








KINSALE INSURANCE

REQUESTED COVERAGE – OUTPATIENT CLINIC

☐ **Requesting Professional Liability:**

Requested Retro Date: _____

Professional Liability Limits		Professional Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting General Liability:**

Requested Retro Date: _____ or ☐ Occurrence Based Coverage

General Liability Limits		General Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $2,500	☐ $15,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $5,000	☐ $20,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $7,500	☐ $25,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $10,000	☐ Other: _____

☐ **Requesting Employee Benefits Liability (supplement required):**

Requested Retro Date: _____

Employee Benefits Liability Limits		Employee Benefits Liability Deductible	
☐ $100,000 / $300,000	☐ $1,000,000 / $1,000,000	☐ $1,000	☐ $10,000
☐ $200,000 / $600,000	☐ $1,000,000 / $2,000,000	☐ $2,500	☐ $15,000
☐ $250,000 / $750,000	☐ $1,000,000 / $3,000,000	☐ $5,000	☐ $20,000
☐ $500,000 / $1,500,000	☐ Other: _____	☐ $7,500	☐ $25,000

☐ **Requesting Non-Owned Auto Liability (supplement required):**

Non-Owned Auto Liability Limits	
☐ $100,000	☐ $500,000
☐ $200,000	☐ $1,000,000
☐ $250,000	☐ Other: _____

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.

Kinsale Insurance Company
P. O. Box 17008
Richmond, VA 23226
(804) 289-1300
www.kinsaleins.com

APPLICATION FOR CLINICS (Medical, Dental, Public Health)

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) _____

2. Mailing Address:_____
   STREET CITY COUNTY STATE ZIP

3. Location Address: Check here if same as mailing: ☐

   (1) _____
   STREET CITY COUNTY STATE ZIP
   (2) _____
   STREET CITY COUNTY STATE ZIP
   (3) _____
   STREET CITY COUNTY STATE ZIP
   (4) _____
   STREET CITY COUNTY STATE ZIP
   Attach Additional Pages as Needed

4. Website Address: **www.**_____ 5. Telephone: _____

6. Inspection contact: _____

7. Date Established _____ Years under current management _____

8. Applicant is a:
   ☐ Individual ☐ Professional Associations
   ☐ Corporation ☐ Partnership
   ☐ LLC ☐ Joint Venture
   ☐ Other:_____

9. Enterprise is: ☐ For Profit ☐ Not For Profit

10. Is this entity owned by, associated with or controlled by any other entity? Yes ☐ No ☐

If yes, please provide details:

_____

_____

OPERATIONS

11. **Please check the category which best describes your organization**

☐ Health and Wellness Center	Center or clinics established for primarily walk-in patients for basic health and health-related services. Primary care providers predominantly RNs or LPNs, NPs, and physician assistants. Facilities in this category would include free clinics open to the public or those provided for students/faculty of schools, colleges, universities.
☐ Primary Care Clinic	Majority of patient visits are scheduled preventative health services. This category can also include extended hours walk-in clinics where urgent care services are not the primary services provided by your organization. Your regular office hours have been extended to include the addition of walk-in care services. Primary care givers during these hours could include physicians or mid-level providers, although physicians are available during the extended hours.
☐ Urgent Care Center	Urgent care services are the primary activities performed by your organization. Physicians regularly staff your locations with the support of mid-level providers. Services provided are sometimes broader in scope than those typically found in a physician's office. Locations may offer a range of services including physical therapy, occupational therapy, occupational health (Workers Compensation exams), on site x-ray and clinical lab.
☐ Emergi-Center	High level of acuity and may include minor invasive procedures such as those provided in emergency care centers/emergency rooms. Services would also include high level treatment for trauma or severe illness and crisis stabilization. Treatments may require moderate to high levels of anesthesia
☐ Other	Please provide a description of your organization if it does not **readily** reflect one of the above categories. _____ _____

12. Please list all accreditations and association memberships held by the applicant's facility (Joint Commission, AAAHC, etc):

_____

_____

13. Days and Hours of Operation: _____

14. Please state sources and amounts of total revenue:

Source	Last 12 months	Next 12 months
Charitable contributions	$_____	$_____
Government Funding	$_____	$_____
Fee for services	$_____	$_____
Other – specify:	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

15. Please indicate number of patient visits:

	Past 12 Months	Estimated Next 12 Months
Emergency Visits	_____	_____
Urgent Care visits	_____	_____
Health/ Wellness Visits	_____	_____
Other:_____	_____	_____
TOTAL VISITS	_____	_____

16. If your facility offers any of the following services on site please provide the number of tests, prescriptions, or imaging studies respectively performed:

	Past 12 Months	Estimated next 12 Months
X-ray / Imaging	_____	_____
Pharmacy	_____	_____
Laboratory	_____	_____

Are any of these services offered to individuals who are not your facility's primary patient? ☐ YES ☐ NO ☐ N/A

17. Please indicate percentage of patients among the following:

_____ % Urgent Care
_____% Emergency Care
_____% General Practice / Family Practice
_____% Dialysis
_____% Occupational health
_____% Students
_____% Surgical
_____% Other (please describe) _____

_____% Alternative Medicine
_____% Women's Health/ Gynecological
_____% Sleep Studies
_____% Psychiatric
_____% Weight loss
_____% Crisis Stabilization

18. Does the applicant maintain any beds for overnight occupancy? ☐ YES ☐ NO
If yes, please provide total number _____

19. Is anesthesia administered by the applicant, the applicant's employees or independent contractors other than topical or local? ☐ YES ☐ NO **If yes, please provide a detail explanation on page 6.**

20. Does the applicant's employees or independent contractors perform any prenatal care or obstetrical procedures? ☐ YES ☐ NO **If yes, please provide details on page 6.**

21. Does the applicant, employees, or independent contractors use drugs for weight reduction? ☐ YES ☐ NO
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs and quantity dispensed.

