Kinsale Insurance Company
P.O. Box 17008
Richmond, VA 23236
(804) 289-1300
www.kinsaleins.com

NURSE ANESTHETIST NEW BUSINESS APPLICATION

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".

The following information must be submitted with the completed application:

- Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
- Copy of your Curriculum Vitae
- Copy of all licenses and board certifications
- Copy of your business letterhead
- Copy of all advertising that you use
- Copy of all reporting endorsements previously issued to you
- 5-year company loss runs, valued within the last 60 days

PERSONAL INFORMATION

Applicant's Name and Degree designation(s): ______________________________

Social Security Number: ________ - ______ - ________ Date of Birth _____ / _____ / ________

Mailing Address: ______________________________
STREET CITY COUNTY STATE ZIP

Practice Address: ______________________________
STREET CITY COUNTY STATE ZIP

E-Mail Address: ______________________ Website Address: ______________________

Are you a U.S. Citizen? ☐ Yes ☐ No If no, indicated status and date of entry ______________________

PRACTICE SPECIALTY AND EDUCATION

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

State	License #	Effective Date	Expiration Date	Active (Yes/No)

2. **Provide the following information:**

	Name of Institution	City	State	Date Completed
Nursing School	______________________	____________	________	___________
Graduate School	______________________	____________	________	___________

3. **List all locations and dates where you have practiced in the last 10 years:**

Practice Name	City/State	From	To

4. **Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy?** If yes,
   a. Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ☐ YES ☐ NO
   b. Provide the name and title of the Applicant's Privacy Officer: ______________________________

5. **Are you a member of any professional societies?** *If yes, list memberships below* ☐ YES ☐ NO

   ____

PRACTICE INFORMATION

6. **Type of practice for which coverage is requested:**

☐ Solo practitioner (unincorporated)
☐ Employee of ______________________
☐ Independent Contractor of ______________
☐ Independent Contractor of Locum Tenens Company
☐ Solo practitioner (incorporated)*
* Name of Entity: ______________________
☐ Employee of Locum Tenens
☐ Free-lance Locum Tenens

7. **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:

Provide the name and address of your full-time position and number of weekly hours, not including on-call

____

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

8. **Do you own a locum tenens company?** .... ☐ YES ☐ NO

   If yes, are you requesting coverage for this company? .... ☐ YES ☐ NO

   If no, attach a Certificate of Insurance for Professional Liability Insurance for locum tenens company

9. **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 Provide 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

SPECIFICS OF PRACTICE/PROCEDURES

10. Principal practice location for which coverage is requested:

____
(Practice Name) (Street)

____
(City) (State) (Zip)

a. Provide the number of weekly hours for your principal practice location (exclude on-call hours): _____________

b. Your principal practice location is a(n):

☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty

11. Secondary practice location for which coverage is requested (If none, check here ☐)

____
(Practice Name) (Street)

____
(City) (State) (Zip)

a. Provide the number of weekly hours for your secondary practice location (exclude on-call hours): ____________

b. Your principal practice location is a(n):

☐ Hospital ☐ Ambulatory Surgery Center ☐ Professional Office with Specialty

12. Are you supervised by an Anesthesiologist at each location for which coverage is requested? ☐ YES ☐ NO

If Yes, is 100% of your practice supervised by an Anesthesiologist? ☐ YES ☐ NO

If No, what percentage of your practice is supervised by the following:

_____% Another CRNA _____% Dentist/Oral Surgeon _____% Podiatrist

_____% Anesthesiologist _____% Ophthalmologist _____% Other Physician ________________

_____% Bariatric Surgeon _____% Plastic/Cosmetic Surgeon

Indicate the approximate percentages of your patients for which coverage is requested:

_____% Bariatric Surgery _____% Dental/Oral Surgery _____% Plastic/Cosmetic Surgery

_____% Pediatric _____% Podiatric

_____% Obstetrical _____% Ophthalmological

_____% Non-Surgical Pain Management (describe) ____

_____% Research or Experimental (describe) ____

_____% Other Surgery or Experimental (describe) ____

13. During administration of all anesthetics, do you use a pulse oximeter monitor? ☐ YES ☐ NO

If no, please explain ____

14. During all anesthetics,

a. Is an electrocardiogram continuously displayed? ☐ YES ☐ NO

If no, please explain ____

b. How often is arterial blood pressure determined and evaluated? _________________________

c. How often is heart rate determined and evaluated? ____________________________________

d. How is circulatory function evaluated? ____

15. During all general anesthesia, do you use an end tidal CO2 monitor? ☐ YES ☐ NO

If no, please explain ____

16. During all general anesthesia using an anesthesia machine, do you:

a. Use an oxygen analyzer with a low concentration limit alarm? ☐ YES ☐ NO

If no, please explain ____

b. Test proper functioning of alarms prior to each use? ☐ YES ☐ NO

If no, please explain ____

17. When ventilation is controlled by a mechanical ventilator, do you:

a. Use a device equipped with a full set of safety alarms? ☐ YES ☐ NO

If no, please explain ____

b. Test proper functioning of alarms prior to each use? ☐ YES ☐ NO

If no, please explain ____

18. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? ☐ YES ☐ NO

If no, please explain ____

19. Provide the following:

	Weekly	**Annually**
a. Average number of patients you saw during the last 12 months for all jobs	__________	__________
b. Estimated number of patients you will see during the next 12 months for all jobs	__________	__________
c. Estimated number of patients you will see during the next 12 months for all jobs for which coverage is requested	__________	__________

