



MEDICAL FACILITIES PROFESSIONAL LIABILITY APPLICATION

INSTRUCTIONS:

- 1. Please type or print clearly in ink.
2. Answer ALL questions completely. If any question, or part thereof, does not apply, print "N/A" in the space provided.
3. If you need more space, continue on a separate sheet and indicate question number.
4. Please attach:
- Recent promotional material or brochures describing activities or services;
- Most recent audited financial statement;
- Risk Management and Quality Improvement Plan;
- Current accrediting agency (JCAHO, AOA, CARF, etc.) report with recommendations and the facility's response to any contingencies;
- Prior carrier loss runs for the previous 5 years, including current year.

I. PRODUCER PROFILE

- A. Company Name:
B. Business Address: Street Address City State Zip
C. Phone: Fax:
D. Surplus Lines Agent Name: Phone:
E. Surplus Lines Agent's Business Address: Street Address City State Zip
F. Surplus Lines Agent's License No.:
G. State in which Surplus Lines Tax is filed:

II. APPLICANT PROFILE

- A. Applicant Name: (include any "DBA's:"):
B. Mailing Address: (PO Box not acceptable) Street Address City State Zip
County: State of Domicile:
Website Address:
C. Contact Person: Phone:
D. Tax Status: [] for profit [] not-for-profit

E. Applicant's Legal Structure: Corporation Joint Venture Partnership Sole Proprietorship LLC
 Other, Explain _____

F. Do you conduct business over the Internet? Yes No If yes, please attach a detailed description of your services.

G. List names, locations and descriptions of all legal entities, including subsidiaries for which the applicant is part in the space below or provide schedule.

<u>Loc. #</u>	<u>Business Name & Address</u>	<u>Description</u>	<u>Date Acquired</u>	<u>Ownership %</u>

H. Please describe any acquired or sold entities in the past 5 years: _____

I. Number of years this facility has been operating: _____ Owned by present managers: _____
 Managed by present management: _____

J. Is applicant owned by or operated at a hospital, whether main location or branch? Yes No
 If YES, do you lease a distinct area? Yes No

K. Is applicant owned or operated by any person holding a M.D. or D.O. degree? Yes No
 If Yes to C. or D., please describe involvement: _____

L. Have you sold, discontinued or acquired any operations in the past five years, or do you plan to in the upcoming year? Yes No If yes, please explain: _____

M. Do you plan to add any new procedures, products or services in the upcoming year? Yes No If YES, please explain: _____

N. Gross Receipts
 Gross Receipts for the past 12 months: \$ _____
 Anticipated Gross Receipts for the next 12 months: \$ _____

III. COVERAGES/LIMITS/DEDUCTIBLES

A. Effective Date of Coverage Requested: _____

B. Coverage Requested:

Professional Liability

Claims-Made

Indicate Retroactive Date: _____

- Occurrence
- General Liability
 - Claims-Made Indicate Retroactive Date: _____
 - Occurrence
- Employee Benefit Administration Liability Indicate Retroactive Date: _____
- Excess Limits (Complete ACORD Application if underlying Automobile or Employers Liability requested)

C. Limits of Liability Requested:

- \$100,000 per Claim/\$300,000 Aggregate
- \$200,000 per Claim/\$200,000 Aggregate
- \$250,000 per Claim/\$750,000 Aggregate
- \$500,000 per Claim/\$500,000 Aggregate
- \$1,000,000 per Claim/\$1,000,000 Aggregate
- \$1,000,000 per Claim/\$2,000,000 Aggregate
- \$1,000,000 per Claim/\$3,000,000 Aggregate
- Other: _____

D. Deductible Requested:

- \$0
- \$5,000
- \$10,000
- \$25,000
- \$50,000
- Other: _____

(Deductible applies to each and every claim and applies to any combination of claim payments and claim expenses).