22. Does the applicant perform laser hair removal, botox injections or dermal filler injections? ☐ YES ☐ NO **If yes, please complete medical spa supplement.**

23. Does the applicant perform any psychiatric shock therapy? ☐ YES ☐ NO

24. Does the applicant perform any chelation therapy services? ☐ YES ☐ NO

25. Does the applicant administer any methadone treatment? ☐ YES ☐ NO
If yes, provide the number of treatments:
Last 12 Months _____ Next 12 Months _____

26. Does the applicant maintain written documentation of procedures for patient intake and follow-up? ☐ YES ☐ NO

27. Please provide name and location of any hospital or medical facility that the applicant refers in practice?
_____

STAFF

28. Please indicate the number of employed and contracted staff:

	Number Employed?		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Acupuncturists					☐ YES ☐ NO	☐ YES ☐ NO
Chiropractors*					☐ YES ☐ NO	☐ YES ☐ NO
Dentists*					☐ YES ☐ NO	☐ YES ☐ NO
Inhalation/ Respiratory Therapists					☐ YES ☐ NO	☐ YES ☐ NO
Laboratory Technicians					☐ YES ☐ NO	☐ YES ☐ NO
Licensed Practical Nurses					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Anesthetists					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Midwives*					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Practitioner					☐ YES ☐ NO	☐ YES ☐ NO
Opticians					☐ YES ☐ NO	☐ YES ☐ NO
Optometrists					☐ YES ☐ NO	☐ YES ☐ NO
Paramedics/ EMT's					☐ YES ☐ NO	☐ YES ☐ NO
Perfusionists					☐ YES ☐ NO	☐ YES ☐ NO
Pharmacists					☐ YES ☐ NO	☐ YES ☐ NO
Physician Assistant					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – Major Surgery*					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – Minor surgery*					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – No surgery*					☐ YES ☐ NO	☐ YES ☐ NO
Physicians – OBGYN*					☐ YES ☐ NO	☐ YES ☐ NO
Physiotherapists					☐ YES ☐ NO	☐ YES ☐ NO
Registered Nurses					☐ YES ☐ NO	☐ YES ☐ NO
Social Workers					☐ YES ☐ NO	☐ YES ☐ NO
Speech Therapists					☐ YES ☐ NO	☐ YES ☐ NO
X-ray Technicians					☐ YES ☐ NO	☐ YES ☐ NO
Other: Specify					☐ YES ☐ NO	☐ YES ☐ NO

* Additional applications required if coverage is desired

29. Please provide the name and specialty of the applicant's Medical Director: _____
    Does the applicant's Medical Director have direct patient care? ☐ YES ☐ NO
    ☐ Full Time or ☐ Part Time

30. Are all above individuals licensed in accordance with applicable state and federal regulations? ☐ YES ☐ NO

31. Do you require contracted staff to carry their own professional liability insurance? ☐ YES ☐ NO
    If yes, what limits do they carry? _____

32. Do all physicians (employed and contracted) carry their own professional liability coverage? ☐ YES ☐ NO
    If yes, what limits do they carry? _____

33. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:
    - ☐ Check of educational background, or residency program, when applicable.
    - ☐ Check of previous employers (☐ In writing ☐ By Telephone)
    - ☐ Criminal background check (☐ STATE ☐ FEDERAL)
    - ☐ Drug / Alcohol / Abuse Screening (circle all that are used)
    - ☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
    - ☐ Require information on any professional liability or work-related claim that has previously been made against any Individual?

34. Does your facility have written job descriptions? ☐ YES ☐ NO

COVERAGE HISTORY AND LOSS HISTORY

35. Please list professional liability insurance carried for each of the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ Aggregate	Deductible	Premium	Retroactive date

36. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ Aggregate	Deductible	Premium	Occurrence or Claims Made

If the current expiring GL policy is claims- made what is the retroactive date? _____

Provide details for all "yes" answers to questions 37-42 on page 6 or attach additional pages as needed

37. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain on page 7 or attach additional pages as needed.** ☐ YES ☐ NO
38. Has the applicant or any of its employees ever been charged with, or convicted of a crime **<u>other</u>** than minor traffic violations? **Explain on page 7 or attach additional pages as needed.** ☐ YES ☐ NO
39. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on page 7 or attach additional pages as needed.** ☐ YES ☐ NO
40. Has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance? **How Many? _____ (Complete Supplemental Claims form for Each.)** ☐ YES ☐ NO
41. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐ NO
42. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐ NO

GENERAL LIABILITY - complete only if you are requesting GL coverage

43. Building Description

	Buildings/Wings #1	#2	#3	#4
Type of Construction:	_____	_____	_____	_____
No. of Stories:	_____	_____	_____	_____
Square Footage	_____	_____	_____	_____
Date Built:	_____	_____	_____	_____
Smoke detectors:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Local/Central station fire alarm:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sprinkler System:	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial

44. Do any of the Applicant's locations have any (explain any "yes" answers on page 6):

a. Exposure to flammables, explosive, chemicals? ☐ YES ☐ NO
b. Catastrophe exposure? ☐ YES ☐ NO
c. Exposure to radioactive materials? ☐ YES ☐ NO

45. Has any claim for General Liability **ever** been made against any person(s) or entity(ies) proposed for this insurance? If Yes, complete a supplemental claims form for each. ☐ YES ☐ NO

46. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? If Yes, answer complete supplemental claims form for each. ☐ YES ☐ NO

SUPPLEMENTAL INFORMATION Use the remainder of this page as needed or to address questions referenced within the application

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: _____

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

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

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

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

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

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: _____