CID Insurance Programs Inc. DBA CID Insurance Services

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS & SURGEONS

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 90 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

Additional information required for this submission:

- Copy of applicant's current curriculum vitae
- Copy of applicant's current declarations page *(Claims Made policies must reflect retroactive date)*
- Currently valued 5 year loss/claims history from prior companies

NOTE: Submission of a completed application confers no obligation upon the company to bind coverage.

SECTION I – GENERAL INFORMATION			
Applicant name:			
Principal practice address:			
City:		State:	Zip:
Phone:	Ext:	Fax:	
E-mail:		Website:	
Social security number:		Date of birth:	

Additional Practice Locations	Percent of Practice
	%
	%
	%
	%

Mailing address ☐ (*Check here if same as Principal practice address*):			
City:		State:	Zip:

SECTION II – ENTITY INFORMATION

Applicant Type: ☐ Individual ☐ Corporation ☐ Partnership ☐ LLC ☐ Other (describe):
☐ Employed Physician – by whom:

Practice Type: ☐ Solo Practice ☐ Group Practice

Entity Name:

"Doing business as" (d/b/a) names used? ☐ Yes ☐ No
If "Yes", specify:

Do you want this entity covered? ☐ Yes ☐ No

How many other physicians practice at this entity? Applicant's percentage of ownership: %

SECTION III – MEDICAL EDUCATION & LICENSE INFORMATION

1. Please complete the following (*If additional space is needed use Section X*):

	Name of institution	Degree/ specialty	Location	Date From	Date To	Completed
Medical school						☐ Yes ☐ No
Internship						☐ Yes ☐ No
Residency						☐ Yes ☐ No
Fellowship						☐ Yes ☐ No

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2. Is Applicant a foreign medical school graduate: ☐ Yes ☐ No

Date of ECFMG certification:

3. Provide the number of hours of continuing medical education Applicant has completed within the past three (3) years.

4. Is Applicant a U.S. citizen? ☐ Yes ☐ No
If "No", indicate,
Applicant's status: Date of entry into USA:

5. Provide the following information for all states in which Applicant is licensed to practice:

State	% of practice	License #	License status
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending

6. Provide Applicant's Federal DEA license number: Status:

7. Are you Board Certified? ☐ Yes ☐ No
☐ Board certified by:
☐ Board eligible – date of exam:
☐ Board qualified *(completed required training)*
☐ Neither Board certified nor Board qualified *(please explain below)*

If Board eligible for over five (5) years, but not Board certified, please explain:

SECTION IV – SPECIALTY

Current practice specialty:	Percentage of practice: %
Subspecialty:	Percentage of practice: %

1. Have there been any changes in Applicant's specialty or practice activities within the past 10 years? ☐ Yes ☐ No
If "Yes", describe changes:

2. Does Applicant anticipate any changes in specialty or practice in the next year? ☐ Yes ☐ No
If "Yes", describe the anticipated changes:

3. Does Applicant perform any procedure not routinely performed by other persons practicing Applicant's specialty or subspecialty? ☐ Yes ☐ No
If "Yes", please provide complete details:

4. Does Applicant now, or has Applicant ever, performed experimental or investigational procedures, or prescribed or dispensed experimental drugs? ☐ Yes ☐ No
If "Yes", please explain under Section X or on a separate sheet.

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SECTION V – PROCEDURE INFORMATION

1. Does your practice include the following:

☐	No Surgery	No surgery with the exception of suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.
☐	Minor Surgery	Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology who may perform any of the following techniques or procedures: Colonoscopy, sigmoidoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography, pneumatic or mechanical esophageal dilation (not with bougie or olive), angiography, arteriography, catheterization—arterial, cardiac or diagnostic (applies only to internists who have completed cardio-vascular subspecialty training), needle biopsy including lung, breast, prostate and superficial and subcutaneous tissue, radiopaque dye injection into blood vessels lymphatics, sinus tracts or fistulae. No procedures performed on a patient while under general anesthesia.
☐	Major Surgery	Involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis or any other operation that presents a distinct hazard to life because of the condition of the patient or the length of circumstances of and operation. It also included discograms, lymphangiography, myelography, phlebography, pneumoencephalography, and radiation therapy. Also included is removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operations using general anesthesia.

