HISCOX

Allied healthcare services
Mainform application

Applicant information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

Street:

City: County:

State: Zip:

Phone: Website:

3. Date established: (if applicant is a facility/entity)

Date of birth: (if applicant is an individual)

4. Applicant's practice is a:

☐ Solo practitioner (unincorporated)	☐ Solo practitioner (incorporated)
☐ Corporation (for-profit)	☐ Corporation (non-profit)
☐ Professional association	☐ Partnership
☐ Individual, employee of (provide name of employer):	

5. Please describe in detail the nature of the applicant's operation and types of services rendered:

6. Please state sources and amounts of total revenue:

	in last 12 months	for next 12 months
Charitable contributions	$	$
Government funding	$	$
Fee for services	$	$
Other – specify:	$	$
Total gross revenue:	$	$

Operations and activities

7. Please indicate the number of:

a. patient/client encounters in the **last** 12 months:

b. tests performed in the **last** 12 months:

(encounters refers to number of visits – not number of patients/clients)

8. Please indicate the number of:

a. estimated patient/client encounters in the **next** 12 months:

b. estimated tests performed in the **next** 12 months:

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9. a. If applicant has a training school, complete the following:

Profession for which students are being trained	Max no. of students per session	Number of sessions per year	Number of faculty per session	Qualification of faculty (e.g. MD RN)

b. What is the total number of faculty members? ☐

c. What is the total annual number of students enrolled? ☐

d. Do all programs meet state mandated curriculum requirements for subsequent applicable licensing or certification of participants? Yes ☐ No ☐

If No, please explain:

10. State approximate division of applicant's patients among:

a.	Alcoholics	%	k.	Psychiatric	%
b.	Communicable	%	l.	Dental	%
c.	Drug addicts	%	m.	General	%
d.	Hemodialysis	%	n.	Holistic medicine	%
e.	Medical	%	o.	Developmentally disabled	%
f.	Obstetrical	%	p.	Pediatric	%
g.	Counseling/family planning	%	q.	Research or experimental	%
h.	Senile or aged	%	r.	Stress testing	%
i.	Surgical	%	s.	Tubercular	%
j.	Other (please specify):				%

11. Does the applicant perform:

a. acupuncture or acupuncture anesthesia? Yes ☐ No ☐

b. angiography/arteriography/venography? Yes ☐ No ☐

c. biopsies and/or endoscopies? Yes ☐ No ☐

d. botox or dermal filler injections? Yes ☐ No ☐

e. catheterization (other than urinary or umbilical)? Yes ☐ No ☐

f. excision of large cysts and/or I&D of deep-seated boils or carbuncles? Yes ☐ No ☐

g. obstetric or gynecological procedures? Yes ☐ No ☐

h. open reduction of fractures? Yes ☐ No ☐

i. psychiatric shock therapy? Yes ☐ No ☐

j. radiation therapy and/or chemotherapy? Yes ☐ No ☐

k. spinal anesthesia (other than saddle blocks or caudals)? Yes ☐ No ☐

l. sterilization procedures? Yes ☐ No ☐

m. surgery other than incision of superficial boils or suturing superficial fascia? Yes ☐ No ☐

If Yes to any of the above, please provide a full description in the comments section.

12. Does the applicant perform hospital emergency room care:
    a. for its own regular patients? Yes ☐ No ☐
    b. for patients not its own? Yes ☐ No ☐
    c. If answer to b. is Yes, please specify:
    the percentage of time devoted to this work:
    the number of hours per month devoted to this work:

13. Does the applicant use drugs for weight reduction of patients? Yes ☐ No ☐
    If Yes, please attach a list of the drugs used and advise on the percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs and quantity dispensed by applicant.

14. Does the applicant administer any methadone treatment? Yes ☐ No ☐
    If Yes, please describe treatment and controls used and indicate number of treatments used during last 12 months and the next 12 months :

15. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes ☐ No ☐
    If Yes, please explain in the comments section.

16. Does the applicant maintain any beds for overnight occupancy? Yes ☐ No ☐
    If Yes, please give total number:

17. State number of x-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom the treatment is given and the number of procedures.

18. Does the applicant (wholly or in part) operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes ☐ No ☐
    If Yes, please give details, including name, location, size, and number of beds:

Staffing information

19. a. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted	Profession	Employed	Contracted
Acupuncturists			Opticians		
Chiropractors			Optometrists		
Hearing aid fitters			Paramedics/ EMT's		
Inhalation/ respiratory therapists			Perfusionists		
Inhalation therapist			Pharmacists		
Laboratory technicians			Physicians – minor surgery		
Nurse anesthetists			Physicians – no surgery		
Nurse midwives			Physiotherapists		

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Nurse practitioner			Prosthetic device fitters		
Nurses, licensed practical			Social workers		
Nutritionists			Speech therapists		
Nurses registered			Other – (specify below)		
			specify:		

i. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐
If No, please explain in the comments section.

ii. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

iii. Do you maintain certificates of insurance to confirm such coverage? Yes ☐ No ☐

b. Has the applicant or have any of the above employees:

i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative 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 ☐
If Yes to any of the above, please explain in the comments section.

20. Provide the name of the applicant's medical director and attach a copy of his/her curriculum citae (CV).

21. a. Do any physicians or dentists perform direct patient care services on behalf of the applicant? Yes ☐ No ☐

b. Do all physicians or dentists performing direct patient care services maintain separate medical malpractice coverage extending to these services? Yes ☐ No ☐
If No, please submit a Physician Supplemental application and CV for each physician or dentist to be included.

Insurance and claims history

22. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐
If Yes, please explain in the comments section.

23. Does any person to be insured have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐
If Yes, please attach complete details including a description of the incident(s).

24. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐
If Yes, please complete a supplemental claim form for each claim.

25. How many claims have been made in the last five (5) years?

26. a. List prior professional liability insurers for the past five years (if none, please tick box). ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

27. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

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Comments section

It is understood and agreed that with respect to questions 21 and 22, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.