

**International Placement Services, Inc.**

101 S. Hanley Rd., Ste 700  
 St. Louis, MO 63105

**CLINIC APPLICATION  
 CLAIMS-MADE COVERAGE**

**I CLINIC PROFILE**

Clinic Name _____				
Primary address	City	State	Zip Code	County
Mailing address	City	State	Zip Code	County
Telephone number	Fax number		Tax I.D. number	

Names and description of all legal entities (indicate below if entity to be insured.)

Name	Description	Entity type e.g., corp. partnership	To be insured?		Prior Acts date (if prior acts coverage is requested)
			Yes	No	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	

**PLEASE ATTACH A COPY OF YOUR CURRENT POLICY DECLARATIONS PAGE AND BUSINESS LETTERHEAD.**

**Desired policy dates**

Effective date: \_\_\_\_\_

Prior Acts date: \_\_\_\_\_

**Desired policy dates**

Professional Liability \_\_\_\_\_ each claim/ \_\_\_\_\_ aggregate

Excess Limits \_\_\_\_\_ each claim/ \_\_\_\_\_ aggregate

Deductible/  Sir Amount \_\_\_\_\_

**COMPANY/AGENCY USE ONLY**

Territory	Dec ISO	PLD code	Policy number	Producer number
Step	Account number		Producer's name	

Please answer all questions completely. If a question does not apply to you, write "NA." Do not leave any questions unanswered. If space is inadequate, use the comments section or attach a separate sheet.

Main location	Street	City	State	Zip Code
<input type="checkbox"/> Owned <input type="checkbox"/> Leased	Square Feet	Number of Floors	Date acquired	
Type of Operation			Hours of Operation	
Location no. 2	Street	City	State	Zip Code
<input type="checkbox"/> Owned <input type="checkbox"/> Leased	Square Feet	Number of Floors	Date acquired	
Type of Operation			Hours of Operation	
Location no. 3	Street	City	State	Zip Code
<input type="checkbox"/> Owned <input type="checkbox"/> Leased	Square Feet	Number of Floors	Date acquired	
Type of Operation			Hours of Operation	
Location no. 4	Street	City	State	Zip Code
<input type="checkbox"/> Owned <input type="checkbox"/> Leased	Square Feet	Number of Floors	Date acquired	
Type of Operation			Hours of Operation	

1. a. Does clinic own property that is leased to other entities?  No  Yes
- b. Clinic entity was established: \_\_\_\_\_
- c. Length of time at main location: \_\_\_\_\_
- d. Within the next 12-month period, does the clinic plan to:
  - obtain another clinic or entity?  No  Yes
  - add to the number of physicians?  No  Yes
  - expand the number of locations?  No  Yes

2. Is the clinic a party to any agreement or contract with any entity other than the legal entities listed on page one?  
 No  Yes — List entities \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. a. Patient mix: 1. Fee for service \_\_\_\_\_ 3. Medicaid \_\_\_\_\_  
 2. Pre-paid/capitated \_\_\_\_\_ 4. Other \_\_\_\_\_  
 b. Please provide explanation for "other."

- c. Average weekly patient load: \_\_\_\_\_ Percentage of transient patients: \_\_\_\_\_
4. How many pre-paid/capitated contracts has the clinic entered into? \_\_\_\_\_
5. Do any contracts restrict the clinic's primary care physician's ability to refer to other physicians/surgeons? \_\_\_\_\_  
 No  
 Yes
6. Do you have procedures in place to follow-up with patients who have been referred to other physicians/surgeons?  
 No  
 Yes
7. Does clinic attract patients because of reputation in any particular field of medicine?  No  Yes  
 If yes, please specify. \_\_\_\_\_
8. Does clinic own, control or staff any of the following?  No  Yes
- |   |  |                       |  |
|---|--|-----------------------|--|
| a. Clinic with inpatient facilities       | <input type="checkbox"/> No <input type="checkbox"/> Yes | g. E.C.T.             | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| b. Hospital                               | <input type="checkbox"/> No <input type="checkbox"/> Yes | h. Radiation facility | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| c. Surgicenter/office with surgical suite | <input type="checkbox"/> No <input type="checkbox"/> Yes | i. Laboratory         | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| d. Emergency room                         | <input type="checkbox"/> No <input type="checkbox"/> Yes | j. Emergency vehicles | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| e. Birthing center                        | <input type="checkbox"/> No <input type="checkbox"/> Yes | k. Pharmacy           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| f. Substance abuse programs               | <input type="checkbox"/> No <input type="checkbox"/> Yes | l. Abortion facility  | <input type="checkbox"/> No <input type="checkbox"/> Yes |