2. With the exception of surgery for obesity, does Applicant's practice include weight reduction or control other than by diet or exercise? ☐ Yes ☐ No
   If "Yes":
   a. What percentage of Applicant's patients are weight control patients? %
   b. Does Applicant dispense any drugs? ☐ Yes ☐ No
      If "Yes", provide the names of the drug(s) dispensed:

3. Check all procedures/treatments performed by Applicant and indicate where performed:

Procedure	Office	Hospital	Other
Abortion *(Does Applicant perform non-therapeutic abortions?* ☐ Yes ☐ No) Which trimester? # per year	☐	☐	☐
Acupuncture	☐	☐	☐
Anesthesia – non-obstetrical	☐	☐	☐
Anesthesia – Obstetrical	☐	☐	☐
Angiography	☐	☐	☐
Angioplasty	☐	☐	☐
Assisting in surgery: ☐ Own patients ☐ Patients of others	☐	☐	☐
Bariatric surgery*: ☐ Gastric banding ☐ Gastric bypass ☐ Gastric bubble ☐ Gastric stapling ☐ Other *(describe)*: **If applicant is performing bariatric surgery, please complete the James River Bariatric Supplement.*	☐	☐	☐
Blepharoplasty	☐	☐	☐
Breast enhancement – silicone	☐	☐	☐
Breast enhancement – saline	☐	☐	☐
Breast enhancement – trans-umbilical	☐	☐	☐
Breast reduction	☐	☐	☐

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Procedure *(continued)*	**Office**	**Hospital**	**Other**
Cardiac catheterization	☐	☐	☐
Cervical biopsy	☐	☐	☐
Chelation therapy: ☐ Lead removal ☐ Arteriosclerotic heart disease	☐	☐	☐
Chemonucleolysis	☐	☐	☐
Chemotherapy	☐	☐	☐
Cryosurgery *(other than use on benign, malignant, or pre-malignant dermatological lesions)*	☐	☐	☐
Cosmetic procedures:			
Botox injection	☐	☐	☐
Chemical peels	☐	☐	☐
Chemobrasion	☐	☐	☐
Collagen injection	☐	☐	☐
Dermabrasion	☐	☐	☐
Fat transfer	☐	☐	☐
Hair transplant	☐	☐	☐
Laser hair removal	☐	☐	☐
Laser skin resurfacing	☐	☐	☐
Smart Lipo	☐	☐	☐
Any other laser procedure or treatment *(specify)*:	☐	☐	☐
Lippodisolve	☐	☐	☐
Mesotherapy	☐	☐	☐
Microdermabrasion	☐	☐	☐
Silicone injection	☐	☐	☐
Other *(describe below or on supplemental sheet)*:	☐	☐	☐
Dilation and Curettage	☐	☐	☐
Echocardiography	☐	☐	☐
Electroconvulsive therapy	☐	☐	☐
Endoscopic procedures	☐	☐	☐
Facial plastic surgery ☐ Elective Cosmetic ☐ Reconstructive	☐	☐	☐
Fracture reduction ☐ Closed ☐ Open	☐	☐	☐
Gynecology Surgery ☐ Cosmetic ☐ Reconstructive	☐	☐	☐
Hormone Replacement Therapy (other than Menopause)	☐	☐	☐
HCG	☐	☐	☐
Hyperbaric medicine	☐	☐	☐
Hysterectomy	☐	☐	☐
Intensive care for newborns	☐	☐	☐
Intensive care medicine for adults	☐	☐	☐
Laparoscopy	☐	☐	☐
Liposuction ☐ Tumescent ☐ Other	☐	☐	☐
Lymphangiography	☐	☐	☐
MOHS micrographic surgery	☐	☐	☐
Myelography	☐	☐	☐
Needle biopsy *(including lung, prostate, liver, or kidney)*	☐	☐	☐
Obstetrics:	☐	☐	☐
Prenatal care ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester	☐	☐	☐
Normal deliveries Provide annual #	☐	☐	☐
C-sections Provide annual #	☐	☐	☐
VBAC deliveries Provide annual #	☐	☐	☐

