Kinsale Insurance Company
P. O. Box 17008
Richmond, VA 23226
(804) 289-1300
www.kinsaleins.com

PHYSICIANS & SURGEONS RENEWAL 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 renewal 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 Curriculum Vitae and letterhead IF CHANGED IN THE PAST 12 MONTHS.
- Current loss runs from a prior insurance company, IF ANY OF THE FOLLOWING APPLIES:
  - There was an open claim, suit or incident pending with a prior insurance company;
  - An Extended Reporting Period (ERP) Endorsement was purchased from a prior insurance carrier within the past 5 years;
  - Coverage was written on an occurrence basis by the insurance company within the past 5 years.
- A Claim Supplemental Form or comprehensive narrative on your letterhead must be completed for each claim resolved/closed or a new claim made, incident surfacing and/or suit brought against you IN THE PAST 12 MONTHS that has not already been reported to Kinsale Insurance Company.

PERSONAL INFORMATION

Applicant's Name: _____ ☐ MD ☐ DO

Business Entity Name:_____

Practice Address: _____

STREET CITY COUNTY STATE ZIP

Mailing Address: _____

STREET CITY COUNTY STATE ZIP

Provide the following information for all states in which you are license to practice:

State	% of Practice	License#	Active	Inactive	Temporary	Pending
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

PRACTICE SPECIALTY

1. Current Practice Specialty: _____ % of Practice: _____
   Subspecialty: _____ % of Practice: _____

2. Do you limit your practice to the above Specialty and/or Sub-Specialty? ☐ YES ☐ NO
   If NO, please explain: _____

3. Have you added or discontinued procedures which are considered to be outside of, or not usual to the above practice specialty, or are experimental in nature within the past year, or do you anticipate doing so in the near future? ☐ YES ☐ NO ***If YES, please list procedures/services and note dates of change(s):*** _____

4. Have you changed your medical specialty within the past year or do you anticipate doing so in the near future? ☐ YES ☐ NO ***If YES, please explain:*** _____

5. Indicate number of CME hours you have completed in past two years: _____

OFFICE STAFF

6. Do you employ, contract with, or supervise any physicians or surgeons? ☐ YES ☐ NO
   If YES, provide the names and attach certificate of insurance for each: _____

7. Do you share office space or have an expense sharing arrangement with any other physician or surgeon other than those named above? ☐ YES ☐ NO ***Please provide details on page 5.***

8. Do you employ, contract with, or supervise any physicians or surgeons? ☐ YES ☐ NO
   If YES, provide the names and attach certificate of insurance for each: _____

9. Please complete the staff table.

TYPE	Number Employed	Coverage Desired?	Number Contracted	Insured Elsewhere?
Midwife*		☐ YES ☐ NO		☐ YES ☐ NO
CRNA*		☐ YES ☐ NO		☐ YES ☐ NO
Nurse Practitioner		☐ YES ☐ NO		☐ YES ☐ NO
Physician Assistant		☐ YES ☐ NO		☐ YES ☐ NO
Surgeon Assistant		☐ YES ☐ NO		☐ YES ☐ NO
Optometrist		☐ YES ☐ NO		☐ YES ☐ NO
Lab Technician		☐ YES ☐ NO		☐ YES ☐ NO
Pharmacists		☐ YES ☐ NO		☐ YES ☐ NO
Nurse (RN or LPN)		☐ YES ☐ NO		☐ YES ☐ NO
X-Ray Technician		☐ YES ☐ NO		☐ YES ☐ NO
Physical Therapist		☐ YES ☐ NO		☐ YES ☐ NO
Other:		☐ YES ☐ NO		☐ YES ☐ NO
Other:		☐ YES ☐ NO		☐ YES ☐ NO
* Separate application must be submitted				

SPECIFICS OF PRACTICE/PROCEDURES

10. Average Weekly Practice Hours: _____

11. Average Weekly Patient Encounters: _____

12. Percentage of Practice that is Locum Tenens Work: _____%

13. Do you work for any Locum Tenens companies as an employee or independent contractor? ☐ YES ☐ NO
If YES, indicate number of hours worked each month:____ AND does the Locum Tenens company provide you with Professional Liability insurance? Yes ☐ No ☐ If YES, provide copy of the COI.

