



**HUDSON SPECIALTY INSURANCE COMPANY**  
**Employed Ancillary Provider Application**  
for surplus lines coverage

- If a question does not apply to you, write "N/A". Do not leave any questions unanswered.
- Include a copy of the following: • CV • Letterhead • Loss Runs • State License(s)  
• Current Declarations Page

**1. PERSONAL DATA**

Name: \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

Designation (PA, NP, CRNA, etc.): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No: \_\_\_\_\_ Gender:  M  F

Clinic Name/Employer: \_\_\_\_\_

Office Address: \_\_\_\_\_ Office Phone: ( ) \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

**2. EDUCATION AND TRAINING**

Name & Location of Medical School: \_\_\_\_\_

Degree/Certification Attained: \_\_\_\_\_ Year Graduated: \_\_\_\_\_

List States in which you are actively licensed: \_\_\_\_\_

**3. INSURANCE COVERAGE REQUESTED**

Requested Effective Date: \_\_\_\_\_ Prior Acts Date (Retroactive Date): \_\_\_\_\_

Requested Coverage:  Shared Limit with Employer  Separate Limit

**4. PRACTICE INFORMATION**

1. Average number of hours worked per week: \_\_\_\_\_ Average number of patient visits per week: \_\_\_\_\_
2. Does your current practice involve the treatment of nursing home residents?  Yes  No  
If "Yes", what percentage of your practice involves treatment of nursing home residents? \_\_\_\_\_ %
3. Does your current practice involve the treatment of prison inmates?  Yes  No  
If "Yes", what percentage of your practice involves treatment of prison inmates? \_\_\_\_\_ %
4. Does your current practice involve work in an Emergency Room / Department?  Yes  No  
If "Yes", what percentage of your practice involves work in an emergency room or department? \_\_\_\_\_ %

**5. INSURANCE HISTORY**

1. Current Carrier: \_\_\_\_\_  Claims-Made  Occurrence  
Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Prior Acts Date: \_\_\_\_\_  
Limits of Insurance: \_\_\_\_\_ Per Claim/ \_\_\_\_\_ Aggregate  
Current Annual Premium: \_\_\_\_\_

2. If you are currently insured on a claims-made policy, are you obtaining Extended Reporting Period (tail) from your current insurance carrier?  Yes  No  N/A (have occurrence coverage now)

**Note:** To prevent possible gaps in your claims-made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.

3. Where have you practiced your profession since completion of your formal training? (include military or any public service organization). If your attached CV provides the same information, you may go on to the next section.  CV attached – skip to next section

City/State: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Solo Practitioner  Part of a group Group Name: \_\_\_\_\_

City/State: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Solo Practitioner  Part of a group Group Name: \_\_\_\_\_

City/State: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Solo Practitioner  Part of a group Group Name: \_\_\_\_\_

**6. UNDERWRITING INFORMATION**

If you answer “Yes” to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

**Within the past 10 years:**

1.	Have you been convicted of a misdemeanor (other than traffic related) or felony or is any such charge pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Have you been admitted to or sought treatment from any mental health or chemical/substance abuse program? If yes, please provide an explanation on a separate sheet of paper.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has your license or certification been denied, restricted, suspended, revoked, surrendered, put on probation or issued on a restricted basis? If yes, please provide an explanation on a separate sheet of paper.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have your privileges been denied, restricted, suspended, revoked or put on probation by any health care facility? If yes, please provide an explanation on a separate sheet of paper.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Have you ever resigned from a health care facility while under investigation or to avoid possible disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Has any hospital, as a result of reviewing your patient care or your performance, conducted a hearing or taken any action concerning your medical staff membership/privileges or required additional supervision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Have any complaints been registered against you with your state licensing body, regulatory body, professional association, employer or healthcare facility at which you practice(d)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Have you ever had a complaint, claim or suit brought against you for alleged sexual misconduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Have you provided any care that resulted in a formal incident report or investigation by any healthcare facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Have Medicare or Medicaid authorities ever investigated or brought charges against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11.	Have you provided any professional services without professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Have any insurers canceled coverage, declined coverage, refused renewal or renewed only under restrictive circumstances your professional liability coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Have you ever treated any patients by means of unconventional therapeutics, or have you utilized non-FDA approved experimental drugs other than through Institutional Review Board (IRB) approved research programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**7. CLAIMS INFORMATION**

If you answer “Yes” to any of the questions below, provide a detailed explanation on a separate sheet of paper, Supplemental Claim Information Form, or in the Comment section provided as appropriate.

**Within the past 10 years:**

1.	Have you been involved in a malpractice claim, lawsuit, incident or occurrence in the last 10 years? If “Yes”, how many? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Are you aware of any circumstances that may result in a malpractice claim or suit being made or being brought against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are you aware of any outstanding incidents, claims, or suits (even if you believe the outstanding claim or suit would be without merit) that have <u>not</u> been reported to your current or prior professional liability carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Have you been contacted by a plaintiff’s attorney or required to produce medical records or statements regarding any case you have been involved with, and you have not been specifically named in the suit or claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**COMMENTS**

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**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 shall be the basis of the contract should a policy be issued. I agree to notify the Company of any change in my practice of medicine within thirty (30) days of its occurrence, including but not limited to the following:

- A. A change in specialty or medical procedures performed;
- B. A change in location of practice, including exposures generated through telemedicine or out-of-state patients;
- C. Investigation, restriction, suspension or surrender of any state medical, DEA license or hospital privileges;
- D. Any physical or mental condition, illness or defect, including treatment for alcohol or substance abuse not previously disclosed to the Company in writing.
- E. Conviction, plea or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses.

For FL, KY, MN, NJ, OH and PA 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.

*This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company.*

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Signature Print Name Date

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

**HUDSON SPECIALTY INSURANCE COMPANY**

**Supplement Claim Information Form**

(make copies of this page as needed)

1. Name of patient: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

2. Describe the allegation made by claimant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Date claim was made or filed: \_\_\_\_\_

4. Date of alleged incident: \_\_\_\_\_

5. Insurance company: \_\_\_\_\_

6. Additional defendants: \_\_\_\_\_

7. Disposition of claim:  Open  Closed

If open: Claimant's settlement demand: \$ \_\_\_\_\_  
Defendant's offer for settlement: \$ \_\_\_\_\_  
Insurer's loss reserve: \$ \_\_\_\_\_  
Deductible amount: \$ \_\_\_\_\_

Is claim in suit?  Yes  No If "Yes", amount asked in summons: \$ \_\_\_\_\_

If closed Date closed: \_\_\_\_\_  Court judgment  Out of court settlement  
 Dismissed with prejudice  Dismissed without prejudice

Total indemnity paid (including deductible): \$ \_\_\_\_\_  
Total defense costs/expenses paid: \$ \_\_\_\_\_  
**Total costs incurred:** \$ \_\_\_\_\_

**Provide complete and detailed information for evaluation. Use reverse side or additional sheets if required.**

8. Condition and diagnosis at time of incidents (include dates of visits)  
\_\_\_\_\_  
\_\_\_\_\_

9. Description of treatment rendered (include dates of visits)  
\_\_\_\_\_  
\_\_\_\_\_

10. Condition of patient subsequent to treatment (include dates of follow-up treatment)  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature Print Name Date

