THE DOCTORS' INSURANCE AGENCY

KINSALE INSURANCE

**REQUEST TO ADD HEALTHCARE PROFESSIONAL**

**TO:** Underwriting Department

RE: **Additional Coverage for Policy #** W2B862200101

Please add _____ to the policy of Cirrus Medical Network, LLC ,
Healthcare Professional Name — Group Name

effective _____ .
Date

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To Be Completed by Healthcare Professional:

1) Have you had more than three medical malpractice claims made against you. Yes / No

2) Have you had any claim paid or reserved in excess of $150,000 in indemnity. Yes / No

3) Have you had any board suspension, license probation, disciplinary action taken or felony conviction. Yes / No

By signing below, you agree that the information provided above is materially, and factually correct.

_____ _____
Physician's SIgnature / Date — Medical License Number

* A"No" answer to the above, will make you ineligible for automatic coverage under this blanket endorsement. To Apply for approval from the Underwriter, submit your written explanation and any supporting documentation.

❒ Please complete the Kinsale Short Physician's Application and return it with this form.

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Approval - To Be Completed by the Group

_____
Signature - Group Administrator / Owner

_____
Print Name

_____
Date


# SHORT FORM PHYSICIAN APPLICATION

**Claims Made and Reported Coverage - CV SHOULD ACCOMPANY APPLICATION**

## GENERAL INFORMATION

1. Applicant's Name: _____ ☐ MD ☐ DO
2. Facility Name: _____
3. Status with above facility? ☐ Employed ☐ Contracted
4. Practice Address: _____
   STREET CITY COUNTY STATE ZIP
5. Number of hours worked per week on behalf of facility named above? _____ hours per week
6. Number of patients seen per week on behalf of the facility named above? _____ patients per week
7. Provide the following information for all states in which you are license to practice:

| State | % of Practice | License# | Active | Inactive | Temporary | Pending |
|---|---|---|---|---|---|---|
| | | | ☐ | ☐ | ☐ | ☐ |
| | | | ☐ | ☐ | ☐ | ☐ |

8. Complete the following:

| | Institution | Location | Degree/Specialty | Completed? |
|---|---|---|---|---|
| Medical School | _____ | _____ | _____ | ☐ YES ☐ NO |
| Internship | _____ | _____ | _____ | ☐ YES ☐ NO |
| Residency | _____ | _____ | _____ | ☐ YES ☐ NO |
| Fellowship | _____ | _____ | _____ | ☐ YES ☐ NO |

9. Current Practice Specialty: _____
10. Board Certified?: ☐ Yes ☐ No - Name of Board(s): _____
11. Board Eligible?: ☐ Yes ☐ No - Name of Board(s): _____

## CLAIMS AND PRACTICE HISTORY – Please explain or complete a supplemental claim for form for ALL "Yes" answers.

12. Has your medical or narcotics license ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ YES ☐ NO
13. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ YES ☐ NO
14. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ YES ☐ NO
15. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? ☐ YES ☐ NO
16. Has any fee or professional relations complaints been registered against you with your medical association, hospital, or a state licensing authority? ☐ YES ☐ NO
17. Have you ever been involved in any professional liability claim or suit, either directly or indirectly? ☐ YES ☐ NO

18. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ YES ☐ NO

19. Are you aware of any request for medical records by a patient or his/her attorney which might result in a claim? ☐ YES ☐ NO

20. Are you aware of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission, or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result notice, or attorney contact? ☐ YES ☐ NO

21. Have all circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit, been reported to your current or prior professional liability company? ☐ YES ☐ NO
**Indicate N/A if you are not aware of any such circumstances** . If yes, how many? ____ ☐ N/A
please complete a supplemental claims form for each.

22. Does your practice on behalf of the facility noted above include the following? Check **ALL** that apply.

| | | |
|---|---|---|
| ☐ | NO SURGERY | No surgery with the exception of: suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization. |
| ☐ | MINOR SURGERY | Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures:<br>• Colonoscopy, sigmiodoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP),<br>• Pneumatic or mechanical esophageal dilation (not with bougie or olive),<br>• Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists who have completed a cardiovascular subspecialty training.),<br>• Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue,<br>• Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae<br>***No procedures performed on a patient while under general anesthesia.*** |
| ☐ | MAJOR SURGERY | Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It includes discograms, lymphangiography, myleography, phlebography, pneumoencephalography and radiation therapy. It also includes removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia. |

## SUPPLEMENTAL INFORMATION (reference question number if applicable)

## FRAUD WARNING

**NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS:** In some states, any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

**NOTICE TO COLORADO APPLICANTS**: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance

company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS**: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO FLORIDA APPLICANTS**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**NOTICE TO HAWAII APPLICANTS:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**NOTICE TO KENTUCKY APPLICANTS**: 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.

**NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO MAINE APPLICANTS**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

**NOTICE TO NEW JERSEY APPLICANTS**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW MEXICO APPLICANTS**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**NOTICE TO NEW YORK APPLICANTS**: Any person who knowingly and with intent to defraud an insurance company or other person 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 and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

**NOTICE TO OHIO APPLICANTS**: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO PENNSYLVANIA APPLICANTS**: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 and subjects the person to criminal and civil penalties.

**NOTICE TO TENNESSEE APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NOTICE TO VIRGINIA APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.**
**The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.**

Applicant: _____ Title: _____

FEIN #: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____

## SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

**If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.**

Name of Patient:_____ Age:_____ Sex:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient?_____

_____

### STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

☐ Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
c. Did you want to settle?
☐ Yes ☐ No

**Court outcome in YOUR favor:**
☐ Jury verdict
☐ Directed verdict

**Court outcome in favor of plaintiff**:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment:
$_____

**Unresolved/Open**
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount:
$_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date:_____

Printed Name: _____