

# CID Insurance Programs Inc. DBA CID Insurance Services

APPLICATION for: **Miscellaneous Medical Malpractice Insurance**

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

1. Name of Applicant: \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

No. of Locations: \_\_\_\_\_ (If multiple names and locations, please attach list.)

3. a) Date Established: \_\_\_\_\_ Corporation  Partnership  Professional Assoc.  Individual   
For Profit  Not for Profit

b) In what states is the entity registered and licensed to practice? \_\_\_\_\_

c) Please specify any professional societies or associations of which you are a member: \_\_\_\_\_

4. a) Is the entity engaged in, owned by, associated with, or controlled by any other business?  Yes  No

b) Is the entity owned by any physician?  Yes  No

c) Is the entity owned by any hospital, or are any services hospital based?  Yes  No

d) Have there been any changes in ownership of the business since the date the entity was established?  Yes  No

If "Yes" to any of the above, please give details: \_\_\_\_\_

5. Professional Activities and Specialty: (Attach narrative description, if necessary.)

Check all that apply:

- \_\_\_\_\_ Acupuncturist/Naturopathic Medicine
- \_\_\_\_\_ Alcohol/Drug/Psychiatric Rehabilitation
- \_\_\_\_\_ Ambulance Services
- \_\_\_\_\_ Ambulatory Surgery Center
- \_\_\_\_\_ Diagnostic Imaging
- \_\_\_\_\_ Dialysis Center
- \_\_\_\_\_ Health/Fitness Center
- \_\_\_\_\_ Home Healthcare Agency
- \_\_\_\_\_ Hospice

- \_\_\_\_\_ Medical Testing/Laboratory
- \_\_\_\_\_ Nurse Registry
- \_\_\_\_\_ Optometry
- \_\_\_\_\_ Out-Patient Medical Clinic
- \_\_\_\_\_ Out-Patient Mental Health Clinic
- \_\_\_\_\_ Pharmacy
- \_\_\_\_\_ Residential Facility
- \_\_\_\_\_ Speech Therapy
- \_\_\_\_\_ Other (Specify): \_\_\_\_\_

6. State approximate division of entity's patients among:

- |                               |   |    |                             |   |    |
|-------------------------------|---|----|-----------------------------|---|----|
| a) Alcoholics                 | ( | %) | k) Obstetrical              | ( | %) |
| b) Counseling/Family Planning | ( | %) | l) Pediatric                | ( | %) |
| c) Communicable               | ( | %) | m) Prisoners                | ( | %) |
| d) Dental                     | ( | %) | n) Psychiatric              | ( | %) |
| e) Drug Addicts               | ( | %) | o) Research or Experimental | ( | %) |
| f) General                    | ( | %) | p) Senile or Aged           | ( | %) |
| g) Hemodialysis               | ( | %) | q) Stress Testing           | ( | %) |
| h) Holistic Medicine          | ( | %) | r) Surgical                 | ( | %) |
| i) Medical                    | ( | %) | s) Tubercular               | ( | %) |
| j) Mentally Retarded          | ( | %) | t) Other: _____             | ( | %) |

7. a. List the number and type of entity's employees and volunteers below: If "None," state None. \_\_\_\_\_

<u>Number</u>	<u>Type of Profession</u>		
i) _____	Acupuncturist	xiv) _____	Optometrists
ii) _____	Counselors	xv) _____	Paramedics
iii) _____	EMT's	xvi) _____	Perfusionists
iv) _____	Home Health Aides	xvii) _____	Pharmacists
v) _____	Inhalation Therapists	xviii) _____	Physician Assistants
vi) _____	Laboratory Technicians	xix) _____	Physicians – Minor Surgery
vii) _____	Massage Therapists	xx) _____	Physicians – No Surgery
viii) _____	Medical Directors	xxi) _____	Physiotherapists
ix) _____	Nurse Anesthetists	xxii) _____	Psychologist
x) _____	Nurses, Licensed Practical	xxiii) _____	Social Workers
xi) _____	Nurse Practitioner	xxiv) _____	Speech Therapists
xii) _____	Nurses, Registered	xxv) _____	Other: _____
xiii) _____	Opticians		

b. List the number and type of independent contractors who provide professional services on behalf of the entity. Use a separate sheet, if necessary. If "None," state None. \_\_\_\_\_

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c. Are all of the individuals listed in questions 7.a. and 7.b. licensed in accordance with applicable state and federal regulations? Yes No  
**If "No," attach explanation.**

d. Are all employed/contracted physicians board certified in their specialty? Yes No  
**(Attach detailed explanation for any "Yes" answers to the following)**

e. 1) Are criminal background checks conducted on all employees? Yes No  
**If "No," attach explanation.**

2) Does the entity conduct pre-employment screenings and any other necessary investigations prior to hiring all staff? Yes No

