HUDSON SPECIALTY INSURANCE COMPANY
Physician 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: • Current Declarations Page • Loss Runs
• CV *(if information is not already provided in application)*

BROKER : ______________________________

1. PERSONAL DATA

Last Name ____________ **First Name** ____________ **M.I.** ______ **Title** ______

Date of Birth: ____________ Social Security No: ____________ Gender: ☐ M ☐ F

Clinic Name/Employer: ______________________________

Office Address: ____________________ Office Phone: ____________

City/State/Zip: ____________________ County: ____________

Number of years at current office location: ________ % of practice at this location: ________

List all other office locations where you will practice your profession:

Address: ____________________ City/State/County: ____________

Address: ____________________ City/State/County: ____________

Residence Address: ____________________ City/State/County: ____________

Office Phone: ____________________ Email address: ____________

2. INSURANCE COVERAGE REQUESTED

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

Requested limits of liability (per claim/aggregate): ☐ $1,000,000/$3,000,000 ☐ Other: $ ________

Deductible: (per claim/aggregate): ☐ $5,000 per claim ☐ Other: $ ________ ☐ None

3. MEDICAL SPECIALTY

Current Medical Specialty: ____________________ % of practice: ________

☐ Surgery ☐ Minor Surgery ☐ No Surgery

Sub-Specialty: ____________________ % of practice: ________

☐ Surgery ☐ Minor Surgery ☐ No Surgery

4. MEDICAL TRAINING AND HISTORY

1. Provide the following information:

	Name of Institution	City	State	Dates Completed
Medical School				
PGY-1/Internship				
Residency – Specialty: ________				
Residency – Specialty: ________				
Fellowship – Specialty: ________				
Others: ________				

2. If you are a graduate of a foreign medical school:

   Are you certified by the Education Council for Foreign Medical Graduates? .... ☐ Yes ☐ No
   Have you passed the FLEX? .... ☐ Yes ☐ No

3. Medical License #: ____________ State: _________ Expiration date: ____________ Status: ___________
   Medical License #: ____________ State: _________ Expiration date: ____________ Status: ___________
   Medical License #: ____________ State: _________ Expiration date: ____________ Status: ___________

4. Narcotics/DEA License #:______________________ Expiration date: ____________ Status: ___________

5. BOARD CERTIFICATION

1. Are you Board Certified? ☐ Yes ☐ No

   Board Name: _________________________ Date Certified: ___________ Expiration Date: ____________

   Board Name: _________________________ Date Certified: ___________ Expiration Date: ____________

2. If you are not Board certified, are you eligible to take the boards in your specialty? .... ☐ Yes ☐ No

   Do you plan to take the Board exam (both written and oral exams)? .... ☐ Yes ☐ No

   When do you plan to take the Board exam? ____

3. Have you ever been denied Board certification or recertification or have you allowed your certification to lapse? If "Yes", state reason: ______________________________________ ☐ Yes ☐ No

6. PRACTICE INFORMATION

1. Do you have hospital privileges? ☐ Yes ☐ No

   Type of Privileges

   Hospital Name: ____ ☐ Full ☐ Restricted
   City/State/County: _______________________________________ ☐ Courtesy ☐ Other

   Hospital Name: ____ ☐ Full ☐ Restricted
   City/State/County: _______________________________________ ☐ Courtesy ☐ Other

   Hospital Name: ____ ☐ Full ☐ Restricted
   City/State/County: _______________________________________ ☐ Courtesy ☐ Other

   (If you have answered "No", "Restricted" or "Other" to question #1 above, explain on your letterhead)

2. Average number of hours worked per week: _______ Average number of patient visits per week: _________
   Average number of surgeries per week: _______

3. Type of Practice (check all that apply):

   ☐ Individual / Solo corporation – Name of corporation: ____
   ☐ Partnership – Name of partnership: ____
   ☐ Employed doctor – Name of employer: ____
   ☐ Independent contractor – Name of physician, partnership or corporation with whom you contract: ____________
   ____

4. Do you request coverage for your corporation? ☐ Yes ☐ No

5. Do you, your partnership or corporation, employ any of the following non-physician providers? If yes, please complete the information below. Indicate the number of each type of professional employed or contracted by the physician. Use a separate sheet, if necessary:

Number of Professional Employees			**Number of Other Healthcare Employees**		
	Employees	Independent Contractors		Employees	Independent Contractors
*Employed Physician/ Dentist			Marriage, Family & Child Counselor		
*Employed Resident			Nurse		
*Nurse Anesthetist			Optometrist		
*Nurse Midwife			Perfusionist		
*Nurse Practitioner			Physical Therapist		
*Physician Assistant			Athletic Trainer		
*Podiatrist			Chiropractor		
*Psychologist			Licensed Clinical Social Worker		
Other			Other		

(Complete a Small Group and Individual Physician or Employed Ancillary Provider Application for each Professional Employee)*

6. Have there been any changes in your specialty, classification or practice activity within the last 5 years? ☐ Yes ☐ No
   If "Yes", explain: ______________________________

7. 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? ______ *%*

8. Does your current practice involve the treatment of prison inmates? ……………………………………... ☐ Yes ☐ No
   If "Yes", what percentage of your practice involves treatment of prison inmates: ______ *%*

9. Do you have faculty appointment? ……………………………………………………………………….. ☐ Yes ☐ No
   If "Yes", provide name of insurance carrier for the educational program: ______________________________

10. Does your current practice involve work in an Emergency Department? ………………………………. ☐ Yes ☐ No
    If "Yes", how many hours each week do you work in an Emergency Department? ______ *hours/week*

11. Do you perform or assist in any surgical procedure in a <u>non-hospital setting</u> during which any anesthesia is administered? ……………………………………………………………………………… ☐ Yes ☐ No

12. Are you employed or contracted to any facility as the medical director? ………………………………. ☐ Yes ☐ No
    If "Yes", provide name of insurance carrier: ______________________________

13. Do you have any medical related duties or practice activities that are insured elsewhere or for which you do not desire coverage? ……………………………………………………………………………... ☐ Yes ☐ No
    If "Yes", provide name of insurance carrier ______________________________

7. MEDICAL PROCEDURES

☐ **No Surgery** – Includes normal office procedures as commonly found in a family practice. Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered "No Surgery". This includes administration of local or topical anesthesia and circumcision. No invasive procedures or special procedures room activities are done.

☐ **Minor Surgery** – Includes all listed in definition of "No Surgery", as well as assisting in major surgery, D&C, and vasectomies. Invasive procedures are done, but the procedures do not open or enter a major body cavity.

☐ **Major Surgery** – Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, any other operation, which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life, removal of tumors, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation done using general anesthesia, and the administration of anesthesia other than local or topical.

1. If you perform any of the following procedures, check all that apply. For each procedure performed, please indicate the type of facility(ies) where the procedure is performed:
H = Hospital **S** = Surgi-center **OF** = Office **OT** = Other (describe in comments section, see page # 7)

Procedure	Type of Facility
☐ Abortions – 1st Trimester	______
☐ Abortions – 2nd/3rd Trimester	______
☐ Acupuncture	______
☐ Adenoidectomy/Tonsillectomy	______
Anesthesia	
☐ General	______
☐ Spinal	______
☐ Epidural	______
☐ Anesthesia – Other (describe) ________________________	
☐ Angiography	______
☐ Angioplasty	______
☐ Anti-aging procedures (describe) ________________________ ________________________	______
☐ Arteriography	______
☐ Assisting in Surgery – on own Patients or the patients of others	______
☐ Breast Implants	______
☐ Breast Reductions	______
☐ Catheterization – other than umbilical cord, urethral or arterial line in a peripheral vessel	______
☐ Cosmetic implantation or injection of silicone or other material	______
☐ Cryosurgery – other than on benign or pre-malignant dermatological lesions	______
☐ Chelation Therapy	______
☐ Dermabrasion/Chemical Peels	______
☐ Dilation & Curettage	______
☐ Discograms	______
☐ Electroconvulsive Therapy	______
☐ Endoscopic procedures	______
☐ Hair Transplants or Suturing of Hairpieces	______
☐ Hyperbaric Medicine	______
☐ Hysterectomies	______
☐ Laser skin resurfacing	______

