Policy Number: _____

DEPARTMENT OF HEALTH SELF-INSURANCE RETENTION PROGRAM

HEALTH CARE PROFESSIONAL/ HEALTH CARE ENTITY LIABILITY INSURANCE APPLICATION

Application Instructions

A. If additional space is needed, please complete Section VIII. Supplement information with a reference to the question.

B. For coverage to exist you must make separate application for any ancillary activity conducted by any separate entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture. ***Additional documentation pertaining to the entity's existence and operations may be requested by the DOH Self-Insurance Retention Program any as necessary.*** For example: Articles of Incorporation, Declaration Page, copy of your most recent entity professional liability policy (including all endorsements), etc.

C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

D. Coverage desire and please initial; **Health Care Professional** ◯____ **Health Care Entity** ◯_____ **Both** ◯ _____

E. I will **NOT** purchase the Department of Health Self Insurance Retention Program Malpractice. By refusing coverage, I understand that I will have to seek and purchase coverage of my own. Please attach proof of Insurance and Sign Here_____

I. Personal Information

A. Last Name, First Name , Middle Initial

Entity Name(s):

Federal Tax I.D. Number

National Provider Identifier Number

Contact's Last Name:

Contact's First Name:

Contact's Title:

Email address:

Business Phone: - -

Business Fax: - -

B. As stated in the Articles of Incorporation and all formal entity/clinic names. Please provide Articles of Incorpoaration to ensure accurate coverage.

Entity Name(s):

Federal Tax I.D. Number -

National Provider Identifier Number

Date Entity Formed: /
MM YYYY

C. If you have a web address, please provide the website address (URL): _____

D. Type of Legal Entity: (Please enter an "X" in the applicable spaces. At least one type must be selected.)

- ☐ Professional Corporation - sole shareholder
- ☐ Professional Corporation - multiple shareholders
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Company (LLC) or Limited Liability Partnership (LLP)
- ☐ General Business Corporation
- ☐ For Profit
- ☐ Not for Profit
- ☐ Other (please explain): _____

E. Type of Organization/Business Practices: (Please enter an "X" in the applicable spaces. At least one type must be selected.)

- ☐ Abortions
  - ☐ Therapeutic - Number Per Year:
  - ☐ Elective - Number Per Year:
- ☐ AIDS/ARC
- ☐ Alternative Medicine (Integrative/Complimentary)
- ☐ Anesthesia
- ☐ Bariatrics
- ☐ Behavioral Health /Psychiatric Facility
- ☐ Blood Banks
- ☐ Cancer Center
- ☐ Community Based Health Center
- ☐ Cosmetic Surgery
- ☐ Dental Services
- ☐ Dialysis Center
- ☐ Emergency Medicine
- ☐ Family Medicine
- ☐ Gastroenterology
- ☐ General Hospital
- ☐ Home Health Care
- ☐ Hospice
- ☐ Internal Medicine
- ☐ Laboratory
- ☐ Managed Care Organization
- ☐ MRI/X-Ray Imaging
- ☐ Nursing Home
- ☐ Obstetrics
- ☐ Ophthalmology
- ☐ Osteopathic Manipulation Therapy
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Plastic Surgery
- ☐ Radiation Therapy
- ☐ Radiology
- ☐ Surgical Center
- ☐ Sports Medicine
- ☐ Surgical Center
- ☐ Urology
- ☐ Urgent Care
- ☐ Wound Care
- ☐ Other (please explain): _____

I. Entity Information

F. Are you insured with another insurance company? ☐ Yes ☐ No

If yes, please provide the Individual, Corporation, or Partnership policy and group number if known.

