NEW ENGLAND EXCESS EXCHANGE

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

PHYSICIAN AND SURGEON 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 Designation: MD ☐ DO ☐		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) Practice Address: _____
City: _____ State: _____ Zip Code: _____

6) Are you a(n): ☐ Corporation ☐ Individual ☐ Partnership ☐ LLC
☐ Employed Physician ☐ Contracted Physician ☐ Other: _____

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

7) Your practice is: ☐ Solo Practice ☐ Group Practice ☐ Other: _____

8) 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 ☐

9) 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 ☐

PRACTICE SPECIALTY AND EDUCATION INFORMATION

10) 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

11) What is your current practice 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? _____ %

12) Please complete the following regarding your board certification:

a. Are you currently: ☐ Board Certified ☐ Board Eligible ☐ Board Qualified ☐ Not Board Eligible

b. Name of Board(s): _____

c. Date of Exam: _____

d. If you are not Board Eligible, why? _____

e. If you have been Board Eligible for over five years, but not Board Certified, please explain: _____

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

	Institution	Location	Degree/Specialty	Completed?
Medical School				Yes ☐ No ☐
Internship				Yes ☐ No ☐
Residency				Yes ☐ No ☐
Fellowship				Yes ☐ No ☐

14) What date did you begin practicing medicine? _____

15) How many CME hours have you completed in the past 3 years? _____

16) Are you a foreign medical school graduate? Yes ☐ No ☐

a. If yes, what is the date of your ECFMG certification? _____

17) Are you ACLS Certified? Yes ☐ No ☐

18) Are you ATLS Certified? Yes ☐ No ☐

PRACTICE AND PROCEDURE INFORMATION

19) Please complete the following table for procedures/treatments that you perform. Check and complete all that apply:

Procedure	Number Performed Last 12 Months	Estimated Number Performed Next 12 months	Procedure	Number Performed Last 12 Months	Estimated Number Performed Next 12 months
☐ Abortions			☐ Acupuncture		
☐ Adenoidectomy			☐ Amputations		
☐ Anesthesia - OB			☐ Anesthesia – Non-OB		
☐ Assist in Surgery – Own Patients			☐ Assist in Surgery – Other Patients		
☐ Arterial Catheterization			☐ Arteriography		
☐ Bariatric Surgeries*			☐ Cardiac Catheterization		
☐ Cervical Biopsy			☐ Clinical Trials		
☐ Chelation Therapy – Cardiac Care			☐ Chelation Therapy – Heavy Metal		
☐ Chemonucleolysis			☐ Chemotherapy		
☐ Closed Reduction Fractures			☐ Cholecystectomies		
☐ Colonoscopy			☐ Complex Flaps and Grafts		

☐ Cosmetic Procedures (complete question 20))			☐ Dilation and Curettage		
☐ Echocardiography			☐ Electroshock Therapy		
☐ Endoscopic Procedures			☐ Hernioplasty		
☐ Hemorrhoidectomies			☐ Hyperbaric Chamber Treatments		
☐ Interphalangeal Joint Surgery			☐ Joint Replacement Surgery		
☐ Intensive Care for Newborns			☐ Intensive Care for Adults		
☐ Laparoscopy			☐ Mastoidectomy		
☐ MOHS Micrographic Surgery			☐ Needle Biopsy		
☐ Office Gynecology			☐ Obstetrics (complete question 21))		
☐ Open Reduction of Fractures			☐ Organ Transplants		
☐ Orthopedic Surgery - Excluding Spine			☐ Orthopedic Surgery - Including Spine		
☐ Osteopathic Manipulative Medicine			☐ Stem Cell or Exosome Therapy		
☐ Platelet Rich Plasma or Fibrin Therapy			☐ Pedicle Screw Insertion		
☐ Pain Management – Medication Only			☐ Pain Management – Surgical Procedures*		
☐ Pain Management – Spinal Injections*			☐ Pneumoencephal-ography		
☐ Penile Augmentation			☐ Penile Prosthetic Implants		
☐ Pericardiocentesis			☐ Permanent Pacemaker Insertion		
☐ Prostatectomy			☐ Prolotherapy		
☐ Refractive Surgery - ICR			☐ Radial Keratotomy		
☐ Radiopaque Dye Injections			☐ Refractive Surgery - LASIK		
☐ Refractive Surgery - PRK			☐ Refractive Surgery - PTK		
☐ Refractive Surgery - AK			☐ Tubal Ligation		
☐ Thoracic Surgery			☐ Transgender Hormonal Gender Conversion		
☐ Transgender Surgery			☐ Vertebroplasty		
☐ Vasectomy			☐ Other: _____		
☐ Other: _____			☐ Other: _____		
☐ Other: _____			☐ NONE OF THE ABOVE	INITIAL TO CONFIRM: _____	

