PSIC | Professional Solutions INSURANCE COMPANY

Protecting Reputations ... One Doctor at a Time®

INTERSTATE HEALTHCARE

24150 Little Mack Ave,
St. Clair Shores, MI 48080
Phone: 800-419-5999

Corporation and Partnership Professional Liability Claims Made Application

A. AGENCY INFORMATION

Agency Name: _____ Agency License Number: _____

Soliciting Producer: _____
Last Name First Middle Initial

Address: _____
Street City State Zip

Office Phone: _____ Email Address: _____
Your email address will never be sold. It will be used to send you important messages.

B. ENTITY APPLICANT INFORMATION

Name of Entity: _____

Contact Person/Insured's Representative: _____
Last Name First Middle Initial

Office Phone: _____ Office Fax: _____

Email Address: _____ Website Address: _____
Your email address will never be sold. It will be used to send you important messages.

Primary Office Address: _____
Street City State Zip County

Mailing Address: ☐ Primary Office Address
☐ Other: _____
Street City State Zip

Billing Address: ☐ Primary Office Address
☐ Mailing Address
☐ Other: _____
Street City State Zip

Type of Entity: ☐ Solo Corporation ☐ Professional Corporation ☐ Partnership/LLC ☐ Joint Venture
☐ Other: _____

C. COVERAGE INFORMATION

1. Desired effective date: From: _____ (MO/DAY/YR) To: _____ (MO/DAY/YR)

2. Retroactive date requested: _____ (MO/DAY/YR)

The retroactive date is the date first continuously insured under a Claims Made policy. Please contact your agent should you have any questions pertaining to Claims Made coverage or the need for Prior Acts coverage.

3. Please indicate limits of liability requested for coverage or a quote: *(not all limits may be available in all states):*

☐ Shared with Physician(s) limits **OR**

☐ $100,000/$300,000
☐ $200,000/$600,000 (only limit available in KS)
☐ $250,000/$750,000
☐ $500,000/$1,000,000
☐ $500,000/$1,500,000 (MI only)
☐ $1,000,000/$1,500,000 (MI only)
☐ $1,000,000/$3,000,000
☐ $2,000,000/$4,000,000

4. Requested deductible(s) for coverage or a quote:

☐ None ☐ $5,000/$15,000 ☐ $10,000/$30,000 ☐ $15,000/$45,000
☐ $25,000/$75,000 ☐ $50,000/$150,000 ☐ $100,000/$300,000 ☐ $200,000/$600,000

©2016 PSIC NFL 9369-161403

C. COVERAGE INFORMATION *(cont.)*

5. Will you be participating in a state-operated patient's compensation fund? ☐ Yes ☐ No

If yes, please indicate the state operating the fund: _____

What is the state of domicile? _____ :

PLEASE ATTACH A COPY OF THE DECLARATIONS PAGE FOR THE CURRENT OR PREVIOUS PRIMARY INSURER.

D. RISK MANAGEMENT

1. 1. Does your organization have a designated Risk Manager? ☐ Yes ☐ No

If yes, Risk Management contact: _____
Last Name First Middle Initial

Phone: _____ *Email Address:* _____
Your email address will never be sold. It will be used to send you important messages.

Does the Risk Manager have the authority to implement changes to policies and procedures? ☐ Yes ☐ No

2. Is there a written, formalized Risk Management plan? ☐ Yes ☐ No

If yes, please attach a copy.

Does the Risk Manager have the authority to implement changes to policies and procedures? ☐ Yes ☐ No

3. Is there an ongoing Quality Assessment or Improvement Plan? ☐ Yes ☐ No

If yes, please attach a copy.

E. OWNERSHIP AND OPERATIONS

Please note: a minimum of 50% of corporate owners and employed practitioners of the corporation must be insured with Professional Solutions Insurance Company to be eligible for this coverage.

1. Please list the names of all owners, stockholders and partners: (If more room is needed, use the last page of this application.)

Name	Specialty	Current Insurer	Limit of Liability	Expiration Date

2. Are there other subsidiaries, DBAs or affiliated entities associated with this Entity? ☐ Yes ☐ No

If yes, please provide information below: (If more room is needed, use the last page of this application.)

Name	Description of Operations	County	Date Acquired	% of Ownership

3. Is the entity providing services at more than one location? ☐ Yes ☐ No

If yes, please provide information below: (If more room is needed, use the last page of this application.)

Name of Facility	Address	County	% of Practice

4. Does your organization currently, or plan to, provide or operate any of the following services? ☐ Yes ☐ No

If yes, please select the services below:

☐ Abortion Clinic ☐ Dialysis ☐ Home Care ☐ Medical Spa ☐ Radiology
☐ Birthing Center ☐ Diagnostic Imaging ☐ Laboratory ☐ Office Based Surgery ☐ Substance Abuse
☐ Pharmacy ☐ Surgical Center

For any that are checked, does the state require that you be licensed to provide these services? ☐ Yes ☐ No

If yes, please provide a copy of these licenses.