- f. Has the Applicant or any of the individuals listed in questions 7.a. and 7.b:
- i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes No
  - ii) Ever been convicted of an act committed in violation of any law or ordinance other than traffic offenses? Yes No
  - iii) Ever been treated for alcoholism or drug addiction? Yes No
  - iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered same? Yes No
8. a) Is there a written/formalized risk management/quality assurance program? Yes No
- b) Does the entity have a written credentialing process for employees and staff? Yes No
- c) Does the entity have written procedures for reporting all incidents? Yes No

**If "No" to any of the above, attach explanation.**

9. State approximate division of services being provided among the following settings:
- |  |                                 |
|--|---------------------------------|
| a) Assisted Living Facilities (       %) | e) Nursing Homes (       %)     |
| b) Clinics (       %)                    | f) Physician Offices (       %) |
| c) Emergency Rooms (       %)            | g) Private Homes (       %)     |
| d) Hospitals (       %)                  | h) Other: _____ (       %)      |

10. For AMBULANCE SERVICES, answer the following:

Number of Ground Ambulances _____	Number of Emergency Calls (per year) _____
	Number of Non-Emergency Calls (per year) _____
Number of Air Ambulances _____	Number of Transports Calls (per year) _____
	Number of Body Transports (per year) _____
Radius of Services _____	Is the Applicant part of a Fire Department? <input type="checkbox"/> Yes <input type="checkbox"/> No

11. For AMBULATORY SURGERY CENTERS, answer the following:

Number of Surgical Procedures in the next 12 months \_\_\_\_\_

Percentage of procedures using general anesthesia \_\_\_\_\_

12. For DIALYSIS CENTERS, answer the following:

Number of hemodialysis treatments in the next 12 months \_\_\_\_\_

Number of peritoneal treatments in the next 12 months \_\_\_\_\_

Hours of service in the next 12 months for in-home treatments \_\_\_\_\_

Number of stations \_\_\_\_\_

13. For ALCOHOL/DRUG/PSYCHIATRIC REHABILITATION CENTERS, answer the following:

Number of total licensed beds \_\_\_\_\_

Are there off-site counseling services? Yes No

Are all counselors licensed? Yes No

Are there intern counselors? Yes No

14. For HEALTH/FITNESS CENTERS, answer the following:

Is there a pool? Yes No

Are there tanning beds? Yes No

15. Does the entity perform: **(Attach detailed explanation for any "Yes" answers to the following)**

- a. Acupuncture or acupuncture anesthesia? Yes No
- b. Angiography/Arteriography/Venography? Yes No
- c. Cardiac Catheterization? Yes No
- d. Catheterization (other than cardiac, urinary or umbilical)? Yes No
- e. Closed reduction of compound fractures? Yes No
- f. Normal Deliveries? Yes No
- g. Dermabrasion? Yes No
- h. Injection of radioisotopes and/or use of irradiated substances? Yes No
- i. IV/Infusion Therapy? Yes No
- j. AIDS Therapy? Yes No
- k. Radiation Therapy and/or Chemotherapy? Yes No
- l. Psychiatric shock therapy? Yes No
- m. Silicone Injections? Yes No
- n. Spinal Anesthesia (other than saddle blocks or caudals)? Yes No
- o. Botox Injections? Yes No
- p. Chelaton Therapy? Yes No
- q. DNA Testing? Yes No
- r. Genetic Testing? Yes No
- s. Environmental Testing? Yes No
- t. Pharmaceutical Testing? Yes No
- u. Testing of any weapons? Yes No
- v. Blood Banking? Yes No
- w. Clinical Trials or Research using animal or human test subjects? Yes No
- x. Teleradiology? Yes No
- y. Telemedicine? Yes No

16. Does the entity perform any: **(Attach detailed explanation for any "Yes" answers to the following)**

- a. Surgery other than incision of superficial boils or suturing superficial fascia? Yes No
- b. Circumcisions? Yes No
- c. Dilation and Curettage? Yes No
- d. Insertion of temporary pacemakers? Yes No
- e. Tonsillectomies and/or Adenoidectomies? Yes No
- f. Caesarean Sections? Yes No
- g. Cosmetic Plastic Surgery? Yes No
- h. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? Yes No
- i. Hysterectomies? Yes No
- j. Open reduction of fractures? Yes No
- k. Surgery for weight reduction of patients? Yes No
- l. Abortions and/or Menstrual extractions? (If "Yes," include trimester, method and number of abortions performed per month in description.) Yes No
- m. Silicone Implants? Yes No
- n. Sterilization Procedures? Yes No
- o. Biopsies and/or Endoscopies? Yes No

- p. Therapeutic Optometry (implantation of prosthetic ocular devices)? Yes No
- q. Sex change operations? (If "Yes," please advise the number performed per year.) Yes No
- r. Other surgery: \_\_\_\_\_ Yes No

17. Does the entity perform hospital emergency room care? Yes No
- a. For its own patients? Yes No
  - b. For patients not its own? Yes No
  - c. If answer to (b) is "Yes," please specify: the percentage of its time devoted to this work = \_\_\_\_\_%, the number of hours per month devoted to this work = \_\_\_\_\_ hours.

