SPG SPECIALTY PROGRAM GROUP

MEDICAL PRACTITIONERS APPLICATION
CLAIMS-MADE COVERAGE

PHYSICIANS' ALTERNATIVE SOLUTIONS - NONSTANDARD PHYSICIANS RENEWAL APPLICATION

Carefully read this page and the questions posed in this application. In order for you to be considered for coverage, this application must be completed in full and submitted along with required attachments and/or supplementary information requested throughout the application. ***In order to expedite the underwriting process, please write legibly and ensure that all questions have been fully answered.*** Additional information may be required upon review of the application. If the application does not provide you with sufficient space to properly respond to a question, please write "*see attached*" and respond via separate attachment. Please be sure to sign and date the attachment.

- **The following required attachments must be submitted along with the fully completed RENEWAL APPLICATION.**

☐ Curriculum Vitae/Resume and letterhead **IF CHANGED IN THE PAST 12 MONTHS.**

☐ Formal, up-to-date loss runs from a prior insurance company **IF ANY OF THE FOLLOWING STATEMENTS APPLY:**

- There was an open claim, suit or incident pending with the prior carrier at last year's anniversary;
- An Extended Reporting Period (ERP) Endorsement was purchased from the insurance carrier within the past 5 years;
- Coverage was written on an occurrence basis by the insurance carrier within the past 5 years.

☐ A *CLAIM SUPPLEMENTAL FORM* or comprehensive narrative on your letterhead must be completed for <u>each</u> claim resolved/closed or new claim made, incident surfacing and/or suit brought against you **IN THE PAST 12 MONTHS** *THAT HAS NOT ALREADY BEEN REPORTED TO CNA.*

- **Please contact your insurance agent if you have any questions concerning this application or the coverage for which this application applies.**

NOTE: This is an application for insurance, not an insurance binder. Your application is subject to underwriting review and approval by the company. The effective date, prior acts date (aka retroactive date or nose coverage), and additional classification and/or rating aspects of this application are also subject to approval by the company. No offer of coverage exists unless and until this application is accepted/approved by the company, **<u>and</u>**, you have received written notification of said acceptance.

I. PERSONAL/PROFESSIONAL DATA

Name (last, first, middle)	Designation ☐ MD ☐ DO
Business/Entity Name	

IN THE PAST 12 MONTHS, has there been any change in your practice structure or ownership (solo practitioner, solo incorporated group practice, employee, etc.)? ☐ No ☐ Yes

Current CNA Policy Number: **NSD-**_____	Social Security Number: _____

Primary practice address	City	State	Zip Code	County

Residence address	City	State	Zip Code	County

Office telephone	Office fax	Residence telephone

Do you have any other Practice Locations? ☐ No ☐ Yes If "Yes", please list:	Email

II. MEDICAL SPECIALTY, TRAINING AND LICENSE HISTORY

Please answer all questions completely. If a question does not apply to you, mark "N/A" or "0." Do not leave any questions unanswered. If space is inadequate, use the space provided under Section V. Comments or use your letterhead.

1. Medical specialty: _____ Percentage of practice: _____ **%**

Sub-specialty: _____ Percentage of practice: _____ **%**

A. Do you limit your practice to the above Specialty and/or Sub-specialty? ☐ No ☐ Yes
IF NO, please explain: _____

B. 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? ☐ No ☐ Yes
IF YES, please list procedures/services and note dates of change(s):

C. Have you changed your medical specialty within the past year or do you anticipate doing so in the near future? ☐ No ☐ Yes
IF YES, please provide complete details and note dates of change(s):

2. Number of hours continuing education completed within the past two years: _____ hrs.

3. Please list your Medical Licenses including all active and inactive and your Narcotics/DEA License:

State	License number	Expiration date	Status

Narcotics/DEA License: _____ Status: _____

IN THE PAST 12 MONTHS:

a. Has any State/Medical Board refused you a medical license? ☐ No ☐ Yes
b. Has any State/Medical Board restricted, suspended or revoked your medical license? ☐ No ☐ Yes
c. Has any State/Medical Board imposed a fine or any other obligation? ☐ No ☐ Yes
d. Has any State/Medical Board issued a letter of guidance or public reprimand? ☐ No ☐ Yes
e. Have you voluntarily surrendered a medical license? ☐ No ☐ Yes
f. Has any State/Medical Board placed you on probation or restricted your practice? ☐ No ☐ Yes
g. Is your medical license currently under investigation for <u>any</u> reason in any state? ☐ No ☐ Yes
h. Has your Narcotics/DEA license been surrendered/refused/suspended/revoked (voluntarily or otherwise)? ☐ No ☐ Yes
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? (e.g., AHCA/DPR/Board of Medicine or Health; Medicare/Medicaid; OSHA; EEOC; etc.) ☐ No ☐ Yes

IF YES to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents.

4. IN THE PAST 12 MONTHS:

a. Have you become American Board Certified or Eligible? ☐ No ☐ Yes
b. Has your board certification or membership in any medical association/society been refused, suspended, revoked or voluntarily surrendered? ☐ No ☐ Yes

5. 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? ☐ No ☐ Yes

b. Have you been diagnosed with, or treated for, a chronic physical illness and/or disability? ☐ No ☐ Yes

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? ☐ No ☐ Yes

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).