E. Additional Insured(s) - name, address and relationship: _____

IV. PROFESSIONAL LIABILITY EXPOSURES

A. Health Care Services Provided.

1. Applicant is best described as a:

- Counseling/Mental Health
- Dialysis Center (Please complete supplement)
- Drug/Alcohol Rehabilitation (Please complete supplement)
- Home Care/Hospice (Please complete supplement)
- Laboratory (Please complete supplement)
- Medical Group Home (Please complete supplement)
- Social Services (Please complete supplement)
- Other: _____

2. Please describe more fully the nature of the Applicant's Operations: _____

3. Does facility have in-patient residential care? Yes No
If so, number of licensed Beds: _____
Daily Average Occupied Beds: _____

B. Medical/Dental Surgical Equipment

1. Are any products manufactured, distributed or sold by the facility to its patients or clients? Yes No
If YES, please give complete details, including revenue generated: _____

a. Owned:

1) Briefly describe your preventive maintenance program: _____

2) If you use a vendor, what limits of liability do you require? \$_____ Each Occurrence/ \$_____ Aggregate
 Do Not Require N/A

b. Leased:

1) Do you repair or sell used equipment of others? Yes No
If YES, please describe: _____

2) Do you service the equipment you sell or lease? Yes No
If NO, who provides preventative or corrective maintenance: _____
What limits do you require them to carry? \$_____ Each Occurrence/ \$_____ Aggregate
 Do Not Require N/A

3) Do you repackage or redesign the equipment you Sell, rent or lease? If YES, describe: _____

4) Is any of the equipment sold with your company's label? Yes No
If YES, please describe: _____

5) Do you have your own sales staff? Yes No
If YES, are they trained by the manufacturer? Yes No

Please attach a copy of your policies on Sales Training, Preventative Maintenance and Patient Education

V. STAFFING AND ADMINISTRATION

A. Medical Director Coverage Requested? Yes No

Does the Medical Director provide direct patient care? Yes No

Name of Medical Director: _____

Specialty: _____

B. Allied Health Care Professionals:

	# Employees Employed	Annual Hours Worked	# Employees Contracted	Annual Hours Worked	# Employees Volunteer	Annual Hours Worked
Administrators						
Athletic Trainer (non-med, non-cert)						
Athletic Trainer (medical, LPT, RPT)						
Clerical						
Counselors						
Dietitians/ Nutritionists						
Educators						
Family Day Care Providers						
Home Health Aides						
Homemakers						
Live-in Companion						
LPN/Licensed Vocational Nurse						
Massage Therapists						
Medical Director						
Medical Office Assistant						
Medical Records Prof/Tech						
Medical Techs/SLPs						
Nurse Aides						
Nurse Practitioner/Clinical Nurse Specialist						
Nurses - Other than Staffing						
Nurses - Temporary Staffing						
Nurses Aides						
Occupational Therapists						
Occupational Therapists Assist.						
Pharmacists						
Physical Therapists						
Physical Therapists Assist.						
Physician Assistant						
Psychologist						
Rehabilitation Therapists						
Rehabilitation Therapists Assist.						
Residence Managers						
Respiratory Therapists						
Respite Care Workers						
Social Worker						
Speech & Hearing Therapists						
Sports Medicine Instructor						
Sports Medicine Therapist						
Surgeon Assistants						
Volunteers Describe:						
Other, Describe:						
Annual Payroll:						

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. These medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

- Insurance Requirements – Please explain any “NO” answers in the comments section below
 1. Indicate if employed or contracted healthcare professional carry Professional Liability Insurance:
 - a. Physicians and Surgeons? Yes No
 - b. Oral Surgeons, Dentists, Nurse Anesthetists, Nurse Practitioners, Physician Assistants and Nurse Midwives? Yes No
 - c. Allied Health Care Professionals? Yes No
 2. Indicate the minimum professional liability insurance limits required for employed or contracted:
 - a. Physicians and Surgeons? \$_____ Each Occurrence/ \$_____ Aggregate
 - c. Oral Surgeons, Dentists, Nurse Anesthetists, Nurse Practitioners, Physician Assistants and Nurse Midwives? \$_____ Each Occurrence/ \$_____ Aggregate
 - c. Allied Health Care Professionals? \$_____ Each Occurrence/ \$_____ Aggregate
 3. How often do you verify professional liability insurance limits? _____