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Procedure *(continued)*	**Office**	**Hospital**	**Other**
Organ transplantation	☐	☐	☐
Orthopedic surgery ☐ Including spinal ☐ Without spinal	☐	☐	☐
Osteopathic manipulative medicine	☐	☐	☐
Pain management *(if other than medication only, please complete supplement)*	☐	☐	☐
Permanent pacemaker insertion	☐	☐	☐
Pneumoencephalography	☐	☐	☐
Radiation therapy	☐	☐	☐
Radiopaque dye injections	☐	☐	☐
Refractive surgery: ☐ LASIK ☐ PRK ☐ AK ☐ PTK ☐ ICR	☐	☐	☐
Rhinoplasty	☐	☐	☐
Sclerotherapy	☐	☐	☐
Thoracic surgery %	☐	☐	☐
Tonsillectomy/Adenoidectomy	☐	☐	☐
Transgender ☐ Surgery ☐ Hormonal gender conversion	☐	☐	☐
Tubal ligation	☐	☐	☐
Urology Surgery ☐ Cosmetic/elective ☐ Reconstructive	☐	☐	☐
Vascular surgery: %	☐	☐	☐
Vasectomy	☐	☐	☐
Vertebroplasty	☐	☐	☐
List any other procedures not listed above:			
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
☐ Applicant does not perform any of the above procedures/treatments.			

SECTION VI – HISTORY & PRACTICE INFORMATION

List all locations and dates where Applicant has practiced in the last 10 years:

Practice name	City	State	Specialty practiced	From	To

1. a. Does Applicant employ, contract with, or supervise any physician(s) or surgeon(s)? ☐ Yes ☐ No
   If "Yes", provide the number and attach a current certificate of insurance for each.
   Number of: employed contracted supervised
   b. Does Applicant have any office or expense sharing arrangement with any other physician(s) or surgeon(s) other than those named in the above question? ☐ Yes ☐ No
   If "Yes", provide the number and attach a current certificate of insurance for each. Number:

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2. Does Applicant employ, contract with, or supervise any non-physician health care extenders? ☐ Yes ☐ No
If "Yes", provide information below:

	# employed	# independent contractors	Are they insured ELSEWHERE?	Is coverage desired?
Nurse practitioner			☐ Yes ☐ No	☐ Yes ☐ No
Physician assistant			☐ Yes ☐ No	☐ Yes ☐ No
CRNA*			☐ Yes ☐ No	☐ Yes ☐ No
Nurse midwife*			☐ Yes ☐ No	☐ Yes ☐ No
Surgeon assistant			☐ Yes ☐ No	☐ Yes ☐ No
Physical therapist			☐ Yes ☐ No	☐ Yes ☐ No
Nurses (RN, LPN, LVN)			☐ Yes ☐ No	☐ Yes ☐ No
Medical assistant			☐ Yes ☐ No	☐ Yes ☐ No
Other:			☐ Yes ☐ No	☐ Yes ☐ No
Other:			☐ Yes ☐ No	☐ Yes ☐ No

**If coverage is desired, please complete a James River Allied Personnel application for each*

3. Is Applicant currently a hospital chief of staff or head of any hospital department? ☐ Yes ☐ No
If "Yes", please describe:

a. Does the Applicant have coverage for this? ☐ Yes ☐ No
If "No", is Applicant requesting that this policy cover this exposure? ☐ Yes ☐ No

4. Does the Applicant or any entity named in Section II own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgery center, abortion clinic, walk-in clinic, or birthing center? ☐ Yes ☐ No
If "Yes", attach a detailed explanation and include the location, name, size, and number of beds.

