NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

ALLIED HEALTHCARE PROFESSIONALS SUPPLEMENTAL APPLICATION

COMPLETE IN FULL INCLUDING SIGNATURES AND DATING BY THE PROVIDER NOT EARLIER THAN 45 DAYS BEFORE THE PROPOSED EFFECTIVE DATE OF COVERAGE.

ATTACH ADDITIONAL SHEETS AS NECESSARY.

ANSWER ALL QUESTIONS. If not applicable, indicate N/A.

GENERAL INFORMATION

1)

Named Insured:	
Professional Title:	Social Security Number:
US Citizen? Yes ☐ No ☐	Date of Birth:
Immigration status:	Entry date:
Federal DEA License #:	DEA License Status:
Phone Number:	Email address:
Brokerage/Broker:	Agency/Agent:
Renewal? Yes ☐ No ☐	Policy Number:
Effective Date:	
Website:	

2) Current/Most Recent Professional Liability Carrier Information:

Carrier:					
Limit of Insurance:					
Deductible:		Premium:			
Policy Term Dates:					
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐		Retroactive date:		

3) Current/Most Recent Commercial General Liability Carrier Information:

Carrier:					
Limit of Insurance:					
Deductible:		Premium:			
Policy Term Dates:					
Offering renewal? Yes ☐ No ☐	Claims made? Yes ☐ No ☐		Retroactive date:		

Please attach copies of the following:

a) Currently valued five year loss runs, including claim detail for all losses

b) Copy of your current Professional Liability insurance Declarations Page and Commercial General Liability insurance Declarations Page (claims made policies must reflect the retroactive date and limits for retro continuity)

c) A copy of all marketing materials, brochures, etc. if a website is not available

d) A copy of your Curriculum Vitae

e) A copy of your business letterhead

f) A copy of all licenses and board certifications held by you

g) A copy of all reporting endorsements previously issued to you

4) Mailing Address: _____

City: _____ State: _____ Zip Code: _____

5) Principal Practice Address: _____

City: _____ State: _____ Zip Code: _____

6) Secondary Practice Address: _____

City: _____ State: _____ Zip Code: _____

7) Are you a(n):
- ☐ Solo Practitioner (unincorporated)
- ☐ Solo Practitioner (incorporated)
- ☐ Partnership: _____
- ☐ Employed Professional
- ☐ Other: _____
- ☐ Professional Corporation (for profit)
- ☐ Professional Corporation (not for profit)
- ☐ Professional Association
- ☐ Contracted Professional

a. If you are employed or contracted, by whom? _____

b. Are you employed or contracted at locations other than your primary or secondary practice locations? If yes, please attach details. Yes ☐ No ☐

c. Do you own or operate any business other than what is shown above? If yes, attach details. Yes ☐ No ☐

8) Your principal practice location is a(n):
- ☐ Hospital
- ☐ Ambulatory Surgery Center
- ☐ Professional Office with Specialty
- ☐ Other: _____

9) Your secondary practice location is a(n):
- ☐ Hospital
- ☐ Ambulatory Surgery Center
- ☐ Professional Office with Specialty
- ☐ Other: _____

10) What is the entity name of your practice? _____

a. What is your ownership percentage? _____ %

b. How many other professionals practice at this entity? _____

c. Are you seeking coverage for this entity? If yes please attach articles of incorporation. Yes ☐ No ☐

11) Please complete the following table for states in which you are licensed to practice:

State	% of Practice	License #	Status
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐
			Active ☐ Inactive ☐ Temporary ☐ Pending ☐

12) Please complete the following table for your revenues and sources if you are the practice owner:

Source	Last 12 months	Next 12 months
Charitable contributions		
Government funding - Medicare		
Government funding - Medicaid		
Government funding - Other		
Fee for services		
Other: _____		
TOTAL GROSS REVENUE:		

PRACTICE SPECIALTY AND EDUCATION INFORMATION

13) Please complete the below table for all locations and dates of practice you have had in the last ten years:

Practice Name	City/State	Specialty	Beginning Date	End Date

14) What is your current professional specialty? _____

a. What percentage of your practice is under this specialty? _____ %

b. What is your current subspecialty: _____

c. What percentage of your practice is under this subspecialty? _____ %

15) Please complete the following table for your education history:

Institution	Location	Dates of Attendance	Degree/Specialty	Completed?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

16) What date did you begin your professional practice? _____

17) Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy act? Yes ☐ No ☐

a. If yes, have you implemented procedures to comply with the HIPPA Privacy Rule? Yes ☐ No ☐

b. Who is your Privacy Officer? _____

18) Are you a member of any professional societies or associations? Yes ☐ No ☐

a. If yes, which one(s)? _____

_____

PRACTICE AND PROCEDURE INFORMATION

19) Do you render professional services directly to patients? Yes ☐ No ☐

a. If yes, please attach a description of services offered, what percentages of each service is supervised, and who is the supervising or collaborating physician for each service.

