HUDSON SPECIALTY INSURANCE COMPANY
Employed Ancillary Provider Application
for surplus lines coverage

- If a question does not apply to you, write "N/A". Do not leave any questions unanswered.
- Include a copy of the following: • CV • Letterhead • Loss Runs • State License(s)
• Current Declarations Page

1. PERSONAL DATA

Name: _____
LAST FIRST MIDDLE INITIAL

Designation (PA, NP, CRNA, etc.): _____

Date of Birth: _____ Social Security No: _____ Gender: ❒ M ❒ F

Clinic Name/Employer: _____

Office Address: _____ Office Phone: (____) _____

City/State/Zip: _____ County: _____

2. EDUCATION AND TRAINING

Name & Location of Medical School: _____

Degree/Certification Attained: _____ Year Graduated: _____

List States in which you are actively licensed: _____

3. INSURANCE COVERAGE REQUESTED

Requested Effective Date: _____ Prior Acts Date (Retroactive Date): _____

Requested Coverage: ❒ Shared Limit with Employer ❒ Separate Limit

4. PRACTICE INFORMATION

1. Average number of hours worked per week: _____ Average number of patient visits per week: _____
2. Does your current practice involve the treatment of nursing home residents? ❒Yes ❒No
   If "Yes", what percentage of your practice involves treatment of nursing home residents? _____ %
3. Does your current practice involve the treatment of prison inmates? ❒Yes ❒No
   If "Yes", what percentage of your practice involves treatment of prison inmates? _____ %
4. Does your current practice involve work in an Emergency Room / Department? ❒Yes ❒No
   If "Yes", what percentage of your practice involves work in an emergency room or department? _____ %

5. INSURANCE HISTORY

1. Current Carrier: _____ ❒ Claims-Made ❒ Occurrence

   Effective Date: _____ Expiration Date: _____ Prior Acts Date: _____

   Limits of Insurance: _____ Per Claim/ _____ Aggregate

   Current Annual Premium: _____

2. *If* you are currently insured on a claims-made policy, are you obtaining Extended Reporting Period (tail) from your current insurance carrier? ❒Yes ❒No ❒N/A (have occurrence coverage now)

   Note: To prevent possible gaps in your claims-made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. ***Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.***

3. Where have you practiced your profession since completion of your formal training? (include military or any public service organization). If your attached CV provides the same information, you may go on to the next section. ❒ CV attached – skip to next section

   City/State: _____ From: _____ To: _____

   ❒ Solo Practitioner ❒ Part of a group Group Name: _____

   City/State: _____ From: _____ To: _____

   ❒ Solo Practitioner ❒ Part of a group Group Name: _____

   City/State: _____ From: _____ To: _____

   ❒ Solo Practitioner ❒ Part of a group Group Name: _____

6. UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.
Within the past 10 years:

1.	Have you been convicted of a misdemeanor (other than traffic related) or felony or is any such charge pending?	❒Yes ❒No
2.	Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program? If yes, please provide an explanation on a separate sheet of paper.	❒Yes ❒No
3.	Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis? If yes, please provide an explanation on a separate sheet of paper.	❒Yes ❒No
4.	Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility? If yes, please provide an explanation on a separate sheet of paper.	❒Yes ❒No
5.	Have you ever resigned from a health care facility while under investigation or to avoid possible disciplinary action?	❒Yes ❒No
6.	Has any hospital, as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision?	❒Yes ❒No
7.	Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?	❒Yes ❒No
8.	Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	❒Yes ❒No
9.	Have you provided any care that resulted in a formal incident report or investigation by any healthcare facility?	❒Yes ❒No
10.	Have Medicare or Medicaid authorities ever investigated or brought charges against you?	❒Yes ❒No
11.	Have you provided any professional services without professional liability insurance?	❒Yes ❒No
12.	Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	❒Yes ❒No
13.	Have you ever treated any patients by means of unconventional therapeutics, or have you utilized non-FDA approved experimental drugs other than through Institutional Review Board (IRB) approved research programs?	❒Yes ❒No

7. CLAIMS INFORMATION

If you answer "Yes" to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.
Within the past 10 years:

1.	Have you been involved in a malpractice claim, lawsuit, incident or occurrence in the last 10 years? If "Yes", how many? _____	❒Yes ❒No
2.	Are you aware of any circumstances that may result in a malpractice claim or suit being made or being brought against you?	❒Yes ❒No
3.	Are you aware of any outstanding incidents, claims, or suits (even if you believe the outstanding claim or suit would be without merit) that have not been reported to your current or prior professional liability carrier?	❒Yes ❒No
4.	Have you been contacted by a plaintiff's attorney or required to produce medical records or statements regarding any case you have been involved with, and you have not been specifically named in the suit or claim?	❒Yes ❒No

COMMENTS

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application shall be the basis of the contract should a policy be issued. I agree to notify the Company of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to the following:

A. A change in specialty or medical procedures performed;
B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
C. Investigation, restriction, suspension or surrender of any state medical, DEA license or hospital privileges;
D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing.
E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

For FL, KY, MN, NJ, OH and PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person who 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. For NY residents only: And shall also be subject to a civil penalty not to exceed five thousand ($5,000) dollars and the stated value of the claim for each such violation.

This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company.

Signature | Print Name | Date

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

HUDSON SPECIALTY INSURANCE COMPANY
Supplement Claim Information Form
(make copies of this page as needed)

1. Name of patient: _____ Age: _____ ❒ Male ❒ Female
2. Describe the allegation made by claimant: _____
3. Date claim was made or filed: _____
4. Date of alleged incident: _____
5. Insurance company: _____
6. Additional defendants: _____
7. Disposition of claim: ❒ Open ❒ Closed

If open:
- Claimant's settlement demand: $ _____
- Defendant's offer for settlement: $ _____
- Insurer's loss reserve: $ _____
- Deductible amount: $ _____
- Is claim in suit? ❒ Yes ❒ No If "Yes", amount asked in summons: $ _____

If closed:
- Date closed: _____ ❒ Court judgment ❒ Out of court settlement ❒ Dismissed with prejudice ❒ Dismissed without prejudice
- Total indemnity paid (including deductible): $ _____
- Total defense costs/expenses paid: $ _____
- **Total costs incurred:** $ _____

Provide complete and detailed information for evaluation. Use reverse side or additional sheets if required.

8. Condition and diagnosis at time of incidents (include dates of visits)
9. Description of treatment rendered (include dates of visits)
10. Condition of patient subsequent to treatment (include dates of follow-up treatment)

Signature _____ Print Name _____ Date _____

HUDSON SPECIALTY INSURANCE COMPANY

FRAUD WARNINGS

To All Prospective Insureds: 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 and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds in:

Colorado: 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 policyholder 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.

Florida and Oklahoma: 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.

New York: 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 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.

Applicant's Signature	Print Name	Date