5. Does Applicant or has Applicant ever provided services to any state, local, or federal correctional facility, jail, or prison? ☐ Yes ☐ No
If "Yes", please describe and give the percentage of services:

a. Does the Applicant have coverage for this? ☐ Yes ☐ No
If "No", is Applicant requesting that this policy cover this exposure? ☐ Yes ☐ No

6. Is Applicant engaged in any "moonlighting" activities? ☐ Yes ☐ No
If "Yes":
a. Describe the activities:

b. Is coverage desired for "moonlighting" activities? ☐ Yes ☐ No

7. Does Applicant treat patients in a nursing home or similar facility? ☐ Yes ☐ No
If "Yes", on average how many patients does Applicant treat there per month?
What is the percentage of practice? %

8. Provide the following information for all hospitals or surgery centers where Applicant is currently on staff:

Name	City	State	% of work	Type of privileges
			%	
			%	
			%	
			%	

9. If no hospital privileges, what process/protocols does the applicant have in place for patients needing hospitalization? ☐ N/A

10. Provide:
a. Average weekly patient load:
b. Average weekly practice hours:
c. Percentage of locum tenens work: %

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11. Does Applicant work in an emergency room, other than to maintain hospital privileges? ☐ Yes ☐ No
    If "Yes", provide the average number of hours Applicant works in the emergency room each month:

12. Does Applicant work for any locum tenens companies as an ☐ employee or ☐ independent contractor? ☐ Yes ☐ No
    If "Yes":
    a. Provide the number of hours worked each month in locum tenens positions:
    b. Does each company provide Applicant with professional liability insurance for locums positions? ☐ Yes ☐ No
       If "Yes", attach a copy(ies) of certificate(s) of insurance.
       If "No", is the Applicant requesting that this policy cover this exposure? ☐ Yes ☐ No

13. Does Applicant render care or perform consultations outside the state of their primary office location including but not limited to the use of telecommunication technology as a medium for rendering medical services? ☐ Yes ☐ No
    If "Yes", please complete and attach the James River Telemedicine Questionnaire.

14. Does Applicant read or interpret films, slides, or specimens of patients who reside in states other than their indicated practice states? ☐ Yes ☐ No
    If "Yes", please complete and attach the James River Telemedicine Questionnaire.

15. Does Applicant read their own x-rays? ☐ Yes ☐ No
    If "Yes":
    a. Will they subsequently be read by a radiologist? ☐ Yes ☐ No
       If "Yes", within how many hours?

16. Does Applicant perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? ☐ Yes ☐ No

17. Does Applicant perform surgical procedures at a same day surgery center other than their own office? ☐ Yes ☐ No

18. Does Applicant perform surgery in their office or private suite using anesthesia other than local or topical? ☐ Yes ☐ No
    If "Yes", please complete and attach the James River Office Surgical Suite Supplement.

19. Is Applicant a sports team physician for any college, university, semi-professional, or professional team? ☐ Yes ☐ No
    If yes, please provide information and percentage of practice.

20. Does Applicant practice any forms of "alternative medicine", including but not limited to; Ayurvedic, Chinese, Homeopathic, Chiropractic, Holistic, or Naturopathic medicine. ☐ Yes ☐ No
    If "Yes", please describe practice:

SECTION VII – CLAIM/LOSS HISTORY INFORMATION

The word "claim" as used in the following questions refers to:

- Any demand for damages, resolved or pending, regardless of the result, arising from Applicant's professional services and brought against Applicant or any partner, associate, employee, or professional corporation or partnership; or
- Circumstances which have been brought to Applicant's attention by a patient or legal representative of a patient, in such a manner as to indicate the possibility of legal action against Applicant or any partner, associate, employee, or professional corporation or partnership.

If Applicant answers "Yes" to any parts of the questions in this section, please complete the Supplementary Claims Information Form under Section XII for all such claims.

