UNDERWRITERS DIRECT ACCESS

8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-585-2853 • Fax 877-585-2854
quotes@primeis.com

COMPLEMENTARY & ALTERNATIVE MEDICINE

A. General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: _____ Fax: _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

_____

Contact Person: _____ Producer's Name: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

_____

_____

Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other: _____

Is this a new business? ☐ Yes ☐ No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: _____

_____

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: _____

_____

_____

Annual Payroll: $ _____ Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: _____

_____

_____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? ☐ Yes ☐ No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: _____

Fax: _____ Years with Company: _____

Employee's Responsibilities: _____

B. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor ever had a claim? ☐ Yes ☐ No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? ☐ Yes ☐ No

If the standard markets are declining placement, please explain why: _____

_____

C. Other Insurance

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	**2**	**3**
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	$	$	$

D. Desired Insurance

Per Act/Aggregate

☐	$50,000/$100,000
☐	$150,000/$300,000
☐	$250,000/$1,000,000
☐	$500,000/$1,000,000
☐	Other: _____

Self-Insured Retention (SIR): ☐ $1,000 (Minimum) ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

E. Business Activities

THE FOLLOWING MUST BE INCLUDED WITH THIS APPLICATION:

☐ Copy of your current professional liability insurance Declarations Page and currently valued loss experience.

☐ Copy of your Curriculum Vitae.

☐ Copies of all advertising that you use, including Yellow Page ads.

☐ Copy of your business letterhead.

☐ Supplementary Applications, Claim Information Supplement(s) and additional documentation as needed.

Date of Birth: _____	Number of years at your current location: _____

Type of Practice:

☐ Solo Practice ☐ Corporation ☐ Limited Liability Company

☐ Partnership (On a separate sheet, please identify partners)

☐ Employed Physician ☐ Other (specify):

Medical Training and Practice History

1. Medical Specialty: Percent of Practice:_____%		2. Medical Sub-Specialty: Percent of Practice:_____%		
	Hospital / College	City & State	Completed?	Year
Medical School			☐ Yes ☐ No	
Internship			☐ Yes ☐ No	
Residency			☐ Yes ☐ No	
Additional Residency			☐ Yes ☐ No	
Fellowship			☐ Yes ☐ No	

3. Are you a U.S. citizen? ☐ Yes ☐ No

   If NO, please provide a copy of documents confirming your status.

4. Are you a Foreign Medical School Graduate? ☐ Yes ☐ No

   Date of ECFMG certification:_____

5. Are you currently Board Certified? ☐ Yes ☐ No

   Name of Board:_____

6. Date you began practicing: _____. Within the last five years have your practice characteristics, procedures performed, or business association(s) changed? ☐ Yes ☐ No

   If YES, please describe details of change on additional sheet.

7. List all primary office locations where you have practiced in the last 10 years. (Use separate sheet if more space is needed).

   Street Address & City County State Dates – From / To

_____

_____

8. Please list below all hospitals where you have staff privileges. (*If no hospital privileges, attach protocol for patient admission*).

HOSPITAL	CITY/ STATE	COUNTY	% OF PRACTICE

9. List the following information for each state where you practice:

STATE	MEDICAL LICENSE NUMBER(S):	DEA LICENSE NUMBER(S):	% OF PRACTICE IN EACH STATE:
			%
			%
			%
			%

10. Please indicate the number of CME hours you have obtained in the past two years: _____

11. Indicate your gross annual receipts for the following:

Major Surgery	$
Minor Surgery	$
Office Visits	$
Obstetrics/Gynecology	$
Plastic Surgery	$
Other (specify):_____	$
TOTAL:	$

12. Identify the percentage of your business operations which are:

Performed by you	%
Performed by your staff	%
Other (specify): _____	%

13. Identify the percentage of your business operations which are:

Performed in your office	%
Performed at a hospital or clinic	%
Other (specify): _____	%

14. Estimate total gross receipts from all operations for the next 12 months:

Major Surgery	$
Minor Surgery	$
Office Visits	$
Obstetrics/Gynecology	$
Plastic Surgery	$
Other (specify):_____	$
TOTAL:	$

15. Estimate total annual gross receipts from all business operations for the next 12 months:

$_____

F. Office Staff

1. Do you employ, contract with, or supervise any physician(s) or surgeon(s)? ☐ Yes ☐ No

   If YES, advise of number and attach current certificate(s) of insurance.

