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

LOCUM TENENS AND CONTRACT STAFFING 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 all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

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

2. Mailing and Location Address: _____

   Please provide list of all additional locations.

3. Website address: www._____

4. Telephone Number: _____

5. Type of Entity: ☐ Corporation ☐ Partnership ☐ Other: _____

6. Date Established _____ Years under current management _____

7. Coverage is requested for: ☐ Locums Tenens ☐ Contract Staffing

8. Requested limits: _____occurrence/ _____aggregate

9. Requested retroactive date: _____

10. Number of employed or contracted providers: Full Time _____ Part Time _____ Total _____

RECRUITMENT AND CREDENTIALING PROCEDURES

11. Is there a designated corporate medical director? Yes ☐ No ☐

12. Has an administrator been designated to oversee recruiters and credentialers and the recruitment/credentialing process? Yes ☐ No ☐

    Please provide copy of CV/Resume for administrator.

13. Please describe the training and experience level of the provider recruiters and credentialers. _____

    _____

    _____

    _____

    _____

14. How are the provider recruiters and credentialers organized? ☐ By Specialty ☐ By State

15. Are there pre-established selection guidelines/protocol for recruiting providers as candidates for the organization? Yes ☐ No ☐

    Please provide a copy of the selection guidelines/protocol.

16. Are references listed by new applicants checked in writing? Yes ☐ No ☐

17. Is there a centralized record keeping system for medical staff credentialing and privilege delineation? Yes ☐ No ☐

18. Is there initially a specified probationary period? Yes ☐ No ☐

    If yes, what is the length of this period? _____

19. Has a formal risk management program been established for your organization? Yes ☐ No ☐

20. Has your organization designated a risk manager to oversee operations? Yes ☐ No ☐

21. Are any non-medical professionals associated with your organization? Yes ☐ No ☐

    If yes, please describe: _____

    _____

22. Does the organization have a formal provider peer review process? Yes ☐ No ☐

LOCUM TENENS (please complete this section if you operate as a locum tenens organization)

23. Please complete the following table indicating total number of annual locum days, States and Placements for each category. If you do not provide staff noted within a particular category please indicate "N/A".

Classification and Description	Annual Locum Days*	States	Annual Locum Days Previous Year	Annual Locum Days Two Years Back
Class 1: Physicians No Surgery / Allied Providers – Level I – General Dentists including minor procedures/ sedation, CRNA's, Nurse Practitioners, Physician Assistants				
Class 2: Physicians No Surgery – Level II – Pathology, Dermatology, Occupational Medicine, Physical Medicine and Rehab, Psychiatry				
Class 3: Physicians No Surgery – Level III (no invasive procedures other than incision of boils or suturing of skin; no obstetrics) – Dermatology, Geriatrics, Gynecology, Otorhinolaryngology, Family Physician/General Practice, Hematology, Nephrology, Pediatrics, Podiatry, Anesthesiology, Cardiovascular Disease, Hospitalist, Internal Medicine, Oncology				
Class 4: Physicians Minor Surgery, Invasive Procedures: – Correctional Medicine, Endocrinology, Gastroenterology, Gynecology, Infectious Disease, Neonatology, Ophthalmology, Pain Management, Podiatry, Urgent Care, Oral Surgery, Family, Physician/General Practice (no OB), Hematology, Infectious Disease, Intensive Care Medicine, Internal Medicine, Neurology, Otorhinolaryngology, Pathology, Pulmonary Medicine, Diagnostic Radiology (Excl Mammography)				
Class 5: Surgery – Level I – Cardiovascular Disease (Minor Surgery), Dental Anesthesia, Neurology (Minor Surgery), Diagnostic Radiology (Minor Surgery), Emergency Medicine (No Surgery), Colon and Rectal, Gastroenterology, Otorhinolaryngology (Excl Plastic), Radiology (Incl Mammography), Urological				
Class 6: Surgery – Level II – Cosmetic, Family Physician/General Practice (Incl OB), Gynecology, Hand, Head/Neck, Otorhinolaryngology (Incl Plastic), Plastic N.O.C.				
Class 7: Surgery – Level III – Emergency Medicine, Orthopedic (Excl Spine), General Surgery N.O.C.				
Class 8: Surgery – Level IV – Cardiovascular Disease, Thoracic, Trauma, Vascular, Abdominal, Orthopedic (Incl Spine)				
Class 9: Surgery – Level V – Obstetrics, Neurology				

***One day is equal to 10 hours for all classifications.**

24. Is the adding of additional specialties contemplated during the coming year? Yes ☐ No ☐

If Yes, please provide details. _____

_____

CONTRACT STAFFING (please complete this section if you operate as a contract staffing organization)

25. Please complete the following table indicating where services are rendered, medical specialty and number of providers.

Name of Facility where services are rendered and location, City and State	**Type of Facility, e.g. Hospital, Clinic**	**Medical Specialty**	**Number of Providers**

26. Estimated annual number of emergency room visits: _____

27. Annual number of emergency room visits last year: _____

28. Estimated annual number of clinic visits: _____

29. Annual number of clinic visits last year: _____

30. Current provider roster:

Name	**Contract/Hire Date**	**Termination Date**

COVERAGE HISTORY AND CLAIMS

31. Please provide previous Professional Liability Insurance carried for the past five years:

Insurer	Dates covered	Limits of Liability Per claim/ Aggregate	Deductible	Premium	Retroactive date

32. Has the applicant or any of its employed or contracted providers ever had any professional license or license to prescribe and/or dispense narcotics limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? Yes ☐ No ☐

If Yes, please provide details. _____

33. Has the applicant or any of its employed or contracted providers ever been charged with, or convicted of a crime **other** than minor traffic violations? Yes ☐ No ☐

If Yes, please provide details. _____

34. Has the applicant or any of its employed or contracted providers ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? Yes ☐ No ☐

If Yes, please provide details. _____

35. Has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance? Yes ☐ No ☐

If Yes, please explain in detail, completing a supplemental claim form for each. _____

36. 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 ☐

37. 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

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 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 Provider: _____

Name of Institution: _____ City/ State: _____

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
- ☐ Suit filed but dropped by claimant
- ☐ Summary judgment in your favor

- ☐ Suit settled out of court
  - a. Date claim paid: _____
  - b. Amount paid: $_____
  - c. 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: _____