1. Has Applicant ever been involved in a malpractice suit or claim, either directly or indirectly? ☐ Yes ☐ No
   If "Yes", how many? *(Provide details for each under Section XII.)*

2. Other than the claims/suits indicated in question 1 above, is Applicant aware of any of the following circumstances that might reasonably lead to a claim or suit being brought even if Applicant believes the claim or suit would be without merit:
   a. A request for records from a patient and/or attorney related to an adverse outcome ☐ Yes ☐ No
   b. A letter from an attorney regarding Applicant's medical treatment of a patient ☐ Yes ☐ No
   c. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability, or the need for follow-up surgery ☐ Yes ☐ No
   d. Patient or family member dissatisfied with the outcome of a procedure, treatment, or diagnosis ☐ Yes ☐ No
   e. Knowledge or information relating to service or services on a Board which might result in a claim ☐ Yes ☐ No
   f. Any other circumstances that might reasonably lead to a claim or suit ☐ Yes ☐ No

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3. Have all circumstances that might reasonably lead to a claim or suit *(even if Applicant believes the possible claim or suit would be without merit)* been reported to Applicant's current or prior professional liability company? ☐ Yes ☐ No
If "Yes", how many? *(Provide documentation of all such reports.)*
If "No", please explain details under Section XII.
For the purposes of this question, check the following box if Applicant is aware of no circumstances that might reasonably lead to a claim or suit ☐ **Not applicable**

If Applicant answers "Yes" to any of following questions (# 4 – 10) please provide details under Section X.

4. Has any licensing authority or hospital ever reprimanded Applicant or ever denied, revoked, suspended, or restricted Applicant's medical license, narcotics license, or practice privileges, or put Applicant on probation? ☐ Yes ☐ No
5. Has any licensing authority or hospital conducted *(or are they currently conducting)* an investigation relating to the nature of Applicant's practice privileges, or to the restriction of Applicant's license or privileges? ☐ Yes ☐ No
6. Has Applicant ever been indicted, charged, arrested *(other than for motor vehicle violations)* or convicted of any offense, crime, or misdemeanor in any state or any federal jurisdiction? ☐ Yes ☐ No
7. Has Applicant ever been evaluated, diagnosed, or treated for any disease or mental, physical, or emotional condition, including without limitation, chemical or alcohol dependency? ☐ Yes ☐ No
8. Has Applicant ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No
9. Does Applicant have a physical handicap or any chronic disease? ☐ Yes ☐ No
10. Has Applicant or Applicant's practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private or public health payors, including but not limited to Medicare or Medicaid? ☐ Yes ☐ No

SECTION VIII – PROFESSIONAL LIABILITY HISTORY INFORMATION

1. Provide details of professional liability insurance for the past five (5) years, including coverage for "moonlighting" positions (CM – Claims Made; Occ - Occurence):

Policy Period	Insurer	Policy Limits	Retroactive date	Policy Type	Premium	Total # of claims
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		

2. Has any insurance company ever cancelled, declined to issue, refused to renew, surcharged Applicant's premium, or issued coverage with any restrictions or exclusions? ☐ Yes ☐ No
If "Yes", provide explanation below under Section X – Supplemental Information.
3. Has Applicant ever been without professional liability coverage since beginning practice? ☐ Yes ☐ No
If "Yes", provide explanation below under Section X – Supplemental Information.
4. Does Applicant have professional liability insurance for work done elsewhere? ☐ Yes ☐ No
If "Yes", provide explanation below under Section X – Supplemental Information.
5. If prior coverage is Claims Made, has a reporting endorsement *("tail" coverage)* been purchased? ☐ Yes ☐ No
If "Yes", provide a copy of the reporting endorsement.
If "No", provide explanation below under Section X – Supplemental Information.

SECTION IX – COVERAGE REQUEST

1. Effective date desired *(Note: Company may not provide desired dates)*:
2. Retroactive date desired:
3. Provide policy limits desired:
☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000 ☐ $500,000/$1,500,000
☐ $1,000,000/$3,000,000 ☐ Other:
4. Please select any optional deductibles desired. No aggregate limit will apply to the deductible.
☐ $0 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ Other:

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SECTION X – SUPPLEMENTAL INFORMATION

Please use this section to provide additional information or to answer any questions.

Section #/Question #	

SECTION XI – SIGNATURE, CONSENT AND AGREEMENT

This Application is the basis for coverage; therefore, any incorrect or incomplete statements or answers could nullify coverage. Completion of this form neither binds coverage nor guarantees that a policy will be issued. *(Not applicable in North Carolina)*

I hereby request that my application for insurance coverage be submitted for consideration to the company shown in this application. Accordingly, I authorize and direct any person or organization whatsoever to release and furnish to that company any and all information requested which may relate to my insurability.