Policy#: Group#: Sub-Group#:

G. Practice Location(s): (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. **% of practice**
Number & Street
Suite City State Zip Code -
County

2. **% of practice**
Number & Street
Suite City State Zip Code -
County

3. **% of practice**
Number & Street
Suite City State Zip Code -
County

H. Billing and Correspondence Address:

☐ Location # (from Question G above): ☐ Other (Please enter below)

Number & Street Suite
City State Zip Code -

I. Other than the Virgin Islands, which state or territory are you authorized to practice?

State of Incorporation: Certificate(s) of Authority: , , , , , , ,

II. General Information

A. Have you or your entity or any of your employees:

1. Ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental licensure board or administrative agency, hospital or professional association? ☐ Yes ☐ No
   If yes, please provide individual(s) involved, date and explanation.
   Individual(s): _____ Date: MM / YYYY
   Explanation: _____

2. Ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, medical license, or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No
   If yes, please provide individual(s) involved, date and explanation.
   Individual(s): _____ Date: MM / YYYY
   Explanation: _____

3. Ever had any professional liability insurance refused, declined, canceled or non-renewed by the insurance company? ☐ Yes ☐ No
   If yes, please provide individual(s) involved, date and explanation.
   Individual(s): _____ Date: MM / YYYY
   Explanation: _____

II. General Information (continued)

B. Do you or the entity own or operate any laboratory? ☐ Yes ☐ No

If yes, is the laboratory providing services solely for your patients? ☐ Yes ☐ No

If no, please explain: _____

C. Will you or the entity be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, practice name, location and insurer name.

Practice Name: _____

Location: _____

Name of Insurer: _____

D. Have you or the entity performed any contract work for or entered into any contract or agreement (written or oral) with any entity/city/county/state/federal agency/clinic including providing care at correctional facilities, prisons, mental health facilities, Veteran's Administration, university, military or indigent care, etc.? ☐ Yes ☐ No

If yes, please explain: _____

_____

E. Please include estimated annual numbers:

Clinic visits: ☐☐☐☐☐☐

Surgeries: ☐☐☐☐☐☐

Gross Revenue: $ ☐☐☐ , ☐☐☐ , ☐☐☐

F. In the last 10 years:

1. Have you or the entity or any of the employees discontinued major surgical procedures, performance of Obstetrics, or any other medical activity? ☐ Yes ☐ No

   If yes, list procedures/activities, reason for discontinuing, and date discontinued. Date: ☐☐ / ☐☐☐☐ (MM / YYYY)

   _____

   _____

   _____

2. Have you or any of the entity's employees performed weight control surgery or prescribed weight control medication? ☐ Yes ☐ No

   a. If yes, what percentage of the practice (% of patient care) was devoted to prescribing anorectic drugs?

   ☐ <1% ☐ 1% - 10% ☐ 11% - 50% ☐ > 50% ☐ Never prescribed anorectic drugs

   b. If yes, what percentage of the practice (% of patient care) was devoted to performing weight control surgery?

   ☐ <1% ☐ 1% - 10% ☐ 11% - 50% ☐ > 50% ☐ Never performed weight control surgery

G. Do you or the entity or any of the physicians working have ownership or financial interests in a weight control clinic? ☐ Yes ☐ No

If yes, what is the name of the weight control clinic with which the entity or physicians are affiliated? _____

_____

III. Anesthesia Information

A. As defined below, please enter an "X" if a shareholder/partner, employee or independent contractor treats patients under:

☐ **Conscious Sedation (excluding Nitrous Oxide)** utilizing a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

☐ Oral ☐ IM/IV

☐ **General Anesthesia (to include deep sedation)** utilizing a controlled state of depressed consciousness or unconsciousness, accompanied by partial or completed loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

If Conscious Sedation or General Anesthesia was checked, please complete the Anesthesia Supplement.

B. ☐ **Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar), or nitrous oxide only. Please continue to Section IV.**

IV. Roster of Staffing

A. Please identify all owners, employed and contracted individuals within your organization, and provide information concerning each member in each category listed in the following table:

Note: Include all applicant(s), all healthcare provider(s), and non-healthcare owner(s).

Individual Status: (Column 5)

A. Applying for coverage elsewhere or covered elsewhere.
B. Shared Limit Coverage with entity for Healthcare Professionals, other than physicians or dentists.
C. Other

	1. Last name first, then first and middle initials (i.e. Smith, J. G.)	2. Degree	3. Specialty (Write In)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status- A,B,C, D, or E (See key above)	6. Past Insurance Policy Number
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

B. Please provide an explanation as to why coverage is not requested for any individuals where Individual Status is C on Roster.

Number from Roster:	Explanation:

V. Loss Information

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below in which the entity's policy was triggered and has **NOT** been covered.