20) Do you render professional services that do not involve contact with a patient? Yes ☐ No ☐

a. If yes, please describe: _____

_____

_____

_____

21) Do you perform radiation therapy? Yes ☐ No ☐

22) Do you perform psychiatric shock therapy? Yes ☐ No ☐

23) Please complete the following table for patient services for which you are seeking coverage. Check all that apply:

Services	Percentage Last 12 Months	Estimated Percentage Next 12 months	Services	Percentage Last 12 Months	Estimated Percentage Next 12 months
☐ Hemodialysis			☐ Holistic Medicine		
☐ Surgical			☐ Stress Testing		
☐ Communicable Disease			☐ Family Planning		
☐ Psychiatric			☐ Substance Abuse		
☐ Obstetrical			☐ Gynecology		
☐ Disability Evaluation			☐ Dental		
☐ Aesthetic Medicine			☐ Pain Management		
☐ Family/General Medicine			☐ Pediatrics		
☐ Bariatrics			☐ Physical Rehabilitation		
☐ Research or Experimental			☐ Other: _____		
☐ Other: _____			☐ Other: _____		

24) If you are performing or assisting in any surgical procedures, please complete the following:

a. What surgical procedures, including minor surgeries, are you performing or assisting in? _____

b. Is anesthesia other than topical or local infiltration administered by yourself or others? Yes ☐ No ☐

c. Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? Yes ☐ No ☐

d. If yes to b. or c., please attach an explanation.

25) Do you dispense any drugs without the countersignature of a physician? Yes ☐ No ☐

a. If yes, please clarify: _____

26) Approximately what percentages of your time is spent at the following work locations? Complete all that apply:

Location	Percent	Location	Percent
Administrative Office	%	Ambulance	%
Classroom	%	Emergency Dept. of Hospital	%
Nursing Home	%	Laboratory	%
Operating Room	%	Outpatient Clinic	%
Patient's Home	%	Hospital Ward	%
Professional Office	%	Correctional Facility/Prison	%
Other: _____	%	Other: _____	%

27) Please complete the following table for your patient encounters:

	Weekly	Annually
Average number of patients you saw during the last 12 months for all jobs		
Average number of patients you saw during the last 12 months for jobs for which coverage is requested		
Estimated number of patients you will see during the next 12 months for all jobs		
Estimated number of patients you will see during the next 12 months for jobs for which coverage is requested		

28) What are your total average weekly practice hours? _____
   a. How many hours on average are at your principal practice location? _____
   b. How many hours on average are at your secondary practice location? _____

29) Have there been any changes in your specialty or practice activities in the last ten years? Yes ☐ No ☐
   a. If yes, please attach an explanation.

30) Do you perform any procedures not routinely performed by others practicing in your specialty or subspecialty? Yes ☐ No ☐
   a. If yes, what procedures? _____

31) Are you employed by the federal, state or local government (full or part time, including active duty military)? Yes ☐ No ☐
   a. If yes, please attach details.

32) Do you advertise your professional services in any manner? Yes ☐ No ☐
   a. If yes, please attach a copy of or provide links to advertisements.

33) Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? Yes ☐ No ☐
   a. If yes, please attach a copy of or provide links to advertisements.

COVERAGE AND LOSS HISTORY

34) Has any licensing authority taken any action against you or any of your employees? Yes ☐ No ☐
If yes, please attach an explanation and copies of all citations.

35) Have you or any of your employees ever had any professional license or license to prescribe and or dispense narcotic ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If yes, please attach an explanation.** Yes ☐ No ☐

36) Have you or any of your employees ever been charged with or convicted of a crime other than minor traffic violation(s)? **If yes, please attach an explanation.** Yes ☐ No ☐

37) Have you or any of your employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

38) During the past five years, has any insurer ever canceled or non-renewed similar insurance to any applicant or has your insurance been canceled for nonpayment of premium by any insurance or finance company. **If Yes, please attach an explanation.** Yes ☐ No ☐

39) Have you ever practiced without Professional Liability insurance in place? Yes ☐ No ☐

40) Do you have Professional Liability insurance in place for work you do elsewhere? Yes ☐ No ☐
If yes, please attach a copy of the policy Declarations page(s).

41) Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization organization fund or other governmentally established malpractice liability funding mechanism? Yes ☐ No ☐
a. If yes, which fund? _____

42) Has any claim or suit for medical malpractice or professional liability ever been filed, or any claim otherwise been made against you or any other person proposed for this insurance, including any partnership or joint venture of which you have been a member or your company's predecessors in business? Yes ☐ No ☐
a. **If yes, please complete the Kinsale Health Care Claim Supplemental.**
b. How many malpractice or professional liability claims have you had? _____
c. Have these claims all been reported to your current or a prior insurer? Yes ☐ No ☐

43) Are you or anyone else proposed for this insurance aware of any occurrences, facts, circumstances, incidents, situations, act, error, omission or records request from a patient or their attorney which may result in a claim or suit? **If yes, please complete the Kinsale Health Care Claim Supplemental.** Yes ☐ No ☐

44) If your Professional Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

45) If your Commercial General Liability insurance coverage history extends beyond the last 12 months, please complete the below table for your four prior carriers:

Insurer	Dates covered	Limits of Liability	Deductible	Premium	Retroactive date

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 #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____