Procedure	Type of Facility
☐ Laser Surgery (describe) ____________	______
☐ Lymphangiography	______
☐ Minimally invasive surgery (describe) ________________________	______
☐ Moh's micrographic surgery	
☐ Myelography	______
☐ Needle biopsies (describe) ____________	______
Obstetrics:	______
☐ Prenatal care beyond the 1st trimester	______
☐ Normal deliveries – annual #: ______	______
☐ Caesarean sections – annual #: ______	______
☐ VBAC deliveries - annual #: ______	______
☐ Open Reduction of Fractures	______
☐ Pain Management (describe) ________________________	______
Plastic – Cosmetic Procedures: *% of practice* ____	______
☐ Blepharoplasty	______
☐ Collagen injections	______
☐ Botox injections	______
☐ Liposuction under 3500 cc's volume	______
☐ Liposuction 3500 cc's or more volume	______
☐ Phalloplasty or penile implant	______
☐ Rhinoplasty	______
☐ Silicone Implants	______
☐ Silicone Injections	______
☐ Other plastic – cosmetic procedures (describe)________________________	______
☐ Pneumoencephalography	
Podiatry	______
☐ Below Knee Surgery	______
☐ Above Knee Surgery	______
☐ Prolotherapy/proliterative therapy	______
☐ Radiation Therapy	______
☐ Radiopaque dye injections into blood vessels, lymphatics, sinus tracts or fistulae	______
☐ Refractive surgery:LASIK, PRK, AK, PTK, ICR	______
☐ Spinal surgery (incl chemonucleolysis or percutaneous, lumbar discectomy)	______

2. Do you perform any Weight Reduction procedures? .... ☐ Yes ☐ No
"If Yes", please provide % of your practice and annual # of procedures performed ______________________

3. Do you prescribe any weight loss medication? .... ☐ Yes ☐ No
"If Yes", please describe ____

4. Do you perform surgery for obesity? .... ☐ Yes ☐ No
"If Yes", complete Bariatric Surgery Supplemental Application

5. Do you own a Medical Spa/Clinic or Anti-Aging Clinic? .... ☐ Yes ☐ No
"If Yes", complete Medical Spa/Clinic or Anti-Aging Clinic Application

6. Do you practice at Medical Spa/Clinic or Anti-Aging Clinic? .... ☐ Yes ☐ No
"If Yes", please provide name and location of Clinic ____

8. INSURANCE HISTORY

1. **Current Carrier:** ______________________________ ☐ Claims-Made ☐ Occurrence

Effective Date: ______________ Expiration Date: ______________ Prior Acts Date: ______________

Limits of Liabililty: ______________ Per Claim/ ______________ Aggregate

☐ Deductible ☐SIR $: ______________ Per Claim/ ______________ Aggregate

Current Annual Premium: ______________

1st prior carrier name: ______________________________ ☐ Claims-Made ☐ Occurrence

Effective Date: ______________ Expiration Date: ______________ Prior Acts Date: ______________

Limits of Liabililty: ______________ Per Claim/ ______________ Aggregate

☐ Deductible ☐SIR $: ______________ Per Claim/ ______________ Aggregate

2nd prior carrier name: ______________________________ ☐ Claims-Made ☐ Occurrence

Effective Date: ______________ Expiration Date: ______________ Prior Acts Date: ______________

Limits of Liabililty: ______________ Per Claim/ ______________ Aggregate

☐ Deductible ☐SIR $: ______________ Per Claim/ ______________ Aggregate

2. If you are currently insured on a claims-made policy, are you obtaining Extended Reporting Period (tail) Coverage 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). **Account for all time since medical school. Explain any gaps in your education or professional practice history.** *If your attached CV provides the same information, you may go on to the 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: ______________________

9. 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.

1.	Are you being investigated or 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?	☐ Yes ☐ No
3.	Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis?	☐ Yes ☐ No
4.	Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility?	☐ 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
14.	Have you had or do you currently have any physical or mental condition, illness or defect?	☐ Yes ☐ No

10. 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.**

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

Applicant's 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