Medical Facilities and Providers Insurance Application

Answer all questions completely. If any questions do not apply, state "N/A". If space is insufficient to answer any question, attach additional pages.

Please attach the following information:

1. Copy of all marketing or advertising brochures used by facility
2. Loss history:
   a. Currently valued loss runs for a minimum of the past 5 years, including current year
   b. Breakdown of total incurred losses paid and outstanding for indemnity and expenses
3. Full details of allegations on all losses paid or outstanding in excess of $50,000
4. Current audited financial statement (proforma if newly formed)
5. Risk management and quality improvement plan

Applicant

Applicant Name: | Telephone Number: | Facsimile Number:

Doing Business As: | State of Domicile:

Mailing Address:

City: | County: | State: | Zip:

Website: www. | Gross Annual Revenue: $

Describe in detail the Professional Services for which coverage is sought:

Provide the following information for Professional Liability Insurance for the current policy year and previous four years:

Policy Period	Carrier	Limits	Deductible/SIR	CM or OCC	Retro Date	Premium
		$	$	Select		$
		$	$	Select		$
		$	$	Select		$
		$	$	Select		$
		$	$	Select		$

Requested Insurance Structure

Coverage	Limit per Occ/Agg	Ded/SIR	Cm or Occ	Retro Date
PL	$	$	Select	
GL	$	$	Select	
EBL	$	$	Select	
Sexual misconduct	$	$	Select	

Applicant: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC ☐ Trust

Tax status: ☐ For Profit Private ☐ Not for Profit ☐ For Profit publicly traded

Does the Applicant conduct any business over the internet? ☐ Yes ☐ No

If Yes, please attach a detailed description of the Applicant's services.

Please list names, locations, and descriptions of all legal entities, for which coverage is requested.

LOC.#	Business Name and Address	Description	Date Acquired	Ownership Percent	Retroactive Date
				%	
				%	
				%	
				%	
				%	

Has the Applicant sold, discontinued, or acquired any operations in the past 5 years, or does the Applicant plan to do so in the upcoming year? If yes, please explain. ☐ Yes ☐ No

Date established: Owned by Present Owners: Managed by Present Management:

List of licenses held by the Applicant's facility including type and expiration date:

List all accreditations (JCAHO, DHHS, etc.) and association memberships held by the Applicant's facility and include a copy of the most recent report:

Does the Applicant plan to add any new procedures, products, or services in the upcoming year? If yes, please explain. ☐ Yes ☐ No

Does the Applicant provide services to any of the following:

Correctional Facility	_____%	Nursing Home, Assisted Living or other Residential Facility	_____%
Physician Offices	_____%	Supplemental Staffing / Nurse Registry	_____%
Hospital	_____%	Other	_____%

If staffing is provided to others, what percentage of Applicant's total revenues is from staffing services? _____%

Please indicate where staffing is provided (Percentage of revenues from staffing services):

_____%	Emergency Department	_____%	Neonatal
_____%	Pediatric	_____%	Intensive Care Unit
_____%	Nursing Home / Assisted Living	_____%	Psychiatric
_____%	Medical Surgical Unit	_____%	Obstetrical/Labor & Delivery
_____%	Other _____		

Is training verified for all placed staff and matched for competency? If No, please explain. ☐ Yes ☐ No

What percentage of the Applicant's patients/clients are under 18 years of age? _____%

Does the Applicant:

a. Prescribe medication to any patient? ☐ Yes ☐ No

b. Administer anesthesia (other than topical)? ☐ Yes ☐ No
   If "Yes," what percentage of procedures require general anesthesia _____%

c. Perform any surgical procedures? ☐ Yes ☐ No

d. Own any biomedical or other equipment used for diagnosis, monitoring or treatment purpose? ☐ Yes ☐ No
   If "Yes," do qualified personnel inspect and maintain the equipment on a regular basis? ☐ Yes ☐ No
   Are manufacturers' recommendations followed for all maintenance and repair of equipment? ☐ Yes ☐ No

e. Maintain any overnight beds? If yes, please explain: ☐ Yes ☐ No

Professional Liability Exposures

Instructions: Please provide projected exposure details for the next 12 Months for the Applicant and any subsidiaries or other entities seeking coverage.
Receipts: Use gross receipts. Do not adjust this figure for items such as profits, uncollectible accounts or amounts billed but not paid.
State annual occupied beds = (Inpatient Days of Care / 365)