Comments: _____

- Hiring, Screening, and Training Procedures for Employees, Contractors and Volunteers
 1. Does screening and hiring procedures include the following?
 - a. Educational background Yes No
 - b. Previous employers/ employment history Yes No
 - c. Personal references Yes No
 - d. Hospital Privileges for Physicians, Oral Surgeons and Dentists Yes No
How often do you update your list of specific privileges? _____
 - e. Pending license suspensions or revocations, or any pending disciplinary actions by other facilities Yes No
 - f. Criminal background check: County State Federal None
 - g. Medical Professional claims history Yes No
 - h. Drug and alcohol abuse screening Yes No
 2. If an individual has had a previous claim, license suspension or revocation, how does that impact your procedures or that person? Are any additional criteria applied? _____
 3. Are each of the above procedures followed and documented? Yes No
If NO, please explain: _____
 4. Have you or any of your employees ever been:
 - a. the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or government agency, hospital or professional association? Yes No
 - b. convicted for an act committed in violation of any law or ordinance other than traffic offenses?

Yes No

If YES to either of the above, please attach a detailed explanation.

5. What training is provided for new staff (e.g. Aides, Volunteer, Technicians)? _____

6. Is continuing education available for all employees? Yes No

7. Are written job descriptions established for all employees and volunteers? Yes No

8. Before staff can provide care, is a competency based checklist used to assess and document their skills? Yes No

VI. CONTRACTUAL AGREEMENTS

A. Does Legal Counsel review all contractual agreements? Yes No

B. Have you agreed to hold harmless or indemnify others under contract? Yes No

C. Please describe any services provided to other entities: _____

D. Please describe any contracted services provided to you: _____

VII. RISK MANAGEMENT

A. Is there a written, formalized Risk Management/Quality Management Program? Yes No

B. Does the governing body periodically review the program for effectiveness and approve necessary changes? Yes No

C. Who coordinates your Risk Management Program?

Name: _____

Title: _____

Telephone Number: _____

Email Address: _____

D. Is the Risk Manager accountable and solely responsible for Risk Management? Yes No

If NO, describe other responsibilities: _____

E. Is the Risk Manager responsible for reviewing incident reports? Yes No

F. Is the staff required to report all incidents, which might result in a claim to the administrator? Yes No

G. Is a complete medical history of each patient or client retained on premises? Yes No

H. Are medical records released to third parties without the consent of the patient or client? Yes No

VIII. BUILDING INFORMATION

A. Date Built: _____

B. Number Stories: _____

C. Total Floor Area: _____

D. Number Exits: _____

E. Number of Elevators: _____

(NOTICE TO MISSOURI RESIDENTS: This question does not apply.)

- E. Is your current carrier offering renewal terms? Yes No
- F. Have you or any of your staff been the subject of disciplinary or investigatory proceedings or reprimanded by a governmental or an administrative agency, hospital or professional association? Yes No
 If YES, please explain _____

- G. Have you been the subject of any license suspension or revocation or been placed under probation? If YES, please explain Yes No

X. CLAIM HISTORY

- A. Has any Professional or General Liability Claim or suit been brought in the past five (5) years against you or any predecessor in interest concerning the facility Yes No
- B. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future?
 Yes No If YES, have you notified your current carrier? Yes No
- C. Please complete the following for each claim, suit or incident. If you need more space, please continue on a separate sheet.

Claimant:	Age:
Date of Accident:	Date of Notice:
Insurance Carrier:	Amount Paid or Reserved:
Allegations:	
Description of Treatment Rendered:	

Claimant:	Age:
Date of Accident:	Date of Notice:
Insurance Carrier:	Amount Paid or Reserved:
Allegations:	
Description of Treatment Rendered:	

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

XI. NOTICE TO APPLICANT

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Notice to Arkansas, Louisiana and New Mexico Applicants: Any person who knowingly presents a false or fraudulent claims 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 Departments of Regulatory Agencies.

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 Kentucky Applicants: Any person who knowingly and with the intents 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 act, which is a crime.

Notice to Maine Applicants: It is a crime to 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 New Jersey Applicants: Any person who included 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 and 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, defend 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.

Notice to Pennsylvania Applicants: Any person who knowingly and with the intent to defraud any Insurance Company or other person files and application for Insurance or statement of claim containing any fact 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 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.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

SIGNATURE OF APPLICANT : _____ **DATE:** _____

(Must be signed by principal partner or officer of group or individual applying for insurance.)