** Additional supplemental application required*

20) If you are performing cosmetic procedures, please indicate which you are performing. Check all that apply:

☐ Breast Implants/Augmentations	☐ Breast Reductions	☐ Botox Injection
☐ Chemical Peels	☐ Chemobrasion	☐ Collagen Injection
☐ Dermabrasion	☐ Fat Transfer	☐ Hair Transplant
☐ Liposuction	☐ Lipodissolve	☐ Mesotherapy
☐ Microdermabrasion	☐ Facial Plastic Surgery - Elective	☐ Facial Plastic Surgery – Reconstructive
☐ Sclerotherapy	☐ Silicone Injection	☐ Laser Hair Removal
☐ Rhinoplasty	☐ Tracheal Shave	☐ Other Laser Procedure: _____
☐ Other Procedure: _____	☐ Other Procedure: _____	☐ Other Procedure: _____

21) If you are performing obstetric procedures, please indicate which you are performing. Check all that apply:

☐ Prenatal Care – 1st Trimester	☐ Prenatal Care – 2nd Trimester	☐ Prenatal Care – 3rd Trimester
☐ Normal Deliveries	☐ Cesarean Sections	☐ VBAC Deliveries

a. Do you accept high-risk patients? _____
b. If yes to a., approximately how many annually? _____
c. Approximately how many normal deliveries do you perform annually? _____
d. Approximately how many cesarean sections do you perform annually? _____
e. Approximately how many VBAC deliveries do you perform annually? _____

22) What are your average weekly practice hours? _____

23) How many weekly patient encounters do you have on average? _____

24) What percentage of your work is Locum Tenens? _____ %

a. Do you work for any Locum Tenens companies as an employee or independent contractor? Yes ☐ No ☐
b. If yes, how many hours each month? _____
c. Does the Locum Tenens company provide you with Professional Liability insurance? Yes ☐ No ☐
d. If yes to c., please attach a copy of the COI.

25) 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.

26) Do you perform any procedures not routinely performed by others practicing in your specialty or subspecialty? Yes ☐ No ☐

a. If yes, what procedures? _____

27) Are you presently on staff at any hospitals or surgery centers? Yes ☐ No ☐

a. If yes, please complete the below table for these exposures:

Facility Name	City and State	Percent of Work	Type of Privileges
		%	
		%	
		%	

b. If no, please attach protocols for patient admission.

28) Are you currently, or have you ever previously been, a hospital chief of staff or head of any hospital department? Yes ☐ No ☐

a. If yes, when? _____
b. What hospital and department? _____
c. If this position is not current, why did you exit the position? _____

29) Do you or any entity named in this application own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center? Yes ☐ No ☐

a. If yes, please attach details.

30) Do you serve as a medical director? Yes ☐ No ☐

a. If yes, please attach a copy of any contract or agreement describing the position and complete the Kinsale Medical Director Supplemental Application.

b. What facility(ies) are you the medical director of? _____

_____

31) Do you work in an emergency room, other than to maintain privileges? Yes ☐ No ☐

a. If yes, how many hours per month on average? _____

b. Does the hospital or stand-alone emergency medical facility cover you for services provided on their behalf? Yes ☐ No ☐

32) 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.

33) Do you treat patients in a nursing home, correctional facility, or similar care facility? Yes ☐ No ☐

a. If yes, what percentage of your practice are these operations? _____ %

b. Please list the facilities: _____

_____

34) Are you a sports team physician or health care provider? Yes ☐ No ☐

a. If yes, are these operations for a professional team? Yes ☐ No ☐

b. Please list the team(s), league, or school(s) for which you are providing treatment: _____

_____

35) Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? Yes ☐ No ☐

a. If yes, please attach a detailed list of the procedures or drugs and a description of protocols and procedures.

36) Does your practice involve weight management/control other than prescribing exercise or FDA approved medication? Yes ☐ No ☐

a. Please attach a list of all medications, injections, supplements, and procedures used for weight management.