14. Check all Procedures/Treatments that you perform:

- ☐ Abortions
- ☐ Acupuncture
- ☐ Adenoidectomy
- ☐ Amputations
- ☐ Anesthesia (circle: OB or non-OB)
- ☐ Angiography
- ☐ Angioplasty
- ☐ Assist in Surgery (circle: own or other patients)
- ☐ Arterial Catheterization
- ☐ Arteriography
- ☐ Bariatric Surgeries: (Supplement Required)
- ☐ Cardiac Catheterization
- ☐ Cervical Biopsy
- ☐ Chelation Therapy (circle: **cardiac care** or **heavy metal**)
- ☐ Chemonucleolysis
- ☐ Chemotherapy
- ☐ Clinical Trials
- ☐ Closed Reduction Fractures
- ☐ Cholecystectomies
- ☐ Intensive Care for Adults
- ☐ Joint Replacement Surgery
- ☐ Laparoscopy
- ☐ Mastoidectomy
- ☐ MOHS Micrographic Surgery
- ☐ Needle Biopsy
- ☐ Office Gynecology

Obstetrics

- ☐ Prenatal Care
  - ☐ 1st Trimester
  - ☐ 2nd Trimester
  - ☐ 3rd Trimester
- ☐ Normal Deliveries (indicate # annually____)
- ☐ VBAC Deliveries (indicate # annually____)
- ☐ High risk patient (indicate # annually____)

- ☐ Open Reduction of Fractures
- ☐ Organ Transplants
- ☐ Orthopedic Surgery Excluding Spine
- ☐ Orthopedic Surgery Including Spine

- ☐ Colonoscopy
- ☐ Complex Flaps and Grafts

Cosmetic Procedures

- ☐ Breast Implants/Augmentations/Reductions
- ☐ Botox Injection
- ☐ Chemical Peels
- ☐ Chemobrasion
- ☐ Collagen Injection
- ☐ Dermabrasion
- ☐ Fat Transfer
- ☐ Hair Transplant
- ☐ Liposuction
- ☐ Lipodissolve
- ☐ Facial Plastic Surgery (circle **Elective** or **Reconstructive**)
- ☐ Mesotherapy
- ☐ Microdermabrasion
- ☐ Sclerotherapy
- ☐ Silicone Injection
- ☐ Laser Hair Removal
- ☐ Rhinoplasty
- ☐ Other Laser Procedure (specify:_____)
- ☐ Other Cosmetic Procedure

- ☐ Dilaton and Curettage
- ☐ Echocardiography
- ☐ Electroshock Therapy
- ☐ Endoscopic Procedures
- ☐ Hernioplasty
- ☐ Hemorrhoidectomies
- ☐ Hyperberic Chamber Treatments
- ☐ Interphalangeal Joint Surgery
- ☐ Intensive Care for Newborns
- ☐ Osteopathic Manipulative Medicine

Pain Management

- ☐ Medication Only
- ☐ Procedures: (Supplement Required)

- ☐ Pedicle Screw Insertion
- ☐ Penile Augmentation
- ☐ Penile Prosthetic Implants
- ☐ Pericardiocentesis
- ☐ Permanent Pacemaker Insertion
- ☐ Pneumoencephalography
- ☐ Prolotherapy
- ☐ Prostatectomy
- ☐ Radial Keratotomy
- ☐ Radiopaque Dye Injections
- ☐ Refractive Surgery (circle LASIK, PRK, PTK, AK, ICR)
- ☐ Thoracic Surgery
- ☐ Transgender Surgery or Hormonal Gender Coversion
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Vertebroplasty