	Projected		Current Year	
Total Number of Employees				
Gross Receipts				
Behavioral health facilities	Beds	Visits	Beds	Visits
Psychiatric/Child Residential Care				
Psychiatric/Adult Residential Care				
Apartments/Independent Living				
Group Homes				
Halfway Houses/Shelters				
Outpatient Visits				
Residential Facilities - Other	Beds		Beds	
Adolescent/Child Residential Care				
Assisted Living				
Group Homes				
Halfway Houses/Shelters				
Substance Abuse Treatment	Beds	Visits	Beds	Visits
Outpatient Counseling Visits				
Detox Beds				
Outpatient Methadone Program				
Inpatient Residential Beds				
Partial Hospitalization Visits				
Hospice Care Facility	Beds		Beds	
Inpatient Beds				
Ambulance	Transports		Transports	
Air Transports				
Ground - Emergent Transports				
Ground - Nonemergent Transports				
Clinical Trials	Participants		Participants	
Pharmaceuticals				
Medical Devices				
Medical/Surgical Procedures				
Day Care	Participants		Participants	
Adult Medical				
Pediatric Medical				
Other - Describe:				
Home Health/Hospice Care	Visits		Visits	
Hospice Home Care				
Infusion Therapy				
Personal Care/Non-medical				
Skilled Care				
Rehabilitation				
Other - Describe:				
Imaging/X-ray	Receipts		Receipts	
CT	$		$	
MRI	$		$	
PET	$		$	
X-Ray Diagnostic	$		$	
Laboratory	Receipts		Receipts	
Blood/Plasma Bank **# Donations**	#		#	
Cardiac Catheterization Lab	$		$	
Clinical Pathology Laboratory	$		$	
Dental Laboratory	$		$	
Medical Laboratory	$		$	
Ocular Laboratory	$		$	
Optical Laboratory	$		$	
Optical Establishment Retail	$		$	
Organ/Tissue Bank Dir. Process	$		$	
Organ/Tissue Bank No Dir. Process	$		$	
Quality Control/Reference Lab				
Other - Describe				

	Projected		Current Year	
Medical Staffing/Nurse Registry	FTE		FTE	
Medical Staffing - all classes				
L&D placements - percentage				
ICU placements - percentage				
ED placements - percentage				
Pharmacy	Receipts		Receipts	
Compounding	$		$	
Infusion	$		$	
Retail	$		$	
Remote Monitoring	$		$	
Specialty	$		$	
Rehabilitation Outpatient	Visits		Visits	
Cardiac Rehabilitation Center				
Developmental Disability				
Physical/Occupational Rehab/Speech				
Trauma Rehabilitation-Skilled Medical				
School-Allied Medical Professional	Students	Faculty	Students	Faculty
Nursing/OT/PT/ST				
Physician Assistant, EMT, Paramedic				
Optometry				
Other - Describe:				
Surgery Centers	# Procedures		# Procedures	
Bariatric				
Cardiovascular				
Colon and Rectal				
Dermatology				
ENT				
GE Endoscopies				
General Surgery				
Gynecological				
Oncology Rad. Treatment/Surgery				
Ophthalmology				
Oral Surgery				
Orthopedic no spinal				
Orthopedic spinal				
Pain Management				
Urology				
Vascular				
Treatment Centers	# Visits/Procedures		# Visits/Procedures	
Cancer Treatment Center				
College or University Health Center				
Community Health Center				
Crisis Stabilization Center				
Dialysis Treatment Center – Hemo				
Dialysis Treatment Center – Peritoneal				
Health Department				
Lithotrispy treatments				
Radiation Therapy				
Sleep Centers				
Other - Describe:				
Telemedicine	Reads or Visits		Reads or Visits	
Telemedicine				
Teleradiology: Preliminary Reads				
Teleradiology: Final Reads				
Urgent Care Centers	Visits		Visits	
Patient Visits				

