McARTHUR
INSURANCE AGENCY

12605 Ulmerton Road Largo, FL 33774
Phone 800-982-0398 Fax 800-749-6445
MikeM@McArthurAgency.com

Professional Liability Insurance Specialists

Application for Intergrated Medical Practices

Section 1

1. Name of Corporation(s) to be covered: ____________________

2. Mailing & Location Address: ____________________

____

3. Main Office Contact: ____________________ Phone#: ____________________

   Email Address: ____________________

4. Website Address(es): (if applicable) ____________________

5. Date Established: (mm/dd/yy) ____________________ 6. Tax ID number for Corp ____________________

7. Is this entity owned by, associated with or controlled by any other entity or are you part of a franchise? Yes No If yes please explain: ____________________

____

8. Do you provide services at a location other than the one listed above? Yes No If yes please explair

____

9. Does the Applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? Yes No

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship, and information on their insurance program(s):

____

____

10. Effective Date: ____________________ Retroactive Date: ____________________

11. Limits of Liability Requested ____________________

Section 2: Provider Information

Chiropractors to be covered under policy:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Please complete the chiropractic provider supplemental application for each provider listed above and include a copy of their Resume, License and Current Certificte of Insurance

Physicians to be covered under policy:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Please complete the Physicians Application for each provider listed above and include a copy of their Resume, License and Current Certificte of Insurance

PA, ARNP, NP, MSN, LMT to be covered under policy:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Please complete the Ancillary Personel Application for each provider listed above and include a copy of their Resume, License and Current Certificte of Insurance

Section 3 Practice Information

1. Will you be doing injections of stem cells? Yes No Number Annually ________

2. Will you be doing IV Infusions of stem cells? Yes No Number Annually ________

3. What type of stem cell treatments will you be doing?

____

4. What type of stem cells will you be adminstering and who will be doing the treatments?

____

5. What company will you be purchasing the stems cells from?

____

6. What type of storage are you using for the stem cells and what is your procedure for handling then

____

7. If you practice Functional medicine what conditions are you treating with Functional Medicine?

____

8. Will you be treating patients as a primary clinic for them? Yes No

9. Will you be accepting Health Insurance? Yes No

10. Describe in detail all of your professional services and indicate the percentage of gross receipts/ revenues derived from each activity:

Chiropractic Services ________________________________

General Medical Care ________________________________

Stem Cell Treatments ________________________________

Miscellanous ________________________________

11. Number of patient visits annually Last Year ________ Upcoming Year ________

12. Revenue for practice annually Last Year ________ Upcoming Year ________

13. Do you require all of your independent contractors to carry professional liability? Yes No

14. Do you want all Independant conrtractors added to this policy? Yes No if yes please make sure to add them to the list in section 2

15. Are all of the above noted employees and independent contractors licensed in accordance with applicable state and federal regulations? Yes No

16. Do you have a Medical Director? Yes No

a. Name of Medical Director ______

b. What is the Specialty of you Medical Director ______

c. Will the medical director be doing direct patient care Yes No

d. Does the Medical Director have supervisory duties over your allied healthcare professionals?

Yes No

e. Do you want the direct patient care for the medical director covered under this policy? Yes No

17. Has the Applicant or any of the above employees and/or independent contractors:

a. Ever been the subject of a disciplinary or investigative proceeding or been reprimanded by a governmental or administrative agency, hospital or professional association? Yes No

b. Ever been convicted of a criminal act other than traffic offenses? Yes No

c. Ever been treated for alcoholism or drug addiction? Yes No

d. Ever had any professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered such license? Yes No

If Yes to any of the above questions, please explain: ______

______

18. Is anesthesia (other than topical or by means of local infiltration) administered by, for or at the Applicant's facility? Yes No If yes please describe: ______

______

19. Does the Applicant sell any products? Yes No If yes please describe: ______

______

20. Does the Applicant have a training school or provide internships? Yes No

If yes please describe: ______

21. Does the Applicant participate in any clinical trials? Yes No If yes please describe: ______

______

Section 4 Risk Management

22. Do you have Risk Management Program in place? Yes No

23. Are background checks performed on all employees, independent contractors and volunteers? Yes No

24. Are all employees, independent contractors and volunteers screened for drugs and alcohol? Yes No

25. How are patients referred to the Applicant? ______________________________

26. Do you have a policy to prevent sexual abuse or allegations of sexual abuse? Yes No

27. Please describe security measures and procedures used to protect private data: __________

____

28. Do you utilize encryption for data stored and data transmitted? Yes No

29. Are your computer systems and networks actively monitored for security breaches? Yes No

30. Have you ever experienced a security breach, data loss event or denial of service attack? Yes No

31. Do you do your own medical billing? Yes No

32. Are you subject to HIPAA regulation? Yes No Are you HIPAA compliant? Yes No

Section 5 Coverage History

33. Please provide the following information as respects the last five years of PROFESSIONAL LIABILITY coverage beginning with the most current coverage: (If none, state NONE)

Carrier	Limit	Deductible	Premium	Policy	Term	Retro Date

Section 6 Claims History

34. Has any application for professional liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, cancelled or have any policies beennon-renewed? Yes No If yes please describe: ______________________________

____

35. Has any claim ever been made against the Applicant or any of its employees? Yes No
If yes please describe:____

____

36. Is the Applicant aware of any errors, omissions, circumstances or incidents which may result in a claim being made against them or their employees, or are there any claims that have not yet been reported? Yes No If yes please describe: ____________________

____

50. Have any of the Applicant's employee(s) or independent contractors been the subject(s) of alleged or actual incidents regarding sexual abuse or molestation or child abuse/neglect? Yes No If yes please describe: ________________________

____

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

1) I have no known losses or claims that have not been reported to my prior insuracne carrier or any other source from which payment might be made.
2) I have no knowledge of act, omissions or circumstances that relate to a professional service which could resonably result in a claim, that has not been reported to a prior insurance carrier
3) I have no knowledge of any request fro medical records by a patient or their attorney which might result in a claim
4) I have no knowledge or information relating to service or services on a Board which might result in a claim
5)I have no knowledge of any prior professional liability carrier refusing for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional services that may result in a claim, threat of claim, letter of intent, adverse result or attorney contact.

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 fact. 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: ____________________

Applicants Signature: _______________________ Date: ____________________

Agent/Broker Name: ____