RENEWAL APPLICATION FOR OUTPATIENT CLINICS

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) _____

2. Current Kinsale Policy Number: _____

3. Mailing Address: _____
   STREET CITY COUNTY STATE ZIP

4. Location Address: ☐ Check here if no changes OR indicate all current locations below (use additional pages as needed)

   (1) _____
   STREET CITY COUNTY STATE ZIP
   (2) _____
   STREET CITY COUNTY STATE ZIP
   (3) _____
   STREET CITY COUNTY STATE ZIP

5. Inspection/Risk Management Contact Name: _____

6. Inspection/Risk Management Contact E-mail: _____

OPERATIONS

7. **Please check the category which best describes your organization**

☐ Health and Wellness Center	☐ Primary Care Clinic	☐ Urgent Care Center	☐ Emergi-Center
☐ Dental Clinic	☐ Not for Profit Clinic		
Other (please describe): _____			

8. Please state sources and amounts of total revenue and patient contacts:

REVENUES / SALES			**PATIENT VISITS / CLIENT CONTACTS**		
Source:	**LAST** 12 months	**NEXT** 12 months		**LAST** 12 months	**NEXT** 12 months
Charitable contributions	$_____	$_____	Emergency Visits	_____	_____
Government Funding	$_____	$_____	Urgent Care Visits	_____	_____
Fee for services	$_____	$_____	Health/ Wellness Visits	_____	_____
Other - specify _____	$_____	$_____	Other - specify	_____	_____
TOTAL GROSS REVENUES	$_____	$_____	_____		

2035 Maywill Street, Ste. 100, Richmond, VA 23230 | (804) 289-1300 phone | (804) 673-5697 fax | kinsaleins.com

9. Since your last application to Kinsale have there been any major changes in exposures (acquisitions, new or discontinued procedures / service offerings? If yes, please provide details below. ☐ YES ☐NO

_____
_____
_____
_____

10. Do you offer any of the procedures noted below? Additional information may be required.

		If "**Yes**":
Cosmetic / Aesthetic Procedures?	☐ YES ☐NO	Please Complete Medical Spa Supplement
Hormone Replacement Therapy?	☐ YES ☐NO	Please Complete Medical Spa Supplement
Erectile Dysfunction Therapy?	☐ YES ☐NO	Please Complete Medical Spa Supplement
Prenatal Care?	☐ YES ☐NO	Check all that apply: ☐1st Trimester ☐ 2nd Trimester ☐3rd Trimester
Abortions?	☐ YES ☐NO	*Coverage not currently available with Kinsale
Any surgical procedures?	☐ YES ☐NO	Please indicate surgical procedures below
Methadone or Suboxone Therapy	☐ YES ☐NO	Do you allow takeaways? ☐ YES ☐NO Total number of Slots*: _____ *Slots, defined as the maximum number of active patients who could be enrolled / licensed client capacity.*

_____
_____
_____
_____
_____

STAFF

11. Please indicate the current number of employed and contracted staff:

	Number Employed?		**Number Contracted**		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Acupuncturists					☐ YES ☐NO	☐ YES ☐NO
Chiropractors*					☐ YES ☐NO	☐ YES ☐NO
Dentists*					☐ YES ☐NO	☐ YES ☐NO
Inhalation/ Respiratory Therapists					☐ YES ☐NO	☐ YES ☐NO
Laboratory Technicians					☐ YES ☐NO	☐ YES ☐NO
Licensed Practical Nurses					☐ YES ☐NO	☐ YES ☐NO
Nurse Anesthetists					☐ YES ☐NO	☐ YES ☐NO
Nurse Midwives*					☐ YES ☐NO	☐ YES ☐NO
Nurse Practitioner					☐ YES ☐NO	☐ YES ☐NO
Opticians					☐ YES ☐NO	☐ YES ☐NO
Optometrists					☐ YES ☐NO	☐ YES ☐NO
Paramedics/ EMT's					☐ YES ☐NO	☐ YES ☐NO
Perfusionists					☐ YES ☐NO	☐ YES ☐NO
Pharmacists					☐ YES ☐NO	☐ YES ☐NO

	Number Employed?		Number Contracted		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Physician Assistant					☐ YES ☐NO	☐ YES ☐NO
Physicians – Major Surgery*					☐ YES ☐NO	☐ YES ☐NO
Physicians – Minor surgery*					☐ YES ☐NO	☐ YES ☐NO
Physicians – No surgery*					☐ YES ☐NO	☐ YES ☐NO
Physicians – OBGYN*					☐ YES ☐NO	☐ YES ☐NO
Physiotherapists					☐ YES ☐NO	☐ YES ☐NO
Registered Nurses					☐ YES ☐NO	☐ YES ☐NO
Social Workers					☐ YES ☐NO	☐ YES ☐NO
Speech Therapists					☐ YES ☐NO	☐ YES ☐NO
X-ray Technicians					☐ YES ☐NO	☐ YES ☐NO
Other: Specify					☐ YES ☐NO	☐ YES ☐NO

* Additional applications required if coverage is desired

12. Please provide the name and specialty of the applicant's Medical Director:

_____

Does the applicant's Medical Director have direct patient care? ☐ YES ☐ NO
☐ Full Time or ☐ Part Time

CLAIMS HISTORY - Provide details for all "yes" answers to questions 13-18

13. In the last 12 months, has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain below or attach additional pages as needed.** ☐ YES ☐NO

14. In the last 12 months, has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain on below or attach additional pages as needed.** ☐ YES ☐NO

15. In the last 12 months, has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on below or attach additional pages as needed.** ☐ YES ☐NO

16. In the last 12 months, has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance (to include any reports to previous carriers)? **How Many? _____ (Complete Supplemental Claims form for Each.)** ☐ YES ☐NO

17. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?
If yes, please explain in detail, completing a supplemental claim form for each. ☐ YES ☐NO

18. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐NO

SUPPLEMENTAL INFORMATION

Use the remainder of this page as needed or to address questions referenced within the application

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: 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, or denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion.
Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance.

All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicant's Signature: _____ Date: _____

Agent/Broker Name: _____

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: _____ Age: _____ Sex: _____
Incident ☐ Claim ☐
Date reported to insurance company: _____
Name of insurance company: _____
Date of incident and your treatment: _____
Allegations / Circumstances:

_____

_____

_____

Additional Defendants: _____
What is the present condition of the patient?

_____

_____

STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount:
$_____

☐ Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
Did you want to settle? ☐ Yes ☐ No

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment: $_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?
Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date: _____

Printed Name: _____