©2016 PSIC NFL 9369-161403

F. MEDICAL PERSONNEL

1. Does the entity employ, or have as independent contractors, any physicians, surgeons, or certified nurse midwives? ☐ Yes ☐ No

   If yes, please provide the following:

Designation	# of Employees or Ind. Contractors Current Year	# of Employees or Ind. Contractors 1 Year Ago	# of Employees or Ind. Contractors 2 Years Ago	# of Employees or Ind. Contractors 3 Years Ago	# of Employees or Ind. Contractors 4 Years Ago
Physicians					
Surgeons					
Certified Nurse Midwives					

2. Has the license of any employed/contracted physician or surgeon been restricted or suspended in the last two years? ☐ Yes ☐ No

   If yes, please provide the name of the individual(s):

3. Have the privileges of any employed/contracted physician or surgeon been restricted or suspended in the last two years? ☐ Yes ☐ No

   If yes, please provide the name of the individual(s): _____

4. Is coverage desired for the entity's employed or contracted physicians, surgeons or midwives? ☐ Yes ☐ No

   If yes, please complete and submit the following applications: ***Physician and Surgeon Group Roster Addendum (PSIC-MDAPP-03) Physician Group Member Professional Liability Application (PSIC-MDAPP-04)*** *for each physician and surgeon*

5. Does the entity employ, or have as independent contractors, any mid-level providers (PA, NP, CRNA, etc.)? ☐ Yes ☐ No

   If yes, please complete the following:

Designation	# of Employees or Ind. Contractors Current Year	# of Employees or Ind. Contractors 1 Year Ago	# of Employees or Ind. Contractors 2 Years Ago	# of Employees or Ind. Contractors 3 Years Ago	# of Employees or Ind. Contractors 4 Years Ago
Nurse Anesthetist					
Nurse Practitioner					
Physician Assistant					
Surgical Assistant					
Other:					
Other:					

6. Is coverage desired for the individual(s) listed above? ☐ Yes ☐ No

   If yes, please complete and submit the following application: ***Mid-Level Employee Roster Addendum (PSIC-MDAPP-06)***

7. Does the entity employ any ancillary healthcare providers (RN, LPN, Medical Assistant, etc.)? ☐ Yes ☐ No

   If yes, please complete the following:

Job Title/Specialty	# of Employees	Job Title/Specialty	# of Employees
RN		Other:	
LPN		Other:	
Medical Assistant			
Other:			

8. Does the entity maintain current certificates of insurance on file for all employed or contracted practitioners and non-physician employees? ☐ Yes ☐ No

9. Have any practitioners performed any new procedures in the last five years? ☐ Yes ☐ No

   If yes, please provide a detailed explanation on the last page of this application.

©2016 PSIC NFL 9369-161403

G. CREDENTIALING

Complete the questions below on the hiring and screening procedures for employees who provide patient care.

1. Is license renewal and credentialing verification conducted for the professional staff? ☐ Yes ☐ No
   *If yes, how often:*_____
2. Are educational backgrounds and/or residency programs checked when applicable? ☐ Yes ☐ No
3. Are previous employers and/or personal references checked either in writing or by telephone? ☐ Yes ☐ No
4. Does the entity verify and research any pending or previous license suspensions, revocations or disciplinary actions by any hospital, healthcare facility or state agency? ☐ Yes ☐ No
   *If yes, what role does this information play in the hiring process?*_____
5. Is information required on any professional liability or work-related claim that has previously been made against any individual ☐ Yes ☐ No
   *If yes, what role does this information play in the hiring process?*_____
   _____

H. CURRENT PRACTICE

1. Does this entity or any subsidiary advertise? ☐ Yes ☐ No
   If yes, please provide a copy of the advertising materials or explain in detail.
2. Does the entity provide services by contract to other entities? ☐ Yes ☐ No
   If yes, have you agreed to indemnify these entities? ☐ Yes ☐ No
   If yes, please include a copy of the contract(s).
3. Is this entity equipped to handle emergency procedures (e.g. cardiac arrests)? ☐ Yes ☐ No
4. Are there protocols in place for transfer to a hospital in case of emergencies? ☐ Yes ☐ No
   If yes, please provide details.
5. Is office-based surgery performed? ☐ Yes ☐ No
   If yes, please explain and answer the following:
   What type of anesthesia is administered? ☐ None ☐ General ☐ Regional
   Who is anesthesia administered by? (Check one or both)? ☐ Board certified anesthesiologist ☐ CRNA
   If CRNA, are CRNAs always supervised by a board certified anesthesiologist? ☐ Yes ☐ No
   If no, please explain.
6. Does this entity or any subsidiary or affiliated entity provide telemedicine activities in a state othr than your Primary Office Location? (Includes, but is not limited to, the prescribing of drugs or providing diagnosis via the Internet.)? ☐ Yes ☐ No
   If yes, please provide details.
7. Does this entity, any subsidiary or employee review treatment of or provide professional services to any state, local or federal correctional facility, jail, prison or inmates? ☐ Yes ☐ No
   *If yes, what percentage of services are devoted to these activities?*_____ *%*
8. Does this entity, any subsidiary or employee provide clinical or administrative services to any nursing home, skilled nursing facility, assisted living center, hospice or similar facility? ☐ Yes ☐ No
   *If yes, what percentage of services are devoted to these activities?*_____ *%*
9. Does this entity, any subsidiary or employee provide professional services or review treatment of any professional athletes? ☐ Yes ☐ No
   *If yes, what percentage of services are devoted to these activities?*_____ *%*
10. Does this entity, any subsidiary or employee participate in any medical research, clinical trials or off-labeled use of drugs or devices? ☐ Yes ☐ No
    If yes, please include copies of any protocols or informed consent documents.