20. Provide the following (exclude on-call hours):

a. Your average number of weekly practice hours for all jobs: ______________

b. Your average number of weekly practice hours for all jobs for which coverage is requested: _________________

21. Do you employ anyone? .... ☐ YES ☐ NO

a. Indicate, by profession, the number of individuals you employ:

_____ Nurse Anesthetists _____ Other Professionals (describe)____________________________________

Attach a detailed explanation of the responsibilities for each profession, including the extent supervised.

b. Are all the above individuals licensed in accordance with applicable state and federal regulations? ☐ YES ☐ NO

If no, please attach explanation.

c. Attach protocols and Certificate of Insurance for Professional Liability Insurance for all individuals you employ.

22. Do you supervise anyone other than your own employees? .... ☐ YES ☐ NO

If yes, indicate by profession the number of individuals you supervise:

______ Nurse Anesthetists _____ Other Professionals (describe) ____________________________________

Attach a detailed explanation of the responsibilities for each profession and your relationships to the entity that employs these individuals.

PRIOR POLICY AND LOSS INFORMATION – Questions 23-38 provide details for all "YES" answers

23. Has your medical or narcotics license ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? ☐ YES ☐ NO

24. Has your board certification or membership in any medical society or association ever been refused, suspended, revoked, or voluntarily surrendered? ☐ YES ☐ NO

25. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? ☐ YES ☐ NO

26. Have you ever been charged with, or convicted of a crime other than minor traffic violations? ☐ YES ☐ NO

27. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? ☐ YES ☐ NO

28. Has any fee or professional relations complaints been registered against you with your medical association, hospital, or a state licensing authority? ☐ YES ☐ NO

29. Provide the following information pertaining to your past 5 years of professional liability insurance coverage:

Carrier	Policy Period	Policy Limits	Deductible	Claims Made? (Y/N)	Retro Date

30. Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? If yes, identity ____ ☐ YES ☐ NO

31. Have you ever practiced without professional liability insurance? ☐ YES ☐ NO

32. Do you have professional liability insurance for work you do elsewhere? If yes, please explain on page 6. ☐ YES ☐ NO

33. Have you ever had any insurance company decline, cancel, rescind, or non-renew any professional liability insurance policy? ☐ YES ☐ NO

34. Have you ever been involved in any professional liability claim or suit, either directly or indirectly? ☐ YES ☐ NO

35. Are you aware of any known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ YES ☐ NO

36. Are you aware of any request for medical records by a patient or his/her attorney which might result in a claim? ☐ YES ☐ NO

37. Are you aware of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission, or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result notice, or attorney contact? ☐ YES ☐ NO

38. Have all circumstances that might reasonably lead to a claim or suit, even if you believe them to be without merit, been reported to your current or prior professional liability company? **Indicate N/A if you are not aware of any such circumstances** . If yes, how many? ____ please complete a supplemental claims form for each. ☐ YES ☐ NO ☐ N/A

REQUESTED COVERAGE

(NOTE: The Company may not offer or quote requested coverage)

Requested Effective Date:_____________

Requested Retroactive Date:________________

Requested Limits of Liability	Requested Deductible
___ $100,000/$300,000	___ $5,000
___ $200,000/$600,000	___ $7,500
___ $250,000/$750,000	___ $10,000
___ $500,000/$1,500,000	___ $25,000
___ $1,000,000/$3,000,000	___ $50,000
___ $2,000,000/ $6,000,000 (VA only)	___ Other $_____________

SUPPLEMENTAL INFORMATION

Use this page to as needed to address questions referenced within the application or to provide information you deem pertinent to our review of your application

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

- I have no known losses or claimsthat have not been reported to my prior insurance carrier or any other source from which payment might be made;
- I have no knowledgeof acts, omissions or circumstances that relate to a professional service which could reasonably result in a claim, that has not been reported to a prior insurance carrier;
- I have no knowledgeof any request for medical records by a patient or their attorney which might result in a claim;
- I have no knowledgeor information relating to service or services on a Board which might result in a claim; and
- I have no knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result, or attorney contact.

My signature on page 9 below confirms the above statements unless otherwise noted

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 fact.

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: _________________________________

Applicants 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. <u>Attach additional sheets if necessary for adequate explanation.</u> 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?____

____

<u>STATUS OF CLAIM</u>

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor
☐ Suit settled out of court
Date claim paid: _____________
Amount paid: $_____________
Did you want to settle? ☐ Yes ☐ No

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

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

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

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: ___________________________________