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Have you or your entity involved now or has it ever been involved in a claim or suit arising out of the rendering or failure to render professional services?

If **yes**, how many? ☐☐☐ None ☐

B. Have you or your entity aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes, but is not limited to, the following:

► Amputation ► Death ► Loss of major organ function ► Loss of vision ► Permanent neurological injury

If **yes**, how many? ☐☐☐ None ☐

C. In the last 12 months, have you or your entity received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit?

If **yes**, how many? ☐☐☐ None ☐

VI. Coverage Information

Notes:

1. Occurence coverage is generally limited to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact DOH Self-Insurance Retention Program should you have any questions pertaining to claims made.

A. Coverage Desired:

Occurrence coverage

coverage

B. Requested Coverage Period (12:01 am): **From:** ☐☐ / ☐☐ / ☐☐☐☐ **To:** ☐☐ / ☐☐ / ☐☐☐☐
Annual policy term will begin and end on the same month and day. MM DD YYYY MM DD YYYY

C. The retroactive date shown on your current policy is: ☐☐ / ☐☐ / ☐☐☐☐
(This date is required for Occurrence with prior acts .) MM DD YYYY

D. Desired Limits: Per Occurrence Filed ☐☐☐, ☐☐☐, ☐☐☐ Annual Aggregate ☐☐☐, ☐☐☐, ☐☐☐

E. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.

1. Current Insurer: _____

☐ Occurrence Coverage From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY MM DD YYYY

2. Previous Insurer: _____

☐ Occurrence Coverage From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY MM DD YYYY

3. Previous Insurer: _____

☐ Occurrence Coverage From: ☐☐ / ☐☐ / ☐☐☐☐ To: ☐☐ / ☐☐ / ☐☐☐☐
MM DD YYYY MM DD YYYY

VII. Notices and Agreements

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments **(hereinafter "Attachments")** for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with Department of Health Self Insurance Retention Program. I agree to notify the Unit if there are any future material changes in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the DOH Self-Insurance Retention Program has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the DOH Self-Insurance Retention Program. has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the DOH Self-Insurance Retention Program until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the DOH Self- Insurance Retention Program may wish to contact persons, hospital, school employers, inusrance agents, professional liability insureres or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issurance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release the DOH Self-Insurance Retention Program any informaion regarding me, which the DOH Self-Insurance Retention Program, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder. I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and VI privacy protection statutes and regulations.

By signing this application on behalf of an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I warrant that I am an Officer, Partner, Office Administrator or other Authorized Representative of the entity applying for coverage.

Application must be signed by a Health Care Professional, President, Chief Executive Officer, or other Officer or Partner of a PC or PA or the Office Administrator or equivalent Authorized Representative.

Certification

Please take note that Title 14 Virgin Islands Code § 843 prescribes criminal penalties for knowingly making a materially false statement on this Government of the Virgin Islands insurance application that an applicant either knew was false or demonstrated a reckless disregard for the truth with a conscious purpose to avoid learning the truth. I hereby certify that I have carefully read this application, and that this application was completed by me, the undersigned. The information contained herein and attached hereto are true and correct and are made for the purpose of determining my eligibility for medical malpractice insurance.

_____
Authorized Representative Signature

Date Signed: __ / __ / ____
MM DD YYYY

_____
Print Name

_____
Health Care Professional Name
(Print Name)

_____
License Number of Health Care Professional

If application is being signed by the applicant's representative: By my signature, I hereby represent that the applicant has granted me full authority to execute this application on his or her behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that applicant understands and agrees that such representations are binding upon him or her, even though I am executing this application on the applicant's behalf. I further acknowledge that any material misrepresentation or omission made on this application may form the basis for the company to terminate my agency agreement with cause.

_____
Authorized Representative Signature

Date Signed: __ / __ / ____
MM DD YYYY

_____
Print Name

VIII. Supplemental Information

Department of Health Self-Insurance Retention Program

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

Note: Additional documentation may be requested at Department of Health's discretion.