©2016 PSIC NFL 9369-161403

H. CURRENT PRACTICE *(cont.)*

11. Does this entity use Locum Tenens Physicians? ☐ Yes ☐ No

If yes, what percentage of services are devoted to these activities?_____ %

IF APPLICABLE, PLEASE PROVIDE A DETAILED NARRATIVE TO THE ABOVE QUESTIONS ON THE LAST PAGE.

I. HISTORY

1. Please provide information on each professional liability insurer you have had for the last 10 years.
Please provide this information in chronological order.

Dates	Insurer	Limits of Liability	Coverage Type	Tail Coverage Purchased?	Any Claims?
			☐ Occurrence ☐ Claims Made	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Occurrence ☐ Claims Made	☐ Yes ☐ No	☐ Yes ☐ No
			☐ Occurrence ☐ Claims Made	☐ Yes ☐ No	☐ Yes ☐ No

ATTACH AN ENTIRE LOSS HISTORY INCLUDING: POLICY NUMBER, CLAIM NUMBER, REPORT DATES, DESCRIPTION OF LOSS AND SETTLEMENT AMOUNT.

2. Is this entity currently, or has it ever been, without professional liability insurance? ☐ Yes ☐ No

3. Has any insurance company ever declined, failed to renew, conditionally renewed, restricted or cancelled the professional liability policy associated with this entity or any subsidiary? *(Missouri residents, skip this question.)* ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO EITHER OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS.

J. LOSS OF INFORMATION

1. In the past 10 years, have you been involved, directly or indirectly, in a claim or suit arising out of the rendering or failure to render professional services?* ☐ Yes ☐ No

If yes, please indicate the number of each:
Number of pending suits: _____
Number of closed claims: _____

2. Other than the situations indicated in Question 1 above, are you aware of any of the following:
Requests for patient records from a patient, family member, attorney or patient representative related to an adverse outcome or treatment of a patient? ☐ Yes ☐ No

A letter from an attorney regarding your treatment of a patient? ☐ Yes ☐ No

A patient, family member or a patient representative's dissatisfaction with the outcome of a procedure, treatment or diagnosis? ☐ Yes ☐ No

Any circumstances that might reasonably lead to a claim or suit, even if the claim or suit is without merit? ☐ Yes ☐ No

3. Have all circumstances listed in Question 2 above been reported to your current or prior insurance carrier? ☐ Yes ☐ No

If yes, please attach a current loss run for each carrier, as appropriate.
If no, please explain why these circumstances were not reported:

**For the purposes of this section the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you, any partner, associate, employee, or any professional corporation or partnership.*

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PROVIDE DETAILS ON A CLAIM INFORMATION FORM.

©2016 PSIC NFL 9369-161403

K. CLAIM MANAGEMENT AND INCIDENT REPORTING PROCEDURES

Please complete the following for the person responsible for handling claims and reporting incidents.

Name: _____ Title: _____

Telephone:_____ Email Address: _____

Your email address will never be sold. It will be used to send you important messages.

Please describe your claims handling/incident reporting procedures: _____

_____

L. REQUIRED DOCUMENTS

Please remember to attach a copy of the following with the application:

- Current Declarations Page
- Brochures and marketing information
- Written procedures for claims handling and risk management
- If available, a complete copy of current policy and endorsements
- Loss runs from all carriers for the previous 10 years, or since the start of the practice, whichever is greater
- List of all past claims. Please complete Claim Information Form(s) as necessary
- Organizational chart
- Schedule of subsidiaries and/or affiliated entities with relationship to applicant

M. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any changes in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: The coverage for which you are applying is written on a CLAIMS MADE basis. Only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

_____ _____

Signature of Applicant Date

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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

©2016 PSIC NFL 9369-161403

N. DETAILS...

Section/Question	Comments

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE.

PSIC | Professional Solutions INSURANCE COMPANY

Protecting Reputations ... One Doctor at a Time®

©2016 PSIC NFL 9369-161403