Please provide information requested for each physician providing services at the Applicant(s) facility:

Name of Medical Director	Specialty	Insurance Carrier/ Policy Period	Limits Carried	Check One:	Hours Per Month
				☐ Employee ☐ Contractor	
Physician Names	**Specialty**	**Insurance Carrier/ Policy Period**	**Limits Carried**	**Check One:**	**Hours Per Month**
				☐ Employee ☐ Contractor	
				☐ Employee ☐ Contractor	
				☐ Employee ☐ Contractor	
				☐ Employee ☐ Contractor	

Note: If coverage is requested for any physician, a supplemental application must be completed for each such physician. Coverage for any physician is not automatically included. The policy, if issued, will determine coverage.

Does the Applicant have written requirements that all clinical staff carry professional liability insurance? ☐ Yes ☐ No

Indicate the minimum professional liability insurance limits required for employed, contracted or affiliated:

	Each occurrence	Aggregate
a. Physicians or surgeons	$	$
b. Dentists, nurse anesthetists, nurse practitioners, physician assistants and nurse midwives	$	$
c. Allied health care professionals:	$	$

Does the Applicant verify staff professional liability insurance on an annual basis? ☐ Yes ☐ No

Allied Health Care Professionals – Indicate number of personnel and annual hours worked in each applicable category

	Employees		Contractors		Volunteers	
	Number of:	Annual Hours:	Number of:	Annual Hours:	Number of:	Annual Hours:
Addiction Counselor						
Case Worker or Case Manager						
Chiropractor						
Dentist						
EMT/Paramedic						
Home Health Aide/Caregiver						
Lab Technician						
Mental Health Counselor						
Nurse - RN						
Nurse - LPN/LVN						
Nurse Aide or Assistant						
Nurse Anesthetist						
Nurse Practitioner/ Advance Practice Nurse						
Occupational/Speech Therapist						
Optometrist						
Pharmacist						
Physical Therapist						
Physician Assistant						
Psychologist						
Respiratory Therapist						
Social Worker						
Surgical Technician						
Other:						

Does the Applicant have any staff members who are not licensed or who have restricted licenses or privileges? If Yes, please explain: ☐ Yes ☐ No

General Liability Exposures – Complete this section if General Liability Coverage is requested.

Does the Applicant sell or lease any medical equipment or product to patients or other in connection with the Applicant's operation? If Yes, please complete the following information: ☐ Yes ☐ No

Total Annual Sales $_____ Total Lease/Rental Receipts $_____

Category	Annual Sales	Lease/Rental Receipts	Applicant included in Manufacturer's Products Liability Coverage	
I.	$	$	☐ Yes	☐ No
II.	$	$	☐ Yes	☐ No
III.	$	$	☐ Yes	☐ No
IV.	$	$	☐ Yes	☐ No

Reference for completion of above table:

Category I. Expendable Items – Intended for one time usage and disposed (i.e. adhesive tape, needles etc.)

Category II. Non-Expendable Items - Excluding diagnostic or treatment equipment or devices. This category include but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lists or hoist, traction apparatus, ambulatory aids such as walker, stroller, canes crutches, wheelchairs, etc. an prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.

Category III. Diagnostic or Treatment Devices - This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.

Category IV. Life Sustaining or Critical Life Monitoring Equipment or Devices - This category includes dialysis or heart/lung machines, apnea monitors, or any other life dependent monitors or any other equipment or devices that if they malfunction/fail could result in death or serious deterioration in a health condition.

