Corporation, Partnership or Other Legal Entity Application

Please legibly print all responses in full. If more room is required than is provided here, please respond at the end of this application or supplement it with additional pages, along with any and all other requested documents.

1. Full Legal Name of Entity (including all dba's and subsidiaries seeking coverage):
   ____
2. Mailing and Location Address (If multiple addresses, include an attachment with all locations.):
   ____
3. Date Established: ____
4. Type of Entity: ☐ Corporations ☐ Partnership ☐ Individual ☐ Other: __________
5. Is this entity owned by, associated with or controlled by any other entity? Yes No
   If yes, give details: ____
6. Requested coverage:
   Limits of Liability:
   - ☐ $100,000 / $300,000
   - ☐ $200,000 / $600,000
   - ☐ $250,000 / $750,000
   - ☐ $500,000 / $1 Million
   - ☐ $1 Million / $3 Million
   - ☐ Other: __________

   Effective Date: ____________________

   What is the retroactive date on your current policy? ___________
7. Professional Activities and Specialty:
   - ☐ Ambulance Service Ground Air
   - ☐ Cosmetic Aesthetics Clinic (Med-Spa)
   - ☐ Dental Practice
   - ☐ Drug and Alcohol Treatment
   - ☐ Home Healthcare Agency
   - ☐ Kidney Dialysis Center
   - ☐ Laser Vision Correction Center
   - ☐ Medical Clinic
   - ☐ Medical Staffing
   - ☐ Methadone Clinic
   - ☐ Mental Health Services
   - ☐ Nurse Registry
   - ☐ Pharmacy
   - ☐ Radiology (Teleradiology Yes No)
   - ☐ Residential Care Facility
   - ☐ Social Services
   - ☐ Surgery Center
   - ☐ Other (Provide Details): ___________
8. State the approximate division of patients:
   - _______ % Substance Abuse – Drug or Alcohol
   - _______ % Cosmetic or Elective
   - _______ % Counseling
   - _______ % Communicable Diseases
   - _______ % Dental
   - _______ % Dialysis
   - _______ % Family Planning
   - _______ % Holistic or Alternative Medicine
   - _______ % General Medicine
   - _______ % Developmentally Disabled
   - _______ % Obstetric
   - _______ % Pediatric
   - _______ % Psychiatric
   - _______ % Research or Experimental
   - _______ % Geriatric
   - _______ % Surgical
   - _______ % Other (Provide Details)

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9. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

	Employees Or Volunteer	**Independent Contractor**	**Insured On Own Med Mal Policy**
Physicians (no surgery)			☐ Yes ☐ No
Physicians (surgery)			☐ Yes ☐ No
Physician Assistants			☐ Yes ☐ No
Surgical Technicians			☐ Yes ☐ No
Certified Nurse Anesthetists			☐ Yes ☐ No
Nurse Practitioner			☐ Yes ☐ No
Registered Nurse			☐ Yes ☐ No
LPN’s or Nurse Aids			☐ Yes ☐ No
X-ray Technicians			☐ Yes ☐ No
Medical Assistants			☐ Yes ☐ No
Optometrists			☐ Yes ☐ No
Opticians			☐ Yes ☐ No
Pharmacists			☐ Yes ☐ No
Pharmacy Technicians			☐ Yes ☐ No
Chiropractors			☐ Yes ☐ No
Massage Therapists			☐ Yes ☐ No
Laboratory Technicians			☐ Yes ☐ No
Paramedics			☐ Yes ☐ No
EMT’s			☐ Yes ☐ No

Social Workers			☐ Yes ☐ No
Aestheticians			☐ Yes ☐ No
Perfusionists			☐ Yes ☐ No
Occupational Therapists			☐ Yes ☐ No
Physical Therapists			☐ Yes ☐ No
Speech Therapists			☐ Yes ☐ No
Other:			☐ Yes ☐ No
Total Staff:			☐ Yes ☐ No

***Please attach copies of declaration pages on all individuals that carry their own medical malpractice.*

If you have a Medical Director, provide name, specialty and CV: ______________________________________

____

Are Medical Director's duties administrative only? Yes No

Does the Medical Director provide direct patient care? Yes No

What medical malpractice limits is the Medical Director required to carry? ______________________

10. Are all the above individuals licensed in accordance with applicable state and federal regulations? If No, Please attach a detailed explanation. Yes No
11. Has the applicant or any of the above employees and/or independent contractors:
    Please attach explanation for any of the questions below answered "Yes":
    A. Ever been the subject of disciplinary or investigated proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? Yes No
    B. Ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? Yes No
    C. Ever been treated for alcoholism or drug addiction? Yes No
    D. Ever had any state professional license or license to prescribe or dispense Narcotics refused, suspended, revoked, renewal refused or accepted only of special terms or even voluntarily surrendered the same? Yes No

DOCTORS professional liability

12. Does the applicant perform any of the following non-surgical procedures or treatment?

Procedure	Response
Acid or chemical peels	☐ Yes ☐ No
Solution Strength If over 30%, is this done by licensed MD?	☐ Yes ☐ No
Acupuncture	☐ Yes ☐ No
Angiography, Arteriography, Venography	☐ Yes ☐ No
Botox Injections	☐ Yes ☐ No
Catheterization (other than urinary or umbilical)	☐ Yes ☐ No
Closed reduction of compound fractures	☐ Yes ☐ No
Collagen Injections	☐ Yes ☐ No
Electrolysis	☐ Yes ☐ No
Laser Treatment (non-surgical) If yes, which of the following:	☐ Yes ☐ No
Hair Removal	☐ Yes ☐ No
Skin Resurfacing	☐ Yes ☐ No
Tattoo Removal	☐ Yes ☐ No
Other:	☐ Yes ☐ No
Lipodissolve	☐ Yes ☐ No
Mesotherapy	☐ Yes ☐ No
Microdermabrasion	☐ Yes ☐ No
Pain Management (non-surgical)	☐ Yes ☐ No
Permanent Makeup Application	☐ Yes ☐ No
Psychiatric shock therapy	☐ Yes ☐ No
Radiation Therapy and/or Chemotherapy	☐ Yes ☐ No

