

LEXINGTON INSURANCE COMPANY
PSYCHIATRISTS' PROFESSIONAL LIABILITY INSURANCE
ANCILLARY STAFF APPLICATION

INSTRUCTIONS:

- Carefully review and **answer each** of the following questions.
- Continue with completion of the application and **return it along with a copy of your most recent certificate of insurance or declarations page and a claims history report from the carrier.**
- If the application is complete, the average underwriting review and processing time is 10-15 business days from the date the application is received in the Underwriting Department. The underwriter will contact you if additional information is required.
- Complete the application in its entirety. Do not leave any question unanswered. Please use a separate sheet of paper for any additional information, explanation or clarification.

ALL APPLICATIONS ARE SUBJECT TO UNDERWRITING APPROVAL.

*If you answer "YES" to any question,
please provide a detailed written explanation and attach copies of all pertinent official documentation.*

- Yes No Has your license to practice medicine been revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?
- Yes No Has your license to prescribe controlled substances been revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?
- Yes No Have you had an application for a license to practice medicine or prescribe controlled substances result in a denial?
- Yes No Have you been previously or currently diagnosed with any physical or mental condition that impairs or could impair your ability to practice medicine?
- Yes No Have you been the subject of an investigation or disciplinary proceedings by any governmental agency, professional society or a professional review board of a hospital, HMO, PPO, or IPA? Or, are you aware of any incident that could lead to such action? (Please provide updated information for any previously reported incidences.)
- Yes No Have you been charged with, convicted of, or pleaded guilty or no contest to a felony?
- Yes No Have you ever been, or are you currently sexually, romantically, or socially involved with any current or former patient or with a key third party of a patient? (Key third parties include, but are not limited to, spouses or partners, parents, guardians, surrogates, and the like.)
- Yes No Have you ever been, or are you currently involved in a business venture with any current or former patient or with a key third party of a patient?
- Yes No Have you ever had a settlement or judgment alleging undue familiarity, professional misconduct, or assault in connection with undue familiarity? **If yes**, please complete the Claims History Supplemental Application.
- Yes No Have you reported any malpractice claims or incidents to any carrier **other than** The Psychiatrists' Program in the past ten years? **If yes**, please complete the Claims History Supplemental Application.
- Yes No Are there any incidents, occurrences, accidents, conduct circumstances, complications or unexpected outcomes resulting in injury or death that might reasonably be expected to result in a claim or suit known to you or which should have been known to you on the date of this application? **If yes**, please complete the Claims History Supplemental Application.

5. Practice Locations: List ALL locations at which you have practiced in the last ten (10) years.
EXPLAIN ANY PERIODS IN WHICH YOU DID NOT PRACTICE. Attach additional pages as needed.

- (a) Name of Practice: _____ From: ___/___/___ To: ___/___/___
 City: _____ State: _____ Country: _____
- (b) Name of Practice: _____ From: ___/___/___ To: ___/___/___
 City: _____ State: _____ Country: _____
- (c) Name of Practice: _____ From: ___/___/___ To: ___/___/___
 City: _____ State: _____ Country: _____

D. COVERAGE REQUEST

Desired Effective Date of Coverage: _____

NOTE: The earliest effective date we can grant, if your application is approved, is the postmark date of your submission.

1. Type of Coverage:

<input type="checkbox"/> Claims-Made (All states) Requested Retroactive Date: _____	<input type="checkbox"/> Claims-Made w/Prepaid Tail (May not be available in all states)	<input type="checkbox"/> Occurrence (May not be available in all states)
<ul style="list-style-type: none"> If prior coverage was on a claims-made policy, was the Extended Reporting Period Endorsement Purchased? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please attach a copy.) Are you requesting Prior Acts coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the Prior Acts Coverage Supplemental Application. Additional information <u>must</u> be completed on the SUPPLEMENTAL APPLICATION for Kansas.		

2. Limits of Liability: (Additional Underwriting Guidelines may apply to selected Limits of Liability; All Limits of Liability may not be available at all states)

- | | |
|--|--|
| <input type="checkbox"/> \$2,000,000/\$6,000,000 | <input type="checkbox"/> \$250,000/\$750,000 |
| <input type="checkbox"/> \$1,300,000/\$3,900,000 (NY ONLY) | <input type="checkbox"/> \$200,000/\$600,000 |
| <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> \$100,000/\$300,000 (LA – REQUIRED LIMIT) |
| <input type="checkbox"/> \$500,000/\$1,500,000 (PA – REQUIRED LIMIT) | |

3. Additional Coverage requested: (If you checked any of these boxes, please complete the supplemental application for Vicarious Liability. Coverage for your entity will not be provided without this additional application.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Employer of other Professionals | <input type="checkbox"/> Incorporated Solo Private Practice | <input type="checkbox"/> Professional Partnership/Association |
| <input type="checkbox"/> Contractor of the services of other Professionals | <input type="checkbox"/> Professional Corporation with more than one shareholder | <input type="checkbox"/> Fictitious Name Entity or DBA |
| | | <input type="checkbox"/> Joint Venture or LLC |

E. CURRENT PRACTICE LOCATIONS:

Please complete a section for **EACH** location at which you are currently practicing. (Please list principal location first). **Include current practice locations covered by another carrier.** Copy this page for additional locations as needed.