2. Do you employ, contract with or supervise any non-physician health care extenders? ☐ Yes ☐ No

   If YES, enter information below:

	NUMBER		NUMBER
LPN		Certified Nurse Midwife (CNM)	
RN		Pharmacist	
CNA		Laboratory Technician	
Physician Assistant:		Other (please describe):	

G. Practice Information

1. Please indicate:
   a. Average number of patients seen each week: _____
   b. Average number of patients seen each month: _____
   c. Average number of patients seen each year: _____
   d. Percentage of locum tenens work: _____%
2. Weekly practice hours: ____ to _____
3. Please list any medical association membership(s): _____

   _____

4. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center? ☐ Yes ☐ No
   If YES, please describe on separate sheet.

5. Do you perform abortions? ☐ Yes ☐ No

   If YES, please tell us:

   a. Indicate number each month: _____ Type: ☐ Elective ☐ Therapeutic

   b. Where performed? (Check all that apply) ☐ Office ☐ Hospital ☐ Other (Explain on separate sheet).

   c. Maximum Gestation Age? _____

6. Does your practice include the following? Check all that apply

☐ No Surgery

No surgery, with the exception of incision of sebaceous boils and cysts. Incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns, and umbilical and urethral catheterization.

☐ Minor Surgery

Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive). *No general anesthesia.*
If YES, indicate the average number of minor surgeries performed per week: _____

☐ Major Surgery

Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen, or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It also includes removal of tumors (except skin tumors), reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation using general anesthesia.
If YES, indicate the average number of major surgeries performed per week: _____

☐ Obstetrics

If checked, please indicate annual:

Number of vaginal deliveries: _____

Number of cesarean sections: _____

Number of Home or Non-Hospital Deliveries: _____
(Please describe on separate sheet)

☐ Elective Plastic Surgery

Please describe procedures and annual number performed on separate sheet.

7. Do you perform any of the following procedures?

Acupuncture?	☐ Yes ☐ No	Kidney, Ureter, and Bladder Surgery?	☐ Yes ☐ No
Amniocentesis?	☐ Yes ☐ No	Laparoscopies?	☐ Yes ☐ No
Angiography?	☐ Yes ☐ No	Laser Treatments via Endoscope?	☐ Yes ☐ No
Arteriography?	☐ Yes ☐ No	Low Forceps Deliveries?	☐ Yes ☐ No
Assisting in surgery on other than your own patients?	☐ Yes ☐ No	Malignant Lesion Surgical Procedures?	☐ Yes ☐ No
Assisting in surgery on your own patients?	☐ Yes ☐ No	Mastoidectomy?	☐ Yes ☐ No
Amputations?	☐ Yes ☐ No	Middle or Inner Ear Surgery?	☐ Yes ☐ No
Blepharoplasty?	☐ Yes ☐ No	Mid-Forceps Delivery?	☐ Yes ☐ No
Breast Augmentation or Reduction?	☐ Yes ☐ No	MOHS Micrographic Surgery?	☐ Yes ☐ No
Breech Deliveries?	☐ Yes ☐ No	Myleography?	☐ Yes ☐ No