A. Is the matter related to: **A** ☐ **B** ☐ **C** ☐ **from the Loss Information section? (Check only one)**

A. Current or prior claim.

B. Complication, incident, or adverse outcome.

C. Written request for records.

B. Patient/Claimant Information:

Last Name _____ First Name _____ Age ____

C. Date of treatment and/or surgery which led, or could lead, to allegations against you. ____ / ____ (MM / YYYY)

D. Date of notice received, if applicable. ____ / ____ (MM / YYYY)

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer: ____ / ____ (MM / YYYY)

Current or former insurer name: _____

If no, please explain: _____

_____

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. _____

_____

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $ _____

If closed:

1. Date of closing: ____ / ____ (MM / YYYY)

2. Was a payment made? ☐ Yes ☐ No

a. If yes, did you consent to the settlement? ☐ Yes ☐ No

b. Total amount of settlement or award: $ _____

c. Total amount of settlement or award paid on your behalf: $ _____

H. Nature of allegations or potential allegations:

Condition Treated: _____

Treatment Provided: _____

Alleged Negligence: _____

Alleged Injury: _____

I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

_____

_____

_____

_____

_____

Department of Health Self-Insurance Retention Program

Anesthesia Supplement

Please make copies if additional forms are needed.

Applicant's Name: _____

A. Number of: **Anesthesiologists** ☐☐ **CRNAs** ☐☐

B. Other than Anesthesiologists or CRNAs, list anyone who administers anesthesia or conscious sedation:

_____

_____

_____

C. Are all the CRNAs supervised on site by an anesthesiologist? ☐ Yes ☐ No

D. Is the anesthesia provider currently licensed in your state? ☐ Yes ☐ No

If no, please explain: _____

E. Are all individuals who administer the sedation certified in one or more of the following? ☐ Yes ☐ No

☐ CPR ☐ ACLS ☐ ATLS ☐ PALS

If no, please explain: _____

F. Are all Anesthesiologists required to be board-certified/eligible in Anesthesiology? ☐ Yes ☐ No

G. Please indicate who administers conscious sedation?

☐ MD/DO ☐ RN/LPN
☐ AA/NA/CRNA ☐ Other (specify):_____

Where is conscious sedation performed?

☐ Office ☐ Licensed Surgical Center
☐ Hospital ☐ Other (specify):_____

For:

☐ Own Patients
☐ Other than own patients

H. Please indicate who administers general anesthesia?

☐ MD/DO ☐ RN/LPN
☐ AA/NA/CRNA ☐ Other (specify):_____

Where is general anesthesia performed?

☐ Office ☐ Licensed Surgical Center
☐ Hospital ☐ Other (specify):_____

For:

☐ Own Patients
☐ Other than own patients

I. Is the office certified for general anesthesia by a state organization? ☐ Yes ☐ No

If administered outside of a hospital or a licensed surgery center, please answer Questions J through P.

J. How often does your staff participate in simulated emergency training?

Every: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: _____

K. What American Society of Anesthesiology (ASA) categories are treated? _____

L. How often does your practice update health histories?

☐ Every_____Month(s) ☐ Every patient visit ☐ Anytime invasive procedures are performed

M. Is a pre-anesthesia evaluation done by an anesthesiologist? ☐ Yes ☐ No

N. Is there a separate informed consent for anesthesia? ☐ Yes ☐ No

O. Please place an "X" next to the equipment utilized.

☐ Fail safe mechanisms on anesthesia machines
☐ Basic Airway Equipment
- ☐ Face Mask Resuscitator
- ☐ Oral and Nasopharyngeal Airways
- ☐ Endotrachael Tubes (Adult/Child size)
- ☐ Laryngoscopes

☐ Sphygmomanometer/Stethoscope
☐ Electrocardiographic Monitoring Equipment
☐ Pulse Oximeter
☐ CO2 Detector
☐ Internal/External Temperature Monitor
☐ Tracheostomy/Crycothyrotomy Equipment

☐ Portable Suction
☐ Capnography
☐ Auxiliary Lighting
☐ Emergency Pharmaceutical Kit
☐ Cardiac Defibrillator
☐ Emergency Tube Thoracostomy Equipment

If you do not utilize any of the above equipment, please explain: _____

_____

1. Who owns and maintains the oxygen equipment? _____
2. Do you monitor the use of reversal agents? ☐ Yes ☐ No

P. Do you treat children? ☐ Yes ☐ No