Other:_____

Other:_____

☐ None of the above procedures apply to my practice.
Please initial _____

15. In the past 12 months:
    a. Has any State/Medical Board refused you a medical license? ☐ YES ☐ NO
    b. Has any State/Medical Board restricted, suspended or revoked your medical license? ☐ YES ☐ NO
    c. Has any State/Medical Board imposed a fine or any other obligation? ☐ YES ☐ NO
    d. Has any State/Medical Board issued a letter of guidance or public reprimand? ☐ YES ☐ NO
    e. Have you voluntarily surrendered a medical license? ☐ YES ☐ NO
    f. Has any State/Medical Board placed you on probation or restricted your practice? ☐ YES ☐ NO
    g. Is your medical license currently under investigation for any reason in any state? ☐ YES ☐ NO
    h. Has your Narcotics/DEA license been surrendered/refused/suspended/revoked (voluntarily or otherwise)? ☐ YES ☐ NO
    i. Has there been any professional conduct or fee complaint filed against you with any Specialty, National, State or County Medical Society, other Professional Association or any licensing or regulatory authority? ☐ YES ☐ NO

If YES to any of the above, describe the circumstances, outcome, dates on Page 6 and attach copies of any relevant documents.

16. In the past 12 months:
    a. Have you become American Board Certified or Eligible? ☐ YES ☐ NO
    b. Has your Board Certification or membership in any medical association/society been refused, suspended, revoked or voluntarily surrendered? ☐ YES ☐ NO

17. In the past 12 months:
    a. Have you been evaluated, treated, or recommended for treatment of alcohol, narcotics, or any other substance abuse, sexual addiction, or mental illness? ☐ YES ☐ NO
    b. Have you been diagnosed with, or treated for, a chronic physical illness and/or disability? ☐ YES ☐ NO
    c. Have you become aware of any physical illness, mental illness and/or disability which affects, or could affect, your ability to practice medicine now or anytime in the future? ☐ YES ☐ NO

    IF YES to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents (including a letter from your treating physician addressing your state of health and whether such condition could adversely affect your ability to practice medicine).

18. IN THE PAST 12 MONTHS, have you been charged with or convicted of a felony or misdemeanor for anything other than a minor traffic violation? ☐ YES ☐ NO ***IF YES, describe circumstances, outcome, dates and attach any relevant documents.*** _____

19. IN THE PAST 12 MONTHS, have your hospital privileges been suspended, denied, revoked, restricted, or otherwise sanctioned? ☐ YES ☐ NO ***IF YES, describe circumstances, outcome, dates and attach any relevant documents.*** _____

20. Are you aware of any request for medical records by a patient or his/her attorney which might result in a claim? ☐ YES ☐ NO ***If YES, please complete Supplemental Claims Information on Page 8.***

21. 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 ***If YES, describe circumstances, outcome, dates and attach any relevant documents.*** _____

22. 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? ☐ YES ☐ NO ☐ N/A
    Indicate N/A if you are not aware of any such circumstances. If yes, how many? _____
    Please complete a supplemental claims form for each.

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 claims that have not been reported to my prior insurance carrier or any other source from which payment might be made;
- I have no knowledge of 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 knowledge of any request for medical records by a patient or their attorney which might result in a claim;
- I have no knowledge or 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 below confirms the above statements

CONSENT, WARRANTY, REPRESENTATIONS and ACKNOWLEDGMENT of UNDERSTANDING FRAUD WARNING

Any person who knowingly, and with the intent to defraud any insurance company or other person, includes any false or misleading information in an application for insurance or statement of claim commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

The applicant declares that the information contained herein is accurate and that no material facts have been suppressed. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. The applicant understands that incorrect information could void coverage.

Signature: _____ Date:_____

Printed Name:_____

SUPPLEMENTAL CLAIMS INFORMATION

If reporting more than one claim, then please photocopy this form 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:_____

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient? _____

_____

Status of Claim

___Suit threatened, no action taken	Court outcome in your favor:	Unresolved/Open
___Suit filed but dropped by claimant	___Jury verdict	___Awaiting mediation
___Summary judgment in your favor	___Directed verdict	___Awaiting court action
___Suit settled out of court	Court outcome in favor of plaintiff:	Reserve amount:
a. Date claim paid: _____	___Jury verdict	$_____
b. Amount paid: $_____	___Directed verdict	
c. Did you want to settle? Yes ☐ No ☐	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: _____