HEALTHCARE*Pros*
Insurance Solutions for Healthcare Service Providers

U.S. Risk Underwriters
Boston (617.342.7116)
Dallas (800.232.5830)
Houston(800.833.8803)

INDIVIDUAL PRACTITIONERS

(Chiropractors, Counselors, Dieticians, Nurse Practitioners, PAs, RNs, Therapists, Vets)
PROFESSIONAL AND GENERAL LIABILITY INSURANCE
(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/healthcare.html

1. APPLICANT INFORMATION:

a. Complete name of applicant (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary):** ____

____

Address: ____

City:__________________ State: ____ Zip:_______ County: _______

Contact name: ______________ Title:___________ Email address: ______________

Phone: __________ Web site Address: ____________________ Fax: ____________

List all other locations **(use an additional sheet of paper if necessary):** ______________________

____

b. Professional degree: ____

c. Place of Birth: ____

d. Applicant is (check all that apply):

- ❑ U.S. Citizen (If not, provide status)
- ❑ Self-employed Individual (unincorporated)
- ❑ Self-employed Individual (incorporated)
- ❑ Partnership
- ❑ Professional Association
- ❑ Professional Corporation (for profit)
- ❑ Professional Corporation (non-profit)
- ❑ Employee of __________ (give name of employer)
- ❑ Other (Describe) __________

e. Please indicate your professional specialty:

- ❑ Chiropractor
- ❑ Counselor
- ❑ Dietician
- ❑ Physician Assistant
- ❑ Nurse Practitioner
- ❑ Registered Nurse
- ❑ Therapist
- ❑ Veterinarian
- ❑ Other (Specify) __________

f. Date established: ____ / ____

g. Please state sources and amounts of total gross annual revenue:

Source of revenue	Amount last 12 months	Amount next 12 months
__________	__________	__________
__________	__________	__________

h. If you practice **other than** as an **employee** OR an **unincorporated solo practitioner, specify**:

(i) Formal business, corporate or partnership name:

(ii) List the names of all partners or members of your professional association/corporation who provide professional services: ____

Attach a copy of your letterhead.

i. Are you associated with or do you work for a physician or surgeon? ❑ Yes ❑ No
If yes, please give the name and specialty of the physician: ____

j. Are you employed by an individual other than that shown in Question 1 above? ❑ Yes ❑ No
If yes, please attach an explanation, including details of your responsibilities.

k. Are you under contract to any individual or entity other than that shown in Question 1above? ❑ Yes ❑ No
If yes, please attach an explanation, including details of your responsibilities. If this contract contains a hold-harmless agreement, please attach a copy of the contract.

l. Are you employed by or under contract to any governmental entity? ❑ Yes ❑ No
If yes, please attach an explanation, including details of your responsibilities.

m. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ❑ Yes ❑ No
If yes, has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ❑ Yes ❑ No
Provide the name and title of the applicant's Privacy Officer ____

n. Provide the following information for all of the states in which you practice:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)
____	__________	____________	____________	____________________
____	__________	____________	____________	____________________

If NONE, please attach an explanation.

o. Are you licensed in accordance with applicable state and federal regulations? ❑ Yes ❑ No
If no, please attach an explanation.

p. Please describe Professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (C.V.).

2. EDUCATION:

a. Describe your professional training:

Institution (Name & Address)	Years of Training	Degree or Certification Attained
______________________________	From ________ To ________	______________________
______________________________	From ________ To ________	______________________
______________________________	From ________ To ________	______________________

3. EXPERIENCE:

Where have you practiced your profession during the last ten years:

a. Prior Experience - From: ________________ To: ______________ Location: ______________________
Practice Activity: ____

b. Prior Experience - From: ________________ To: ______________ Location: ______________________
Practice Activity: ____

c. Prior Experience - From: ________________ To: ______________ Location: ______________________
Practice Activity: ____

d. Have you ever failed any professional licensing or specialty organization examination? ❑ Yes ❑ No
If yes, please attach a detailed explanation, including dates and location.

4. YOUR PRACTICE:

a. Please give the approximate percentages of time spent in the following work locations:

_____% Administrative Office
_____% Hospital Ward (specify) ______________________________
_____% Ambulance
_____% Operating Room
_____% Other (specify)
_____% Classroom
_____% Outpatient Clinic
______% Laboratory
_____% Nursing Home/Assisted Living
_____% Patient's Home
______% Surgery Center
_____% Professional Office (specify profession) ______________________
______ % Emergency Dept of hospital

b. Please indicate the approximate division of your patients or clients among:

Hemodialysis	_______%	Bariatrics	________%	Ophthalmologic	________%
Holistic Medicine	_______%	Obstetrical	________%	Cosmetic Surgery	________%
Dental	_______%	Podiatric	________%	Disability Evaluation	________%
Stress Testing	_______%	Pediatric	________%	Research or Experimental	________%
Communicable	_______%	Pain	________%	(describe)________________________	
Family Planning	_______%	Management (describe)		Surgical (describe)	________%
		______________________		______________________________________	
					100%

c. **Chiropractors – please complete the following:**

a. Are you licensed to practice any other health care practices? ❑ Yes ❑ No
If Yes, please circle: MD DO DPM ND RN RPT LAC MIDWIFE Other: ________________________________

b. Please indicate those procedures or devices used in your practice:

	Yes	No		Yes	No
(i) General merric adjusting	❑	❑	(XVI) Messages	❑	❑
(ii) Upper cervical specific	❑	❑	(xvii) Short wave diathermy	❑	❑
(iii) Instrumental adjusting	❑	❑	(xviii) Knesiology	❑	❑
(iv) Gonstead/diversified	❑	❑	(xx) Whirlpool	❑	❑
(v) Direct non-force	❑	❑	(xxi) Stressology	❑	❑
(vi) Sacro-occipital	❑	❑	(xxii) Internal cocoyx adjustment	❑	❑
(vii) Hydroculator/heat packs	❑	❑	(xxiii) Gemstone therapy	❑	❑
(viii) Electrical stimulation	❑	❑	(xxiv) Toftness devise	❑	❑
(ix) Ice-cryotherapy	❑	❑	(xxv) Treat cancer	❑	❑
(x) Trigger point	❑	❑	(xxvi) Treat epilepsy	❑	❑
(xi) Cold laser	❑	❑	(xxviii) Manipulation under anesthesia	❑	❑
(xii) Activator	❑	❑	(xxx) Prenatal care & normal deliveries	❑	❑
(xiii) Galvanic	❑	❑			
(xiv) Ultraviolet	❑	❑			
(xv) Ultrasound	❑	❑			

d. If the answer to any of the questions below is No, please attach details. Do you:

(i) Use the Georges test, the Vertebral Artery Ischemia Test or the Cerebrovascular Craniocervical Function Test when initially seeing a patient or when seeing a patient you have not seen for six months? ❑ Yes ❑ No
If No, please describe how you assess vascular flow.
If an unusual finding results, do you refer the patient to the appropriate medical practitioner? ❑ Yes ❑ No

(ii) Make a differential diagnosis? ❑ Yes ❑ No

(iii) Always record the patient's account of his/her progress? ❑ Yes ❑ No

(iv) Always record objective findings? ❑ Yes ❑ No

(v) Always record details of treatment procedures? ❑ Yes ❑ No

e. The practice for which coverage is requested is:
❑ full-time ❑ part-time ❑ "moonlighting"
If the practice for which coverage is requested is part-time or "moonlighting" answer the following:

(i) Provide the name and address of your full-time position and number of weekly hours not including on-call.
____

(ii) Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice. __

f. Do you work for and/or accept work assignments or placements from any locum tenens company? ❑ Yes ❑ No
If Yes, complete the following for each company:

Name of Company	Address	Employee or Independent Contractor	No. of Hrs. Each Month	Is Prof. Liab. Insurance Provided to You? (Yes/No)*

* If Yes, attach a copy of your Certificate of Insurance.
If No, are you requesting coverage for this activity? ❑ Yes ❑ No

g. Are you a free-lance locum tenens not placed by or associated with any locum tenens company? ❑ Yes ❑ No

h. Are you currently in active military service? ❑ Yes ❑ No

i. Do you render professional services directly to patients? ❑ Yes ❑ No

If yes, please describe these services in detail and indicate whether you are supervised and by whom.

Detailed Description of Professional Services	Percent of time Supervised	Qualifications of Supervisor
____________________	________ %	____________________
____________________	________ %	____________________
____________________	________ %	____________________

j. Do you render professional services that do not involve contact with a patient? ❑ Yes ❑ No
If yes, please describe these services in detail. ____________________

k. Do you administer any anesthesia? ❑ Yes ❑ No
If yes, please explain and indicate whether you are supervised and by whom. ____________________

____

l. (i) Do you perform or assist in any surgical procedure(s)? ❑ Yes ❑ No
If yes, please answer (ii) below.
(ii) Please list ALL surgical procedures performed (including minor surgery): ____________________
(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ❑ Yes ❑ No
If yes, please attach a detailed explanation.
(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ❑ Yes ❑ No
If yes, please attach a detailed explanation.

m. (i) Do you perform radiation therapy? ❑ Yes ❑ No
(ii) Psychiatric shock therapy? ❑ Yes ❑ No

n Do you prescribe or dispense any drugs without the countersignature of a physician? ❑ Yes ❑ No
If yes, please provide a detailed explanation.

____

o. Do you:
(i) Use acupuncture? ❑ Yes ❑ No
If Yes, do you use the National Council on Certification of Acupuncturists (NCCA) clean needle technique? ❑ Yes ❑ No
If No, do you use disposable needles? ❑ Yes ❑ No
If No, please attach details.
(ii) Dispense or prescribe: Drugs? ❑ Yes ❑ No

(iii) Use x-ray or imaging in treatment determination? ❑ Yes ❑ No
(iv) Engage in any procedure, other than acupuncture or the drawing of blood for diagnostic purposes, requiring the penetration of the skin? ❑ Yes ❑ No
(v) Perform investigational or experimental research or therapy on human patients? ❑ Yes ❑ No

5. APPLICANT HISTORY (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS)

a. Have you:
(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ❑ Yes ❑ No
(ii) Ever been convicted for 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
(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ❑ Yes ❑ No

6. Do you currently carry the following insurance:

a. **Professional Liability Insurance**? ❑ Yes ❑ No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period From: MM/DD/YY	To: MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy? ________________________________

b. **Commercial General Liability Insurance?** ❑ Yes ❑ No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy? ________________________________

7. CLAIMS HISTORY:

a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ❑ Yes ❑ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS

IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ❑Yes ❑ No

If yes, provide full details. ____

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ❑ Yes ❑ No

If yes, fully describe the circumstances and follow up action taken: ____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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 FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

*Notice applicable in most 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 conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

______________________________/_________________ ____________________

Applicant's Signature **Title** **Date**