18. Does the entity use drugs for weight reduction for patients? Yes No
- If "Yes," list drugs used and advise:** Percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by entity:
- \_\_\_\_\_
- \_\_\_\_\_

19. Does the entity administer any methadone treatments? Yes No

20. Is anesthesia (other than topical or by means of local infiltration) administered by either the applicant or others? Yes No
- If "Yes," attach detailed explanation.**

21. Does the entity maintain any beds for overnight occupancy? Yes No
- If "Yes," number of licensed beds by location:** \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

22. State number of x-ray machines owned or operated and whether they are used for diagnosis or treatment or both:
- \_\_\_\_\_
- \_\_\_\_\_
- State by whom treatment is given and number of procedures: \_\_\_\_\_
- \_\_\_\_\_

23. Does the entity own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes No
- If "Yes," give details, including name, location, size and number of beds:** \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

24. Does the entity sell or lease any equipment for use by any other persons or entities? Yes No
- If "Yes," give details, including name, location, size and number of beds:** \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

25. a) State sources and amounts of total revenue:

<u>Source</u>	<u>Amount Last Policy Year</u>	<u>Est. Amount This Policy Year</u>
1. Charitable Contributions:	\$ _____	\$ _____
2. Government Funding:	\$ _____	\$ _____
3. Fee for Services:	\$ _____	\$ _____
4. Other: _____	\$ _____	\$ _____
5. Other: _____	\$ _____	\$ _____
<b>TOTAL GROSS REVENUE</b>	<b>\$ _____</b>	<b>\$ _____</b>

b) For PHARMACIES, state sources and amounts of total revenue:

<u>Source</u>	<u>Amount Last Policy Year</u>	<u>Est. Amount This Policy Year</u>
1. Prescription Sales:	\$ _____	\$ _____
2. Non-Prescription Sales:	\$ _____	\$ _____
3. Other: _____	\$ _____	\$ _____

c) Are all drugs dispensed approved by the FDA?  Yes  No

If "No," attach explanation.

26. Number of estimated patient encounters in the last 12 months \_\_\_\_\_ and/or patient tests carried out \_\_\_\_\_. (Note: "patient encounters" refers to number of visits – not number of patients.)

27. Number of estimated patient encounters and patient tests in the next 12 months:  
(Note: "patient encounters" refers to number of visits – not number of patients.)

Patient encounters \_\_\_\_\_  
Patient Tests \_\_\_\_\_

28. Describe Professional Liability coverage for last five years for the entity:

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration (Mo/Day/Yr)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If the expiring policy is claims made, what is the retroactive date? \_\_\_\_\_

29. Has any insurer cancelled or refused to renew any similar insurance during the past five years?  Yes  No

If "Yes," please describe: \_\_\_\_\_

\_\_\_\_\_

30. Is the Applicant currently insured under a Commercial General Liability Policy?  Yes  No  
If "Yes," please give details:

<u>Insurance Company</u>	<u>Type of Coverage</u>	<u>Limits BI</u>	<u>Limits PD</u>	<u>From</u>	<u>To</u>
_____	_____	_____	_____	_____	_____



31. Has any application for Professional Liability Insurance made on behalf of the entity, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? Yes No

If "Yes," please describe: \_\_\_\_\_

**Please answer Questions 32 and 33 below if the entity does not currently have Miscellaneous Medical Professional/General Liability through NAS Insurance Services, Inc.**

32. Has any claim ever been made against the entity or any of its employees? Yes No  
**If "Yes," please attach details stating:** 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

33. Is the applicant aware of any circumstances which may result in any claim against him, the entity, his predecessors in business, or any of the present or past Partners and Officers? Yes No  
**If "Yes," please give full details on the same basis as question 31.**

34. **Please answer this question if the entity currently has Miscellaneous Medical Professional/General Liability through NAS Insurance Services, Inc.**  
 Has the entity notified NAS Insurance Services of all litigation, administrative proceedings, demand letters, formal or informal governmental investigations or inquiries which have occurred in the past 12 months? Yes No None to Report

**If "Yes," please indicate number of events in the last 12 months:** \_\_\_\_\_  
**If "No," please forward notice to NAS Insurance Services, Inc., on behalf of Underwriters, immediately.**

35. Limits of Liability requested \_\_\_\_\_ Deductible \_\_\_\_\_

36. Desired term of policy: From \_\_\_\_\_ To \_\_\_\_\_

**FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.**

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on file by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein proper to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

For Kentucky residents:

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.

Name of Applicant: \_\_\_\_\_  
 Please print Title Date

Signature: \_\_\_\_\_  
 Name Date