1. Entity Name: _____ Street Address: _____ City/State/Zip: _____ County: _____ Telephone: _____ Fax: _____ Beginning Date of Practice: _____ Average weekly practice: (in hours): _____ Average number of patients per week: _____	This location is a: <input type="checkbox"/> Private Office <input type="checkbox"/> Nursing Home <input type="checkbox"/> Office in the Home <input type="checkbox"/> Detention Facility (Jail, Prison, Home for Juveniles, half-way houses for those convicted of or awaiting trial or criminal charges, or institutions for the treatment and confinement of those found “not guilty by reason of insanity”, “guilty but mentally ill”, etc.) <input type="checkbox"/> For-Profit Hospital <input type="checkbox"/> Not-For-Profit Hospital <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> Government Hospital (Federal, State, Local) <input type="checkbox"/> Other (Specify): _____
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- a) Is coverage desired for your work at this location? **If your practice activities at this location will be covered by another professional liability insurance carrier, please provide the name of the carrier:** _____ Yes No
- b) Do you want a Certificate of Insurance for this location? Yes No
- c) If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization? Yes No
- d) If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization? Yes No
- e) Do you teach at this location? Yes No
 Classroom Teaching Clinical Teaching Average number of weekly hours spent clinical teaching: _____

F. PRACTICE PROFILE: Please attach a separate sheet for any required explanations.

1. Do you create and maintain a medical record for each patient under your care? Yes No
If no, please explain: _____
2. Do you prescribe controlled substances? Yes No
3. Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics? Yes No
4. Do you have patients sign an arbitration agreement? Yes No
If yes, is signing a condition of treatment? Yes No
5. Do you write prescriptions for patients you have not clinically evaluated **other than to cover for another colleague** whose patient requires a minimal refill on an existing prescription. Yes No
If yes, please explain under what circumstances: _____
6. Do you provide medication management for patients who see another professional (e.g., Ph.D., MSW) as their primary therapist and see you for medication management only? Yes No
For how many patients per week? _____ How often do you see each patient? _____
7. Do you regularly treat general medical conditions presented by your psychiatric patients? **If yes**, please indicate Yes No
 - Average number of patients per week you provide general medical treatment to: _____
 - Nature of the conditions you treat and the type of treatment you provide: _____
8. Do you advertise as a **specialist**? **If so**, what specialty? _____ Yes No
If yes, how many patients for each specialty? _____ What percentage of your total patient load? _____
**Note: "Specialist" is indicated by 1) advertisements, 2) marketing materials, 3) letterhead, or 4) employment, contractual relationship or admitting privileges at any institution with a special interest in any of the above.*
9. Does your practice include forensic activities, e.g., child custody and visitation; criminal responsibility; competence, civil and criminal; correctional psychiatry; juvenile justice and violence? Yes No
 - What is the percent of your total practice time devoted to this activity? _____%
 - On a separate sheet, please explain the exact type of forensic activities.
10. Do you communicate with patients via e-mail? Yes No
 - What is the percent of your total patient load that you communicate with by email? _____%
 - Do you utilize e-mail to render psychiatric services? Yes No
 - Do the patients reside in a state other than the state in which you are licensed to practice? If yes, please explain. Yes No
 - Do you obtain informed consent regarding at least confidentiality/privacy issues involved with email communication, the topics generally not appropriate for email, and the risks and benefits including possible clinical limitations when using email? Yes No
 - On a separate sheet, please explain the nature of communications in detail.
11. Does your practice include telemedicine activities, e.g., direct interaction with patients through electronic means (video, computer, or telephone) in order to provide healthcare to patients who are geographically separated from the clinicians involved? Yes No
If yes:
 - a) What is the percent of your total practice time devoted to this activity? _____%
 - b) While being treated, are the patients physically located outside the state or jurisdiction where your practice is located? Yes No
 - a. If yes, are you currently licensed to practice in the state or jurisdiction where the patient is located at the time of treatment? Yes No
 - b. Is the jurisdiction outside the U.S.? Yes No
 - c) On a separate sheet, please explain the details of the telemedicine arrangement (i.e. the location, equipment, conditions being treated, number of patients, mental health professionals and/or other resources available to the patient at his/her location, etc.)
12. Do you engage in any clinical and/or pharmaceutical research or research involving medical devices? **If yes**, please complete the Clinical/Pharmaceutical Research Supplemental Application. Yes No
13. Do you treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment? Yes No
If yes, please describe: _____
14. Do you have a website, or are you affiliated with a website? Yes No
Website address: _____

15. Does your practice include the use of narcotic drugs for opioid addiction treatment?
If yes, please provide proof of special DEA registration or of a DATA 2000 waiver.

Yes No

G. DECLARATIONS

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON 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, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON 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 AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Applicants Personal Signature

Date

The Psychiatrists' Program Administered By:
Professional Risk Management Services, Inc.
1515 Wilson Boulevard, Suite 800
Arlington, VA 22209

