HISCOX

Allied Health Care Services

Application

1. Applicant name:

Principal business address:

Telephone number:

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

3. 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)
- ☐ Partnership
- ☐ Professional Association
- ☐ 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:

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

7. Please indicate the number of:

a. patient encounters in the last 12 months:
(patient encounters refers to number of visits - not number of patients)

b. patient tests carried out in the last 12 months:

8. Please indicate the number of:

a. estimated patient encounters in the next 12 months:

b. estimated patient tests carried out in the next 12 months:

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)

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b. What is the total number of faculty members?

10. If applicant is an ambulance service, please complete the following:

Number of ground ambulances:		Number of emergency calls:	
Number of non-emergency calls:		Number of air ambulances:	
Radius of services:			

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

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

12. a. List the number and type of applicant's staff:

	Employed	Contracted
Acupuncturists		
Chiropractors		
Dentists		
Dental hygienist		
Hearing aid fitters		
Inhalation/respiratory therapists		
Laboratory technicians		
Nurse anesthetists		
Nurse midwives		
Nurse practitioner		
Nurses, licensed practical		
Nutritionists		
Nurses registered		
Opticians		
Optometrists		
Paramedics/EMT's		

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	Employed	Contracted
Perfusionists		
Pharmacists		
Physicians – minor surgery		
Physicians – no surgery		
Physiotherapists		
Prosthetic device fitters		
Social workers		
Speech therapists		
Other (please specify):		

b. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐
If No, please attach an explanation.

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

ii. Do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

d. 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 attach an explanation.

13. Does the applicant perform:

a. Acupuncture or acupuncture anesthesia? Yes ☐ No ☐

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

c. Catheterization (other than urinary or umbilical)? Yes ☐ No ☐

d. Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? Yes ☐ No ☐

e. Injection of radioisotopes and/or use of irradiated substances? Yes ☐ No ☐

f. Radiation therapy and/or chemotherapy? Yes ☐ No ☐

g. Psychiatric shock therapy? Yes ☐ No ☐

h. Silicone injections? Yes ☐ No ☐

i. Laser treatments? Yes ☐ No ☐

j. Hypnosis? Yes ☐ No ☐

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

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If Yes to any of question 13, please describe/explain:

14. Does the applicant perform:

a. Surgery other than incision of superficial boils or suturing superficial fascia? Yes ☐ No ☐

b. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? Yes ☐ No ☐

c. Obstetric procedures? Yes ☐ No ☐

d. Cosmetic plastic surgery? Yes ☐ No ☐

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

f. Hysterectomies? Yes ☐ No ☐

g. Open reduction of fractures? Yes ☐ No ☐

h. Surgery for weight reduction of patients? Yes ☐ No ☐

i. Silicone implants? Yes ☐ No ☐

j. Sterilization procedures? Yes ☐ No ☐

k. Biopsies and/or endoscopies? Yes ☐ No ☐

l. Sex change operations? Yes ☐ No ☐

m. Other surgery? Yes ☐ No ☐

If Yes to any of the above, please describe:

15. 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: ☐

16. Does the applicant use drugs for weight reduction of patients? Yes ☐ No ☐

If Yes, please attach a list of the drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs and quantity dispensed by applicant.

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17. 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

18. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes ☐ No ☐

If Yes, please attach a detailed explanation.

19. Does the applicant maintain any beds for overnight occupancy? Yes ☐ No ☐

If Yes, please give total number:

20. 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 number of procedures:

21. 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:

22. 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?

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

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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? ☐

24. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please attach an explanation.

25. 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).

26. 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 claims information form for each claim and attached currently valued company loss runs.

It is understood and agreed that this application shall become part of the application for Professional Liability Errors and Omissions Insurance.

Name of applicant: ☐

☐

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

☐

Date:

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