6. IN THE PAST 12 MONTHS, have you been charged with or convicted of a felony or misdemeanor for **other than** a minor traffic violation? ☐ No ☐ Yes

IF YES, describe circumstances, outcome, dates and attach any relevant documents.

7. IN THE PAST 12 MONTHS, have your hospital privileges been suspended, denied, revoked, restricted or otherwise sanctioned? ☐ No ☐ Yes

IF YES, describe circumstances, outcome, dates and attach any relevant documents.

III. CURRENT MEDICAL PRACTICE

1. Do you employ, supervise or contract with **any other physicians**? ☐ No ☐ Yes

2. Do you employ, supervise or contract with any of the following? ☐ No ☐ Yes

NOTE: For the "**Status**" column, please indicate as follows:
'**E**' = Employee
'**S**' = Supervise only (i.e. not your employee)
'**I/C**' = Independent Contractor

No	Yes		Status: 'E', 'S' or 'I/C'	How many?	No	Yes		Status: 'E', 'S' or 'I/C'	How many?
☐	☐	Aesthetician			☐	☐	Optometrist and/or Optician		
☐	☐	CRNA			☐	☐	Physical Therapist		
☐	☐	Electrologist/Laser Tech			☐	☐	Physician Assistant		
☐	☐	Lay Midwife			☐	☐	Registered Nurse		
☐	☐	Nurse Anesthetist			☐	☐	Scrub Nurse (in OR)		
☐	☐	Nurse Midwife			☐	☐	Surgeon Assistant		
☐	☐	Nurse Practitioner			☐	☐	Med Tech/Other Assistants		
☐	☐	Other: ↔ Description: _____							

3. Which of the following describes your practice?

☐ **No Surgery** — perform neither surgery nor obstetrical procedures. Incising of boils and superficial fascia, suturing or minor lacerations, removal of superficial skin lesions by other than surgical excision and assisting in surgery are not considered surgery.

☐ **Minor Surgery** — applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following medical techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive), tonsillectomies, and adenoidectomies.

Please list types of procedures routinely performed: _____

_____

☐ **Major Surgery** — includes operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen, pelvis or any other operation which because of the condition of the patient or length of the circumstances of the operation presents a distance hazard to life. It also includes: removal of tumors, open bone fractures, amputations, termination of pregnancy, the removal of any gland or organ (excluding tonsillectomies and adenoidectomies), plastic surgery and any operation done using general anesthesia.

Please list types of procedures routinely performed and number per year:_____

_____

4. Provide average number of patients seen per week: _____

5. Is any percentage of your practice devoted to practicing as a locum tenens? ☐ No ☐ Yes **IF YES**, what _____ %

6. Are you professionally associated with (either directly or indirectly) and/or do you provide professional services on behalf of and/or do you have a financial interest in any of following. Please answer all that apply.

No	Yes	Loc. Code #	Location Type	No	Yes	Loc. Code #	Location Type
☐	☐	**01**	Abortion Clinic	☐	☐	**23**	Industrial Firm Medical Care Facility
☐	☐	**02**	Administrative Position	☐	☐	**24**	Inpatient (bed/board) type Facility
☐	☐	**03**	Adult Congregate Living Facility	☐	☐	**25**	Massage Parlor/Establishment
☐	☐	**04**	Adult Day Care type Facility	☐	☐	**26**	Medical Laboratory
☐	☐	**05**	Ambulatory Surgery Center or Surgi-Center	☐	☐	**27**	Military Service (active or reserve)
☐	☐	**06**	Birthing Center	☐	☐	**28**	Nursing Home
☐	☐	**07**	Chemotherapy or Infusion Center	☐	☐	**29**	Occupational or Orthopaedic Rehab Center
☐	☐	**08**	College/University Sports (team or individual)	☐	☐	**30**	Palliative Care
☐	☐	**09**	Cruise Ship	☐	☐	**31**	Paramedical Services
☐	☐	**10**	Day Spa	☐	☐	**32**	Pharmacy
☐	☐	**11**	Developmentally Disabled Facility	☐	☐	**33**	Private Practice
☐	☐	**12**	Dialysis Center	☐	☐	**34**	Psychiatric Facility
☐	☐	**13**	Educational Institution	☐	☐	**35**	Radiology and/or Imaging Center
☐	☐	**14**	Facial Salon	☐	☐	**36**	Rehabilitation Facility
☐	☐	**15**	Fitness Center	☐	☐	**37**	Sanatorium
☐	☐	**16**	Governmental Entity	☐	☐	**38**	Semi or Professional Sports (team or individual)
☐	☐	**17**	Grade or High School Sports (team or individual)	☐	☐	**39**	Tattoo Parlor/Establishment
☐	☐	**18**	Hair Restoration or Laser Hair Removal Clinic	☐	☐	**40**	Urgent Care or E-Care type facility
☐	☐	**19**	Home Health Care Services	☐	☐	**41**	Vein Clinic
☐	☐	**20**	Hospital-Based Practice	☐	☐	**42**	Walk-In Clinic
☐	☐	**21**	Hotel	☐	☐	**43**	Weight Loss Center
☐	☐	**22**	Other(s) ↔ please explain:				