**II INSURANCE HISTORY**

9. Carrier information	Current carrier	First prior carrier	Second prior carrier
Insurance company			
Coverage form	<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence
Policy Period			
Limit of liability per per claim/aggregate			
Deductible or S.I.R. and amount	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R.	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R.	<input type="checkbox"/> Deductible <input type="checkbox"/> S.I.R.
Prior Acts date			

10. Has your insurance for medical malpractice ever been canceled, suspended, non-renewed or declined?  
 No  Yes — Explain: \_\_\_\_\_
11. Have you ever had professional liability insurance provided by CNA?  No  Yes

**II INSURANCE HISTORY (continued)**

12. If you are currently insured by a claims-made policy:

- A. Are you obtaining an extended reporting endorsement from your current insurance company?  No  Yes
- B. Is Prior Acts coverage being requested?  No  Yes  
 If yes, show Prior Acts effective date \_\_\_\_\_ and **attach a copy of your most recent policy declaration page.**

**NOTE: To prevent possible gaps in your Claims-Made coverage, either Extended Reporting or Prior Acts coverage must be purchased**

**III CLINIC STAFF**

13. Administration

- a. Name of chief executive officer: \_\_\_\_\_
- b. Name of medical director: \_\_\_\_\_
- c. Name of administrator/risk manager: \_\_\_\_\_

14. a. Physicians (Individual applications required - Use form G-119639-A (new business) or G-121045-A (renewal))

**Please indicate the number of:**

- Full-time physicians  
 Part-time physicians  
 Dentists  
 Total

Current year	First prior year	Second prior year
_____	_____	_____
_____	_____	_____
_____	_____	_____
0	0	0

14. b. Do any of the people listed above have coverage independent of you?  No  Yes

15. a. Indicate the number and type of your ancillary staff. If any type A employee is to be provided with separate limits of coverage, check the box. The Ancillary Personnel application must be completed for each person with separate limits and an additional charge will apply. Separate limits of liability are not available to type B personnel.

Type A	Number	X	Type B	Number
H/L perfusionist	_____	<input type="checkbox"/>	Audiologist	_____
Nurse anesthetist	_____	<input type="checkbox"/>	Dental hygienist	_____
Nurse midwife	_____	<input type="checkbox"/>	Full-time medical student	_____
Nurse practitioner	_____	<input type="checkbox"/>	Medical aide	_____
O/R technician	_____	<input type="checkbox"/>	Medical lab technician	_____
Paramedic	_____	<input type="checkbox"/>	Nurse (RN & LPN)	_____
Physician assistant	_____	<input type="checkbox"/>	Optometrist/optician	_____
Scrub nurse	_____	<input type="checkbox"/>	O/R technician (set-up only)	_____
Surgeon assistant	_____	<input type="checkbox"/>	Pharmacist	_____
		<input type="checkbox"/>	O/R technician (set-up only)	_____
		<input type="checkbox"/>	Pharmacist	_____
		<input type="checkbox"/>	Physical therapist	_____
		<input type="checkbox"/>	Physiotherapist	_____
		<input type="checkbox"/>	Podiatrist	_____
		<input type="checkbox"/>	Psychologist	_____

