NEW ENGLAND EXCESS EXCHANGE

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

RENEWAL - 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:			
Title:	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:			

Please attach copies of the following:

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

b) A copy of your Curriculum Vitae

c) A copy of your business letterhead

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

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

2) Mailing Address: _____

City: _____ State: _____ Zip Code: _____

3) Practice Address: _____

City: _____ State: _____ Zip Code: _____

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

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

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

6) 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 ☐

PRACTICE SPECIALTY RENEWAL INFORMATION

7) Have you had any changes to your specialization in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: _____

8) Have you had any changes to your contractual arrangements in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: _____

9) Have you had any changes to partnerships, corporations, or associations in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: _____

10) How many CME hours have you completed in the past 12 months? _____

11) Have you had any changes to your locations or practice in the past 12 months? Yes ☐ No ☐
   a. If yes, please describe: _____

12) In the past 12 months (please attach details for all "yes" answers):
   a. Have you become American Board Certified? Yes ☐ No ☐
   b. Has any State/Medical Board refused you a medical license? Yes ☐ No ☐
   c. Has any State/Medical Board restricted, suspended or revoked your medical license? Yes ☐ No ☐
   d. Has any State/Medical Board imposed a fine or any other obligation? Yes ☐ No ☐
   e. Has any State/Medical Board issued a letter of guidance or public reprimand? Yes ☐ No ☐
   f. Have you voluntarily surrendered a medical license? Yes ☐ No ☐
   g. Has any State/Medical Board placed you on probation or restricted your practice? Yes ☐ No ☐
   h. Is your Medical license currently under investigation for any reason in any state? Yes ☐ No ☐
   i. Has your Narcotics/DEA license been surrendered/refused/suspended/revoked (voluntarily or otherwise)? Yes ☐ No ☐
   j. Has there been any professional conduct or fee complaint filed against you with any Specialty, National, State or County Medical Society, other Professional Association or any licensing or regulatory authority? Yes ☐ No ☐
   k. Has your membership in any Medical association/society been refused, suspended, revoked, or voluntarily surrendered? Yes ☐ No ☐
   l. Have you been evaluated, treated, or recommended for treatment of alcohol, narcotics, or any other substance abuse, sexual addiction, or mental illness? Yes ☐ No ☐
   m. Have you been diagnosed with, or treated for, a chronic physical illness or disability? Yes ☐ No ☐
   n. Have you become aware of any physical illness, mental illness and/or disability which affects, or could affect, your ability to practice dentistry now or any time in the future? Yes ☐ No ☐

PRACTICE AND PROCEDURE INFORMATION

13) 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 questions 21))		
☐ Open Reduction of Fractures			☐ Organ Transplants		
☐ Orthopedic Surgery - Excluding Spine			☐ Orthopedic Surgery - Including Spine		
☐ Osteopathic Manipulative Medicine			☐ Pedicle Screw Insertion		
☐ Pain Management – Medication Only			☐ Pain Management – Surgical Procedures*		
☐ Pain Management – Spinal Injections*			☐ Platelet Rich Plasma or Fibrin Therapy		
☐ Penile Augmentation			☐ Penile Prosthetic Implants		
☐ Pericardiocentesis			☐ Permanent Pacemaker Insertion		
☐ Pneumoencephal-ography			☐ Prolotherapy		
☐ Prostatectomy			☐ Radial Keratotomy		

☐ Radiopaque Dye Injections			☐ Refractive Surgery - LASIK		
☐ Refractive Surgery - PRK			☐ Refractive Surgery - PTK		
☐ Refractive Surgery - AK			☐ Refractive Surgery - ICR		
☐ Thoracic Surgery			☐ Tubal Ligation		
☐ Transgender Surgery			☐ Transgender Hormonal Gender Conversion		
☐ Vasectomy			☐ Vertebroplasty		
☐ Stem Cell or Exosome Therapy			☐ Other: _____		
☐ Other: _____			☐ Other: _____		
☐ Other: _____			☐ NONE OF THE ABOVE	INITIAL TO CONFIRM: _____	

** Additional supplemental application required*

14) 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: _____

15) 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? _____

16) What are your average weekly practice hours? _____

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

18) Have you had any changes to your procedures performed in the past 12 months? Yes ☐ No ☐

a. If yes, please describe: _____

19) Have you had any changes to your hospital or surgi-center privileges in the past 12 months? Yes ☐ No ☐

a. If yes, please describe: _____

STAFF INFORMATION

20) 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*

21) 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: _____

_____

_____

22) 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 ☐

COVERAGE AND LOSS HISTORY

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

24) In the last 12 months have you or any of your employees been charged with or convicted of a crime other than minor traffic violation(s)? **If yes, please attach an explanation.** Yes ☐ No ☐

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

26) 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 ☐

27) 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

28) 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: _____