Sclerotherapy	☐ Yes ☐ No
Silicone Injection	☐ Yes ☐ No

13. Does the applicant perform any of the following surgical procedures?

Abortions If Yes, please answer the following:	☐ Yes ☐ No
What is the maximum trimester?	☐ Yes ☐ No
What methods?	☐ Yes ☐ No
How many per month?	☐ Yes ☐ No
Bariatric Surgery If Yes, attach a list of types performed	☐ Yes ☐ No
Biopsies	☐ Yes ☐ No
Circumcisions	☐ Yes ☐ No
Colonoscopies or Endoscopies	☐ Yes ☐ No
Cosmetic Plastic Surgery If Yes, what percentage of practice?	☐ Yes ☐ No
Cryosurgery	☐ Yes ☐ No
Deliveries ☐ Yes ☐ No ☐ If Yes, C Sections?	☐ Yes ☐ No
Dilation and Curettage	☐ Yes ☐ No
Hysterectomies	☐ Yes ☐ No
Minor Surgical Procedures Only	☐ Yes ☐ No
Major Surgical Procedures	☐ Yes ☐ No
Mastectomies or lumpectomies	☐ Yes ☐ No
Neurosurgery	☐ Yes ☐ No
Organ Transplant Surgery	☐ Yes ☐ No
Orthopedic Surgery other than spinal	☐ Yes ☐ No

DOCTORS professional liability

Penile Lengthening or Enhancement Surgery	☐ Yes ☐ No
Sex change operations or Sexual Reassignment Surgery	☐ Yes ☐ No
Spinal Surgery	☐ Yes ☐ No
Surgical Podiatry	☐ Yes ☐ No
Vasectomies	☐ Yes ☐ No
Other:	☐ Yes ☐ No

14. Does the applicant administer methadone treatment? Yes No
    If Yes, how many slots? ______________________________
15. Does the applicant administer detoxification treatment? Yes No
    How many patients annually? ______________________________
16. Does the applicant maintain any beds for overnight occupancy? Yes No
    If Yes, what is the total number of beds? ______________________________
17. Does the applicant provide services to Nursing Home or Assisted Living Centers? Yes No
    If Yes, please provide description of the services and the percentage (%) of these services:
    ____
18. Is anesthesia (other than topical or by means of local infiltration) administered at the applicants' facility? Yes No
    If Yes, what percentage of procedures required general anesthesia? ______________________________
19. Does the applicant sell any products? Yes No
    If Yes, please include product brochures.
    - What kind of products? ______________________________
    - Do any of these products require a physician's prescription? Yes No
    - Do you re-label these products in your own name? Yes No

20. Please provide the number of annual patients encounter or client visits:

	Last 12 months	Estimate for next 12 months
Outpatient Visits (non-surgical)		
Surgical Procedure (not including above)		
Other		

21. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If None, state NONE)

Carrier	Limit	Deductible	Premium	Policy Term

22. What is the retroactive date on your current policy? ____________________

23. Is the applicant currently insured under a Commercial General Liability policy? Yes No
    If Yes, please attach copies of the declaration page.
24. Does the applicant own, operate or manage a business other than the one(s) described in this application for which you are applying for coverage? Yes No
    If Yes, please provide complete details, including name of entity, your ownership interests or contractual relationships and information on their insurance program.
25. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? Yes No
    If Yes, please provide details including name of carrier and dates.
26. Has any claim ever been made against the applicant or any of its employees? Yes No
    If Yes, please complete the supplemental claim information form with your submission.

27. Is the applicant aware of any circumstances which may result in any claims against them or their employees? Yes No
    If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.
28. Does the applicant have a Risk management and Risk Control Program in place? Yes No
    Who is responsible for the Program? ____________________
    Title: ____________________ Contact email: ____________________
    Phone Number: ____________________

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AND APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION OF A MATERIAL NATURE, MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICANTS REPRESENTATIONS, WARRANTIES AND AUTHORIZATIONS

I understand that no coverage will be bound until after Doctors Professional Liability RRG has reviewed this completed application and formally bound the requested coverage.

I understand that no insurance will be provided for: 1) any claim known to the applicant prior to the effective date of this insurance, whether or not reported to any prior insurer; or 2) any claim that may arise out of any incident known to the applicant prior to the effective date of this insurance, whether or not reported to any prior insurer.

I specifically represent and warrant to Doctors Professional Liability RRG that the information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this application or that might be material to the acceptance of the risk described to the underwriter in this application. I further agree that any false or misleading statement in this application shall be ground for the insurer to cancel and void coverage at its sole and absolute discretion. I understand that a photocopy or facsimile of this application will serve as if it were the original.

I authorize the release of any underwriting and/ or claim information (and release from any and all liability for the provision of information) from all prior and current insured, all professional societies or associations, any state licensing authority, or any hospitals or healthcare institutions, to Doctors Professional Liability RRG, and its subsidiaries or agents.

I agree to cooperate with the risk management department of Doctors Professional Liability RRG, and its subsidiaries or agents, and to support its efforts to enhance the quality of patient care.

______________________	______________________	______________________
Signature	Title	Date

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