**III CLINIC STAFF (continued)**

- Research PhD \_\_\_\_\_
- Scrub nurse (set-up only) \_\_\_\_\_
- X-ray technician \_\_\_\_\_
- Other (please list) \_\_\_\_\_

15. b. Are any of the people listed above independent contractors?  No  Yes — List and provide certificates of insurance: \_\_\_\_\_
16. Are all physicians, surgeons, dentists and medical personnel in this group practice duly licensed/certified to practice medicine in your state? If no, please provide reason on your letterhead.  No  Yes

**IV RISK MANAGEMENT**

17. Risk management
- a. Does the clinic have a risk management program?  No  Yes
  - b. Does the formal process exist for:
    - Peer review  No  Yes
    - Credentialing  No  Yes
    - Quality improvement  No  Yes
    - Safety  No  Yes
  - c. Are fee-related complaints investigated before being forwarded to a collection agency?  No  Yes
  - d. Does the clinic provide time off and reimbursement for CME classes?  No  Yes
  - e. Are any research or teaching programs conducted?  No  Yes
  - f. Do you have written guidelines for obtaining informed consent from your patients?  No  Yes  
If yes, please describe. \_\_\_\_\_

18. New physicians
- a. Do you perform background investigation into:
    - 1. Claim history  No  Yes
    - 2. Medical and narcotics licenses  No  Yes
    - 3. Hospital privileges  No  Yes
  - b. Are all physicians required to be board certified or qualified?  No  Yes  
If no, please explain. \_\_\_\_\_

19. Accreditation
- a. Are you a member of a national organization?  
MGMA \_\_\_\_\_ AGPA \_\_\_\_\_ Other \_\_\_\_\_
  - b. Is the entity certified or accredited by any of the following?  
AAAHC \_\_\_\_\_ ARC \_\_\_\_\_ CAP \_\_\_\_\_ JCAHO \_\_\_\_\_ Other \_\_\_\_\_

20. Does clinic edit or sell publications, video tapes or other media?  
Explain \_\_\_\_\_

### V CLAIM HISTORY

21. Has any claim or suit for alleged malpractice ever been brought against the clinic or any ancillary personnel or are you aware of any circumstances that might lead to such a claim or suit?

No  Yes — Complete the following claims questionnaire. If you need more space, use comments section or attach an additional sheet.

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence

Allegations

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Clinic named? <input type="checkbox"/> No <input type="checkbox"/> Yes	Ancillary personnel named? <input type="checkbox"/> No <input type="checkbox"/> Yes Which ones?
<input type="checkbox"/> Claim open.	Amount paid on your behalf
<input type="checkbox"/> Claim closed.	Amount reserved on your behalf?

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence

Allegations

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Clinic named? <input type="checkbox"/> No <input type="checkbox"/> Yes	Ancillary personnel named? <input type="checkbox"/> No <input type="checkbox"/> Yes Which ones?
<input type="checkbox"/> Claim open.	Amount paid on your behalf?
<input type="checkbox"/> Claim closed.	Amount reserved on your behalf?

**V CLAIM HISTORY (continued)**

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence
Allegations	

Clinic named? <input type="checkbox"/> No <input type="checkbox"/> Yes	Ancillary personnel named? <input type="checkbox"/> No <input type="checkbox"/> Yes Which ones?
<input type="checkbox"/> Claim open.	Amount paid on your behalf
<input type="checkbox"/> Claim closed.	Amount reserved on your behalf?

Patient's name	Date of occurrence
Insurance carrier	Location of occurrence
Allegations	

Clinic named? <input type="checkbox"/> No <input type="checkbox"/> Yes	Ancillary personnel named? <input type="checkbox"/> No <input type="checkbox"/> Yes Which ones?
<input type="checkbox"/> Claim open.	Amount paid on your behalf?
<input type="checkbox"/> Claim closed.	Amount reserved on your behalf?

**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.

*For FL, KY, MN, NJ, NY, OH and OA 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.

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**Signature in Full**

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**Date**

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**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 CNA. CNA is a registered service mark of the CNA Financial Corporation.