Catherizations? (Right Heart)	☐ Yes ☐ No	Needle Biopsies?	☐ Yes ☐ No
Cervical Biopsy?	☐ Yes ☐ No	Neurological Surgery?	☐ Yes ☐ No
Cervical Cautery?	☐ Yes ☐ No	Norplant Insertion?	☐ Yes ☐ No
Chelation Therapy?	☐ Yes ☐ No	Obesity/Weight Control Surgery?	☐ Yes ☐ No
Chemical Peels?	☐ Yes ☐ No	Office Gynecology?	☐ Yes ☐ No
Cleft Lip or Palate Surgery?	☐ Yes ☐ No	Oophorectomy?	☐ Yes ☐ No
Clinical Trials?	☐ Yes ☐ No	Open Reduction of Fractures? (Plating & Pinning)	☐ Yes ☐ No
Closed Reduction of Fractures?	☐ Yes ☐ No	Ophthalmologic Surgery? (Laser or other)	☐ Yes ☐ No
Collagen Lip Injection?	☐ Yes ☐ No	Organ Transplants?	☐ Yes ☐ No
Colonoscopy?	☐ Yes ☐ No	Orthopedic Surgery? (Including Spinal Surgery)	☐ Yes ☐ No
Complex Flaps and Grafts?	☐ Yes ☐ No	Orthopedic Surgery? (No Spinal Surgery)	☐ Yes ☐ No
Conization of Cervix?	☐ Yes ☐ No	Oloplasty?	☐ Yes ☐ No
Culdocentesis?	☐ Yes ☐ No	Pedicia Screw Insertion?	☐ Yes ☐ No
Diagnostic Radioology?	☐ Yes ☐ No	Penile Augmentation?	☐ Yes ☐ No
Dilation and Curetage?	☐ Yes ☐ No	Penile Implants?	☐ Yes ☐ No
Electroshock Therapy?	☐ Yes ☐ No	Pericardiocentesis?	☐ Yes ☐ No
Endomeinal Biopsy?	☐ Yes ☐ No	Permanent Eyeliner Procedures?	☐ Yes ☐ No
Endoscopic Retrograde / Cholangiopancreatography?	☐ Yes ☐ No	Pregnancy Care into Second Trimester?	☐ Yes ☐ No
Episiotomy?	☐ Yes ☐ No	Pregnancy Care into Third Trimester?	☐ Yes ☐ No
Experimental Procedures?	☐ Yes ☐ No	Prostatectomy?	☐ Yes ☐ No
Gastric Bubble Procedures?	☐ Yes ☐ No	Radiation Therapy? (Radium Implants)	☐ Yes ☐ No
Hair Transplant Procedures?	☐ Yes ☐ No	Reconstructive Plastic Surgery?	☐ Yes ☐ No
High Risk Pregnancies?	☐ Yes ☐ No	Scalp Reduction Surgery?	☐ Yes ☐ No
Hyperbaric Chamber Treatments?	☐ Yes ☐ No	Sex Change Operations?	☐ Yes ☐ No
Hypnosis?	☐ Yes ☐ No	Sterilization Procedures?	☐ Yes ☐ No
Interphalangeal Joint Surgery?	☐ Yes ☐ No	Suction Lipectomy Procedures?	☐ Yes ☐ No
Hysterectomies?	☐ Yes ☐ No	Thrombectomy of Arteries and Veins?	☐ Yes ☐ No
Joint Replacement Surgery?	☐ Yes ☐ No	Toxemia Management?	☐ Yes ☐ No
Vascular Surgery?	☐ Yes ☐ No	Herbal Treatments	☐ Yes ☐ No
Traditional Chinese Medicine	☐ Yes ☐ No	Anti-Aging Medicine	☐ Yes ☐ No
Colon Hydrotherapy	☐ Yes ☐ No	Reiki	☐ Yes ☐ No
Magnet Therapy	☐ Yes ☐ No	Hormone Replacement	☐ Yes ☐ No
Reflexology	☐ Yes ☐ No	Carboxy Therapy	☐ Yes ☐ No
Massage Therapy	☐ Yes ☐ No	CAM Modalities	☐ Yes ☐ No
Auriculotherapy	☐ Yes ☐ No	Bariatrics	☐ Yes ☐ No

Bio-oxidative Therapy	☐ Yes ☐ No	Prolotherapy	☐ Yes ☐ No
Sclerotherapy	☐ Yes ☐ No	Hydrogen Peroxide Therapy	☐ Yes ☐ No
Hyperbaric Oxygen Therapy	☐ Yes ☐ No	Nevral Therapy	☐ Yes ☐ No
Botanical Medicine	☐ Yes ☐ No	Naturopathy	☐ Yes ☐ No
Hypnosis	☐ Yes ☐ No	UV Blood Irradiation	☐ Yes ☐ No
Ayurvedic medicine	☐ Yes ☐ No	Biofeedback	☐ Yes ☐ No
Chiropractic	☐ Yes ☐ No	Homeopathy	☐ Yes ☐ No

8. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? ☐ Yes ☐ No
   If YES, please describe on separate sheet.
9. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ Yes ☐ No
   If YES, please describe on separate sheet.
10. Are you now, or have you ever been involved in any professional liability claim or suit? ☐ Yes ☐ No
11. Are you aware of any circumstances that might lead to a claim or suit? ☐ Yes ☐ No

    If YES, has this information been reported to a current or prior insurance carrier? ☐ Yes ☐ No
12. Has your professional liability insurance ever been refused, cancelled, or non-renewed? ☐ Yes ☐ No
    If YES, please explain on a separate sheet. (*Response not required in the state of Missouri*).
13. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
14. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? ☐ Yes ☐ No
15. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
16. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s), or a state licensing authority? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
17. Do you own or operate a Laboratory? ☐ Yes ☐ No
    If yes,

    a. Does the laboratory provide services solely for your patients? ☐ Yes ☐ No

    b. If <u>not</u> limited to your patients, please explain on separate sheet.
18. Are you now or have you ever performed experimental or investigational procedures or prescribed/dispensed experimental drugs? ☐ Yes ☐ No
    If YES, please explain on a separate sheet.
19. Do you now or have you ever treated prisoners in a state, federal, or any correctional institution? ☐ Yes ☐ No
20. Do you practice as a company doctor (excluding treatment of workers compensation patients)? ☐ Yes ☐ No

    If YES, please answer:

    a. What products are manufactured by the company? _____

    _____

    b. Do you review or establish plant/employer safety standards? ☐ Yes ☐ No

c. Do you provide medical treatment to company employees? ☐ Yes ☐ No

Company Name: _____ Location: _____

21. Does your practice include weight reduction/control by other than diet and exercise? ☐ Yes ☐ No
If YES, please complete the information below or attach separate sheet if needed:

a. What percentage of patients are treated exclusively for weight control? _____

b. List injections used for weight control: _____

_____

c. If you prescribe or dispense drugs for weight control, please list drugs and describe protocols:

_____

_____

d. Describe any other weight control procedure, including surgery, that you provide to your patients:

_____

_____

22. Do you authorize any collection agency, at its own discretion, to file a claim or suit? ☐ Yes ☐ No

23. Do you work in an Emergency Room for other than maintaining hospital privileges? ☐ Yes ☐ No
Please indicate the average number of hours you work in the Emergency Room each month:

24. Are you a sports team physician or health care provider? ☐ Yes ☐ No
If YES, check all that apply: ☐ High School ☐ College ☐ Professional ☐ Other

Name and location of teams: _____

_____

25. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director, or are you under contract to provide professional services, at any Nursing Home or similar facility? ☐ Yes ☐ No

If YES, describe percentage of your practice and name(s) of nursing home facilities: _____

_____

26. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director of a hospital or hospital department, sanitarium, ambulatory care clinic with bed and board facilities, health maintenance organization, preferred provider organization, or any other business enterprise? ☐ Yes ☐ No

If YES, please identify, provide address, and explain details on a separate sheet.

27. Do you serve in a 'Gatekeeper' capacity—that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization? ☐ Yes ☐ No

If YES, please advise of percentage of your practice devoted to Gatekeeper activity: ____%

28. Do you engage in tele-medicine activity? ☐ Yes ☐ No
If YES, please describe on separate sheet.

29. Do you prescribe drugs or provide diagnosis via the Internet? ☐ Yes ☐ No
If YES, please describe on separate sheet.

30. Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)? ☐ Yes ☐ No
If YES, please describe on separate sheet.

H. Anesthesia / Office Surgery

1. Do you perform or assist in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis? ☐ Yes ☐ No
   If YES, please complete the questions below:

   a. Description and annual number of procedures: _____

   _____

   b. Annual number of procedures with: General Anesthesia: _____

      Spinal or Caudal Anesthesia: _____

      Other: _____

   c. Anesthesia administered by: _____

   d. Distance to nearest hospital: _____

   e. Description of life-saving equipment/supplies: _____

   _____

   _____

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
PHYSICIANS AND SURGEONS CLAIMS-MADE COVERAGE
ADDITIONAL INFORMATION FORM

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheets if necessary.

QUESTION #	COMMENTS

REPRESENTATIONS AND WARRANTIES

The “Applicant” is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant’s request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant’s losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____	Dated: _____
Applicant:	Agent/Broker:
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name