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MEDICAL DIRECTOR SUPPLEMENTAL APPLICATION

COMPLETE IN FULL INCLUDING SIGNATURES AND DATING BY THE PROVIDER, OWNER, PARTNER, OR OFFICER 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:	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 Director ☐ Contracted Director ☐ Other: __________

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

7) What is the entity name of your practice? ______________________________

a. What is your ownership percentage? ______________ %

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

8) 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 ☐

PRACTICE SPECIALTY AND EDUCATION INFORMATION

9) 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

10) 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? ______________ %

11) 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: ______________

____

____

12) 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 ☐

13) What date did you begin practicing medicine? ______________________________

14) How many years of experience do you have as a Medical Director? ______________________

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

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

16) Are you ACLS Certified? Yes ☐ No ☐

17) Are you ATLS Certified? Yes ☐ No ☐

FACILITY PRACTICE AND PROCEDURE INFORMATION

18) Approximately how many total outpatient visits or tests are performed per year at the facility? __________

19) What is the projected revenue for the facility for the next 12 months? $______________________

20) Please complete the following table for the patient census of the facility which you are the Medical Director of:

Patient Census	Percentage Last 12 Months:	Estimated Percentage Next 12 Months
Substance Abuse/Addiction Treatment		
Mentally Retarded		
Psychiatric		
Alzheimer's/Senility or Aged		
Counseling/Family Planning		
Dental/Orthodontic		
Hemodialysis		
General Public		
Pediatric		
Surgical		
Holistic Medicine/Acupuncture		
Obstetrics		
Research or Experimental		
Aesthetics/Cosmetic Center		
Other: ______________________		
Other: ______________________		
TOTAL		

21) Is the facility presently covered by a medical malpractice policy? Yes ☐ No ☐

a. If yes, please attach a copy of the policy Declarations page.

22) Does the facility have beds for overnight occupancy? Yes ☐ No ☐

a. If yes, how many is the facility licensed for? ______________________

b. What is the typical occupancy percentage? ______________________ %

23) If the facility is performing obstetric procedures, please indicate which are performed. Check all that apply:

☐ Prenatal Care – 1st Trimester ☐ Prenatal Care – 2nd Trimester ☐ Prenatal Care – 3rd Trimester

☐ Normal Deliveries ☐ Cesarean Sections ☐ VBAC Deliveries

a. Does the facility accept high-risk patients? ______________________

b. If yes to a., approximately how many annually? ______________________

c. Approximately how many normal deliveries does the facility perform annually? ______________________

d. Approximately how many cesarean sections does the facility perform annually? ______________________

e. Approximately how many VBAC deliveries does the facility perform annually? ______________________

24) Have there been any changes in the facility specialty or practice activities in the last ten years? Yes ☐ No ☐

a. If yes, please attach an explanation.

25) Is the facility currently or has it 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.

26) Does the facility provide 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.

27) Do you provide medical services/direct patient care at the facility? Yes ☐ No ☐

a. If yes, how many hours per week? ______________________

b. Do you have a medical malpractice policy for these services? Yes ☐ No ☐

c. If yes, please attach a copy of the policy Declarations page

28) How many hours per week are dedicated strictly to your Medical Director responsibilities? ______________________

29) Do you have a written job description? If yes, please attach a copy. Yes ☐ No ☐

FACILITY SURGICAL PRACTICE AND PROCEDURE INFORMATION *(complete only if surgery is performed at your facility)*

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

31) Does the facility provide surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? Yes ☐ No ☐

32) Does the facility perform surgery 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

33) Please complete the following for the facility staff:

	Number Employed		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full-Time	Part-Time	Full-Time	Part-Time		
Physicians					Yes ☐ No ☐	Yes ☐ No ☐
Surgeons					Yes ☐ No ☐	Yes ☐ No ☐
Midwife					Yes ☐ No ☐	Yes ☐ No ☐
CRNA					Yes ☐ No ☐	Yes ☐ No ☐
Respiratory Therapist					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 ☐
Optician					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 ☐
Perfusionist					Yes ☐ No ☐	Yes ☐ No ☐
Other: ____________________					Yes ☐ No ☐	Yes ☐ No ☐

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

35) Which of the following procedures does the facility 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

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

37) Have you or any of the facility 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 ☐

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

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

40) 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 ☐

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

42) Has a claim ever been made against you solely as respects to your duties as a Medical Director? **If yes, please complete the Kinsale Health Care Claim Supplemental.** Yes ☐ No ☐

43) 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 ☐

44) 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 ☐

45) 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

46) 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: ____