail: _____
10. Preferred **Mailing** Address: ☐ Principal Practice (above) or ☐ Other, below
11. Other Address

    Address: _____

    _____

Telephone: _____ E-Mail: _____

12. Is this Other Address: ☐ Residence ☐ Other, Specify: _____

13. Are you a U.S. Citizen? If no, indicate your status and entry date into the U.S. ☐ Yes ☐ No

_____

EDUCATION AND TRAINING INFORMATION

14. Please complete the following regarding your professional healthcare related education & training:

Institution, Name & Address	Dates Attended From/To	Degree or Certification Attained

CURRENT & PRIOR EMPLOYMENT/EXPERIENCE

15. Please complete the following regarding your professional healthcare related employment and/or experience for the preceding 10 years, beginning with the most recent:

Location, Name & Address	Dates Worked From/To

APPLICANT AFFILIATIONS

16. Are you associated with or do you work for a physician or surgeon (group or individual). ☐ Yes ☐ No
If yes, provide the group or physician(s) name & practice specialty: _____

_____

17. Are you employed by any group or individual other than that referenced above? ☐ Yes ☐ No

18. Are you under contract to any individual or entity other than that shown above? ☐ Yes ☐ No
If yes, does that contract contain a hold-harmless agreement? ☐ Yes ☐ No

19. Do you own or operate any business other than that referenced above? ☐ Yes ☐ No

20. Are you employed by or under contract to any governmental entity? ☐ Yes ☐ No

PRACTICE INFORMATION

21. Please identify your Practice type:

Are you an: ☐ Owner ☐ Employee ☐ Independent Contractor; for: _____

Is your practice an:

☐ Solo Practitioner, Incorporated
☐ Solo Practitioner, Unincorporated
☐ PA/Professional Association
☐ PC/Professional Corporation
☐ LLC/Limited Liability Company
☐ Partnership
☐ Other, please specify: _____

22. Please provide the full, legal Entity name: _____

23. Please list the names of all partners or members of your professional association/corporation who provide professional services: _____

_____

24. Do you have established, in-force policies/procedures to comply with applicable HIPAA privacy rules? ☐ Yes ☐ No

25. Total number of employees, contractors, others:

	Full-Time	Part-Time
Employees		
Independent Contractors		
Others, specify:_____		

26. Please indicate the number, by type, of employees, contractors, volunteers and others:

_____ Nurse Practitioners _____ Physician Assistants
_____ Surgical Assistants _____ Nurse Anesthetists
_____ Other, *specify*: _____
_____ Other, *specify*: _____

27. Are all of the above identified individuals certified and/or licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
If no, please explain on separate sheet.

28. Do you supervise any individuals who are not your own employees/contractors/volunteers? ☐ Yes ☐ No
If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

29. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? ☐ Yes ☐ No
If yes, please attach a copy of all your advertising materials.

HEALTHCARE SERVICES INFORMATION

30. Please provide the following practice statistics. Please note, Patient Visits/Encounters reflects the count each time a patient visits or is tested, *not* the number of patients:

	Last 12-months	Projected/Estimated next 12-months
Total Patient Visits/Encounters		
Total Patient Tests Completed		

31. Do you render professional services, including the administration of anesthesia, directly to patients? If yes, please complete the following: ☐ Yes ☐ No

Detailed Description of Professional Services	% of time supervised	Title/Designation of Supervisor
	%	
	%	
	%	

32. Do you render professional services that do not involve direct contact with a patient? ☐ Yes ☐ No

33. a.) Do you perform or assist in any surgical procedure(s)? ☐ Yes ☐ No
b.) If yes**,** please list all surgical procedures, including minor surgeries: _____

c.) any surgical procedure(s) in an office, surgery center or similar non-hospital facility? ☐ Yes ☐ No

d.) during surgical procedure(s), is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ☐ Yes ☐ No

If yes to c.) or d.) above, attach a detailed explanation.