Explain your professional and/or financial relationship with each:_____

_____

_____

7. Do you perform the following procedures?

A.	Elective cosmetic surgery	☐ No	☐ Yes —	% of practice:	%
B.	Itinerant surgery	☐ No	☐ Yes **		
C.	Vaginal deliveries	☐ No	☐ Yes —	# per year:	# of VBACs: _____
D.	Cesarean sections	☐ No	☐ Yes —	# per year:	
E.	Deliveries outside the hospital	☐ No	☐ Yes **		
F.	Abortions	☐ No	☐ Yes —	# per year:	% > 1st Trimester? ☐ No ☐ Yes
G.	Neonatology	☐ No	☐ Yes —	% of practice:	%
H.	Professional/collegiate sports medicine	☐ No	☐ Yes **		
I.	Angiography/arteriography/cardiac catheterization	☐ No	☐ Yes		
J.	Experimental procedures	☐ No	☐ Yes **		
K.	Weight control by drugs/diet only	☐ No	☐ Yes **	% of practice:	%
L.	Bariatric/Weight Control Surgery	☐ No	☐ Yes —	# per year:	
M.	Acupuncture	☐ No	☐ Yes —	% of practice:	%
N.	Botox Injections	☐ No	☐ Yes —	# per year:	
O.	Chemical Peels	☐ No	☐ Yes —	% of practice:	%
P.	Clinical Trials	☐ No	☐ Yes —	% of practice:	%
Q.	Collagen injections	☐ No	☐ Yes —	# per year:	
R.	Colonoscopy	☐ No	☐ Yes		
S.	Needle Biopsies	☐ No	☐ Yes		
T.	Organ Transplants	☐ No	☐ Yes		
U.	Penile Implants	☐ No	☐ Yes		
V.	Reconstructive Plastic Surgery	☐ No	☐ Yes		
W.	Sex change operations	☐ No	☐ Yes		
X.	Laser therapy	☐ No	☐ Yes **		

IF YES to any of the above marked with an asterisk (**), please explain fully under Section V. or on your letterhead.

8. Have you become a **Medical Director** or have you accepted similar type responsibilities for or on behalf of a medical office (not owned be you), hospital, nursing home, sanitarium, out-patient type facility or an entity providing patient / medical related services within the past year or anticipate doing so in the near future? ☐ No ☐ Yes

9. Have you provided professional services on behalf of a **jail, prison, correctional facility, detention center, halfway house** or similar type facility for adults and/or juveniles within the past year or anticipate doing so in the near future? ☐ No ☐ Yes

IF YES, provide total number of hours per month: _____

10. Have you performed/provided consultations, diagnosed and/or treated, provided medical advice and/or opinions, reviewed slides or specimens, prescribed medications, sold any products (as a distributor or for products you make, produce and/or manufacture), or sold any type of services via telecommunications, video, electronic information systems or the Internet? ☐ No ☐ Yes

IF YES, provide details (including list of states in which services were provided) under Section V. or on your letterhead.

11. Have you performed any procedures/surgeries considered to be experimental in nature **and/or** not currently approved by the FDA within the past year or anticipate doing so in the near future? ☐ No ☐ Yes

IF YES, provide details under Section V. or on your letterhead.

12. Have you become involved or associated with any devices (including implants) considered to be experimental? **and/or** not currently approved by the FDA? ☐ No ☐ Yes

IF YES, provide details under Section V. or on your letterhead:

13. Have you worked in a hospital Emergency Room ***other than*** to fulfill requirements for your hospital privileges? within the past year or anticipate doing so in the near future? ☐ No ☐ Yes

IV. CLAIMS HISTORY

1. **IN THE PAST 12 MONTHS**, have there been any claims made, incident surfacing and/or suit brought against you alleging damages resulting from a medical incident? ☐ No ☐ Yes

IF YES, have all such matters been reported to and acknowledged by CNA? ☐ No ☐ Yes

IF YES, have all such matters been reported to and acknowledged by any other insurance carrier? ☐ No ☐ Yes

COMPLETE A CLAIM SUPPLEMENTAL FORM OR A NARRATIVE ON YOUR LETTERHEAD PROVIDING COMPLETE DETAILS.

2. **IN THE PAST 12 MONTHS**, have any claim(s) reported on last year's application been adjudicated, settled, closed, dismissed or otherwise changed in status? ☐ No ☐ Yes

IF YES, please provide details:_____

_____

_____

V. COMMENTS SECTION

Question number	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 does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to $15,000.) (For Colorado Tennessee and Virginia Residents only: Penalties may include imprisonment, fines, denial of insurance benefits and civil damages.)

_____ _____

Signature in Full **Date**

_____

Name - Please print

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

This program is underwritten by and Application is made to one of the CNA Insurance Companies. CNA is a registered service mark of the CNA Financial Corporation.