I hereby indicate that the aforementioned statements and answers are correct and complete. I further understand that an incorrect or incomplete statement or answer could void my protection.

I hereby consent to the review by the company shown in this application of any incidents or occurrences likely to result in malpractice allegation or claim. I agree to cooperate in the review of claims and incidents which apply to the coverage requested.

Where applicable, I hereby consent to the review of my application by the committees appointed by my county or state professional association/ society. I agree to cooperate with these committees.

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COPY OF NOTICE OF INFORMATION PRACTICES (PRIVACY) HAS BEEN GIVEN TO THE APPLICANT.

(Not required in all states, contact your agent or broker for your state's requirements.)

Personal information about you, including information from a credit or other investigative report, may be collected from persons other than you in connection with this application for insurance and subsequent amendments and renewals. Such information as well as other personal and privileged information collected by us or our agents may in certain circumstances be disclosed to third parties without your authorization. Credit scoring information may be used to help determine either your eligibility for insurance or the premium you will be charged. We may use a third party in connection with the development of your score. You may have the right to review your personal information in our files and request correction of any inaccuracies. You may also have the right to request in writing that we consider extraordinary life circumstances in connection with the development of your credit score. These rights may be limited in some states. Please contact your agent or broker to learn how these rights may apply in your state or for instructions on how to submit a request to us for a more detailed description of your rights and our practices regarding personal information. *(Not applicable in AZ, CA, DE, KS, MA, MN, ND, NY, OR, VA, or WV. Specific ACORD 38s are available for applications in these states.)*

NOTICE TO APPLICANT

The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

FRAUD STATEMENTS

Applicable in AL, AR, DC, LA, MD, NM, RI and WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Applies in MD Only.*

Applicable in CO

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony (of the third degree)*. **Applies in FL Only.*

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

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 conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties* (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. **Applies in NY Only.*

Applicable in ME, TN, VA and WA

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 and denial of insurance benefits. **Applies in ME Only.*

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

☐ ***I have read the statements above, understand their meaning and agree.***

Applicant's signature:

Date:

Applicant's name:

Applicant's title:

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SECTION XII – SUPPLEMENTAL CLAIM INFORMATION

If reporting more than one claim, please photocopy this form, and complete a separate form for each claim. If space is insufficient to answer any question fully, please attach a separate sheet. All questions must be answered or marked not applicable (N/A).

1. Patient's name: Age: Sex:
2. Date reported to insurance company:
3. Date of incident and Applicant's treatment:
4. Name of insurance company:
5. Allegations:
6. What is the present condition of patient?
7. Did Applicant in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that Applicant did so, pertaining to this claim? ☐ Yes ☐ No
8. What is the status of the claim:

☐ Suit threatened, no action taken	Court outcome in Applicant's favor:	Unresolved/open claim:
☐ Suit filed but dropped by claimant	☐ Jury verdict	☐ Awaiting mediation
☐ Summary judgment in Applicant's favor	☐ Directed verdict	☐ Awaiting court action
☐ Suit settled out of court		
a. Date claim paid:	Court outcome in favor of plaintiff:	Reserve amount:
b. Amount paid:	☐ Jury verdict	
c. Did Applicant want to settle claim? ☐ Yes ☐ No	☐ Directed verdict	
	Amount of loss payment:	

9. Provide the name and address of the attorney assigned to this case:
10. To Applicant's knowledge, was any settlement paid by another party involved *(P.A., P.C., partners, employees, etc.)*? ☐ Yes ☐ No
    If "Yes", what was the amount of the settlement?
11. Explain in detail what action(s) Applicant has taken to prevent recurrence of this type of claim:

Applicant's signature:

Date:

Applicant's name:

Please submit completed applications to submissions@cidinsurance.com
Attn: Lexi Johnson
Any questions, please call (800) 922-7283
or fax to (619) 593-2008