McARTHUR INSURANCE AGENCY

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MikeM@McArthurAgency.com
Professional Liability Insurance Specialists

Application for Integrated Medical Practices

Section 1

1. Name of Corporation(s) to be covered: _____
   - Please provide article of incorporation

2. Mailing & Location Address: _____

3. Main Office Contact _____ Phone#: _____

Email Address _____

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?
   - ☐ No
   - ☐ If yes, please explain _____

8. Do you provide services at a location other than the one listed above?
   - ☐ No
   - ☐ If yes, please explain _____

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?
   - ☐ 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 Certificate 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 Certificate of Insurance.

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

1._____

2._____

3._____

4._____

5._____

Please complete the Ancillary Personnel Application for each provider listed above and include a copy of their Resume, License and Current Certificate of insurance.

Section 3 Practice Information

1. Alternative Therapies	☐ Yes	☐ No
2. Cosmetic - Anti-aging	☐ Yes	☐ No
3. Hormone Therapy	☐ Yes	☐ No
4. Stem Cell Therapy	☐ Yes	☐ No
5. Stem Cell Harvesting	☐ Yes	☐ No
6. Chelation Therapy or other Heavy Metals	☐ Yes	☐ No
7. HCG	☐ Yes	☐ No
8. Hyperbaric Oxygen Therapy	☐ Yes	☐ No
9. Massage or Manipulation	☐ Yes	☐ No
10. Ozone Therapy	☐ Yes	☐ No
11. IV drip of any kind	☐ Yes	☐ No
12. O and or P shot	☐ Yes	☐ No
13. PRP	☐ Yes	☐ No
14. Weight Loss	☐ Yes	☐ No

Please explain with specificity all YES answers and annual number of 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 them?__
_____

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 your professional services and indicate the percentage of gross receipts/ revenues derived from each activity:

Chiropractic Services_____
General Medical Care_____
Stem Cell Treatments_____

Miscellaneous

11. Number of patient visits annually

Last Year_____ Upcoming Year_____

12. Revenue for practice annually

Last Year_____ Upcoming Year_____

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

14. Do you want all independent contractors added to this policy?
- ☐ No
- ☐ If yes, please make sure to add them to the list in section 2

15. Are all the above noted employees and independent contractors licensed in accordance with applicable state and federal regulations?

- ☐ Yes
- ☐ No

16. Do 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?

- ☐ No
- ☐ If yes, please describe:_____

19. Does the Applicant sell any products?
- ☐ No
- ☐ If yes, please describe: _____

20. Does the Applicant have a training school or provide internships?
- ☐ No
- ☐ If yes, please describe: _____
_____

21. Does the applicant participate in any clinical trials?
- ☐ 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?

- ☐ If Yes, are you HIPAA compliant?_____
- ☐ 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 been non-renewed?

- ☐ If Yes, please describe _____
- ☐ No

35. Has any claim ever been made against the Applicant or any of its employees?

- ☐ If Yes, please describe_____
- ☐ No

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?

- ☐ If Yes, please describe_____
- ☐ No

37. 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?

- ☐ If Yes, please describe_____
- ☐ No

Stem Cell Questionnaire

38. Do you do any stem cell transplantation or treatments *other than* autologous?If No, please skip to question 6 ○ Yes ○ No

39. (a) What type of stem cell products are you using?

(b) Are all of the above-listed stem cell products FDA approved? ○ Yes ○ No

40. Are any of the stem cell products you use allogeneic ☐ or ☐ heterologous?

41. From whom do your purchase your stem cell products? List all vendors and confirm that all are US based, FDA registered, CGMP compliant manufacturers.

☐ US based ☐ FDA registered ☐ CGMP compliant manufacturers

42. Have you verified that all of the stem cell products you use have been tested for viral, bacterial or fungal infections? ○ Yes ○ No

43. a) What type of stem cell procedures/treatments are being performed including which ailment or condition are they meant to treat?

b) Have such procedures undergone clinical trials and have they been FDA approved? Please provide details. ○ Yes ○ No

44. What are the credentials of the practitioners who will be performing the stem cell therapy/treatment? Please provide any training documentation.

45. Do you process and use the stem cells during the same visit in which they were collected? Yes No
If No, do you have a formal chain of custody procedure to make sure collected stem cells are only used by the donor?
Please provide details.

46. What type of laboratory stem cell processing equipment do you use?Is it FDA approved? Yes No

47. Is the clinic adequately prepared to handle emergencies such as a serious adverse reaction to such treatment? Yes No

48. Are you or any of your employees or physicians currently participating in stem cell treatment related clinical trials? Yes No
If yes, please provide complete details.

49. Do you use an informed consent for every stem cell treatment you offer? Please attach copies.

Yes No

50. Do you advertise your stem cell treatments anywhere other than your website?If yes, please provide details and copies of all advertising materials related to stem cells.

Yes No

51. Do you or your principals have ownership interest in any other stem cell related businesses such as research facilities or manufacturing operations?

If yes, please provide complete details.

Yes **No**

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

1) I have no known losses or claims that have not been reported to my prior insurance 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 reasonably result in a claim, that has not been reported to a prior insurance carrier
3) I have no knowledge of any request for 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)1 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:_____