37) Do you practice any forms of Alternative Medicine including but not limited to Ayurvedic Medicine, Chinese Medicine, Homeopathic Medicine, Chiropractic Medicine, Holistic Medicine, or Naturopathic Medicine? Yes ☐ No ☐

a. If yes, please attach an explanation.

38) Are you engaged in any moonlighting activities? Yes ☐ No ☐

a. If yes, what activities are you performing? _____

_____

b. Are you requesting coverage for these activities? Yes ☐ No ☐

39) If you are a radiologist, what percentage of your reads are mammography? _____ %

40) If you are not a radiologist, do you read your own x-rays? Yes ☐ No ☐

a. If yes, approximately how many hours before they are subsequently read by a radiologist? _____

41) Do you read or interpret films, slides, or specimens of patients who reside in states other than your indicated practice states? Yes ☐ No ☐

a. Which states do you offer these services in? _____

b. What percentage of your practice are these operations? _____ %

42) Do you render care or perform consultations outside the state of your primary office location including but not limited to the use of telecommunication technology as a medium for rendering medical services? Yes ☐ No ☐

a. Do you prescribe drugs or provide diagnosis via the internet or telehealth? Yes ☐ No ☐

b. If yes to 40) or a., are these services limited to current patients whom you have previously had at least one in-office visit? Yes ☐ No ☐

SURGICAL PRACTICE AND PROCEDURE INFORMATION *(complete only if you are performing surgery)*

43) Are surgeries limited to incision of boils and superficial abscesses or suturing and superficial fascia? If yes, please skip to Staff Information. Yes ☐ No ☐

44) Do you perform surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? Yes ☐ No ☐

45) Do you perform surgical procedures at a same-day surgery center other than your own office? Yes ☐ No ☐

46) Do you perform surgery in your office or private suite using anesthesia other than local or topical? Yes ☐ No ☐

a. If yes, please complete the following table:

Procedures	Anesthetic or Parenteral Sedation	Emergency Equipment/Procedures in place

STAFF INFORMATION

47) Please complete the following for your staff:

	Number Employed		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full-Time	Part-Time	Full-Time	Part-Time		
Midwife*					Yes ☐ No ☐	Yes ☐ No ☐
CRNA*					Yes ☐ No ☐	Yes ☐ No ☐
Nurse Practitioner					Yes ☐ No ☐	Yes ☐ No ☐
Physician Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Surgeon Assistant					Yes ☐ No ☐	Yes ☐ No ☐
Optometrist					Yes ☐ No ☐	Yes ☐ No ☐
Lab Technician					Yes ☐ No ☐	Yes ☐ No ☐
Pharmacist					Yes ☐ No ☐	Yes ☐ No ☐
RN, LPN					Yes ☐ No ☐	Yes ☐ No ☐

Physical Therapist					Yes ☐ No ☐	Yes ☐ No ☐
X-Ray Technician					Yes ☐ No ☐	Yes ☐ No ☐
Lab Technician					Yes ☐ No ☐	Yes ☐ No ☐
Other: _____					Yes ☐ No ☐	Yes ☐ No ☐

** Requires separate application*

48) Are all of the individuals included in the table above licensed in accordance with applicable State and Federal regulations? Yes ☐ No ☐

49) Do you employ, contract with or supervise any physicians or surgeons? Yes ☐ No ☐

a. If yes, please list their names and attach certificates of insurance for each: _____

_____

_____

50) Do you share office space or have an expense sharing arrangement with any other physician or surgeon other than those named above? If yes, please attach an explanation. Yes ☐ No ☐

51) Which of the following procedures do you use for hiring/screening professionals and paraprofessionals who provide patient care services in your operations other than surgeons and anesthesia providers? Check all that apply:

☐ Check of educational background
☐ Check of residency program
☐ Check of previous employers – In writing
☐ Check of previous employers – By telephone
☐ Criminal background check – State
☐ Criminal background check – Federal
☐ Driver's license verification
☐ MVR Check
☐ Drug screening
☐ Alcohol screening
☐ Abuse screening
☐ Reference verification
☐ Verification of license validity, suspensions, revocations, citations, or pending disciplinary actions
☐ Verification of any pending disciplinary actions by current or previous employers
☐ Verification of Professional Liability or other workplace related claims history against the applicant
☐ Other: _____

COVERAGE AND LOSS HISTORY

52) 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.

53) 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 ☐

54) 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 ☐

55) 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 ☐

56) 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 ☐

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

58) 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).

59) 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 ☐

60) 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 ☐

61) 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

62) 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: _____