34. Do you perform radiation therapy? ☐ Yes ☐ No

35. Do you perform Psychiatric shock therapy? ☐ Yes ☐ No

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

37. Do you provide professional service(s) or consultation(s) in any sovereign nation other than the United States (including American or Alaskan Native lands)? ☐ Yes ☐ No
If yes, please provide details: _____

38. Do you participate in an ACO/Accountable Care Organization? ☐ Yes ☐ No
If yes, state the ACO name(s): _____

39. Do you now, or have you in the past, ever:
- performed investigational and/or experimental procedures? ☐ Yes ☐ No
- prescribed or dispensed experimental drugs? ☐ Yes ☐ No

If yes to either, please provide details: _____

INSURANCE INFORMATION

40. Requested Effective date: _____

41. Requested Retroactive date: _____

42. If prior acts coverage is not being requested, are you purchasing extended reporting (tail) coverage from your prior carrier? ☐ Yes ☐ No

    If no, please explain: _____

43. Requested limits of insurance:

    Per Claim: _____ Aggregate: _____

44. Are you currently covered under another professional liability policy for activities outside those for which you are now requesting coverage? ☐ Yes ☐ No

    If yes, please list name of employer and insurance company: _____

45. Have you ever practiced without insurance? ☐ Yes ☐ No

    If yes, please outline uninsured dates and provide details: _____

46. Beginning with your most recent or current insurer, please list all professional liability insurers for the past 5 years.

Name of Insurer	Occurrence or Claims-Made	Limits of Liability	Policy Period	Premium	Deductible	# of Claims

Please provide total number of claims reported regardless of status and indemnity or expense payment.

47. Have you ever had Professional Liability insurance cancelled, declined, rescinded, or non-renewed? (Missouri residents do not answer) ☐ Yes ☐ No

    If yes, please provide details: _____

UNDERWRITING INFORMATION

For the following questions, explain any "Yes" response on a separate sheet of paper.

48. Have you, or any of your employees, contractors, volunteers or others you are legally responsible for ever:

a.) had a license or authorization/certification to practice medicine or provide professional services denied, refused, suspended, limited, placed on probation, restricted, revoked or surrendered, voluntarily or otherwise, in any state? ☐ Yes ☐ No

b.) had any professional society or association membership refused, suspended or revoked? ☐ Yes ☐ No

c.) been investigated, requested to resign from, or been involved in an official or un-official proceeding brought by or on behalf of a hospital, managed care organization or other similar healthcare organization in which your privileges have been denied, revoked, limited, suspended, restricted or non-renewed, whether voluntarily or involuntarily? ☐ Yes ☐ No

d.) had a license/permit to prescribe or dispense drugs denied, refused, restricted, suspended, limited, placed on probation, revoked or surrendered, voluntarily or otherwise, in any state? ☐ Yes ☐ No

e.) now or in the past been, treated for, evaluated for, hospitalized for or suffered from alcohol or other chemical/substance abuse or dependency? ☐ Yes ☐ No
*If **"Yes",** please complete the Aspen **Substance Abuse/Impairment Supplemental Application**.*

f.) incurred or become aware of any illness, or physical, emotional or mental health condition or circumstance that, despite reasonable accommodation(s), impairs, limits, restricts or could impair, limit, or restrict their ability to practice medicine? ☐ Yes ☐ No

g.) been convicted, had charges brought against, or are currently under investigation for a crime other than a traffic offense? ☐ Yes ☐ No

h.) used any non-FDA approved devices, drugs or procedures? ☐ Yes ☐ No

i.) been notified to appear before or respond to, or been investigated by any licensing or regulatory agency, board or body regarding a complaint of any nature, including but not limited to unethical or unprofessional conduct? ☐ Yes ☐ No

j.) had or been involved in any claim or suit for alleged medical professional liability malpractice? ☐ Yes ☐ No
If **"Yes",** please complete a ***Claim Information Supplement*** for each**.**

k.) become aware of any circumstance, specific act or omission involving particular or specific professional service(s) that may result in a claim or suit, that has not been reported to a prior insurance carrier? ☐ Yes ☐ No

l.) had any claims, suits or losses that have not been reported to and accepted by any prior insurance carrier or other any source from which coverage and/or payment could be made? ☐ Yes ☐ No

m.) received or been made aware of, or had any requests for medical records by a patient or his/her legal representative(s) or attorney which might result in a claim or suit? ☐ Yes ☐ No

n.) had any information relating to service(s) on any Board(s) which might result in a claim or suit? ☐ Yes ☐ No

o.) had any current or prior professional liability carrier ever refused coverage for, or declined to accept a report of a specific act, error, omission or circumstance involving a particular and specific professional service or act that may result in a claim, suit, threat of a claim or suit, letter of intent, adverse act, outcome or result notice or attorney contact? ☐ Yes ☐ No

FRAUD WARNING

NOTICE TO APPLICANTS IN ALL STATES: ANY PERSON WHO KNOWINGLY, AND WITH THE INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION OR CONCEALS FOR THE PURPOSES OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES AND DENIAL OF INSURANCE BENEFITS.

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

Date (Mo./Day/Yr.)

Applicant Signature

Print or Type Name

Title