Please indicate any additional insured to be included under the Applicant's General Liability Coverage, including an explanation of their interest.

Business Name and Address:	Interest

Hiring/ Screening/ Training Procedures for Employees, Contractors and Volunteers

1. Does screening/ 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 ☐ Yes ☐ No
   e. Pending license suspensions or revocations, or any pending disciplinary actions by other facilities? ☐ Yes ☐ No
   f. Criminal background check: ☐ County ☐ State ☐ Federal ☐ Yes ☐ No
   g. Medical professional claims history ☐ Yes ☐ No
   h. Drug/alcohol abuse screening ☐ Yes ☐ No

2. If an individual has had a previous claim, license suspension, or revocation, how does that impact the Applicant's procedures for hiring that person?

3. Does the Applicant have specific credentialing procedures for employed and contracted physicians? ☐ Yes ☐ No
4. Are each of the above procedures followed and documented? ☐ Yes ☐ No
   If No, please explain in the comments section below.
5. Is training provided for new staff (e.g., aides, volunteers, technicians)? ☐ Yes ☐ No
   If Yes, please describe in the comments section below.
6. Are written job descriptions established for all employees and volunteers? ☐ Yes ☐ No
7. Before staff can provide care is a competency-based checklist used to assess and document their skills? ☐ Yes ☐ No

Comments section:

Contractual Agreements

1. Does legal counsel review all contractual agreements? ☐ Yes ☐ No
2. Has the Applicant agreed to hold harmless or indemnify others under any contracts? ☐ Yes ☐ No
   Please provide details on indemnification agreements.

3. Please describe any services provided to other entities:

4. Please describe any contracted services provided to the Applicant:

Admission/Discharge Criteria

Please explain any No answers in the Comments Section below.

1. Is there an admission policy in place? ☐ Yes ☐ No
2. Is there a medical records policy in place? ☐ Yes ☐ No
3. Is there a discharge policy in place? ☐ Yes ☐ No
4. How long are medical records maintained? _____ years

Comments Section:

Risk Management/Quality Management

1. Is there a written, formalized Risk Management/ Quality Improvement program? ☐ Yes ☐ No
2. Does the governing body periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No
3. Who coordinates the Risk Management program?

Name	Title	Telephone number	Email address

4. Is the Risk Manager accountable and solely responsible for Risk Management? ☐ Yes ☐ No
5. Is the Risk Manager responsible for reviewing incident reports? ☐ Yes ☐ No

Policy and Loss Information

Please include loss runs and attach a detailed explanation to any Yes answers.

1. Is the Applicant aware of any accident, circumstance, or loss that has occurred that might give rise to a claim or suit in the future? ☐ Yes ☐ No
2. Has the Applicant had any professional claims or suits during the last 5 years? ☐ Yes ☐ No
3. Has the Applicant or any of the Applicant's staff been the subject of disciplinary or investigatory proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
4. Has any insurance company ever canceled, non-renewed, or declined to accept the Applicant's professional or general liability insurance? ☐ Yes ☐ No
5. Has the Applicant been the subject of any license suspension or revocation or been placed under probation? ☐ Yes ☐ No

Fraud warnings

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 Alaska residents: "A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law."

Notice to Arizona residents: "For the Applicant's protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

Notice to California residents: "For the Applicant protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Notice to Colorado residents: "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 Agencies."

Notice to Delaware residents: "Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Notice to Florida residents: "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 of the third degree."

Notice to Idaho residents: "Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Notice to Indiana residents: "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony."

Notice to Kansas residents: "A 'fraudulent insurance act' means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for

payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto."

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

Notice to Maryland residents: "Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Maine residents: "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 Minnesota residents: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

Notice to New Hampshire residents: "Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

Notice to New Jersey residents: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Notice to New Mexico residents: "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 civil fines and criminal penalties."

Notice to Ohio residents: "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 residents: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an 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 Oregon residents: "Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law."

Notice to Pennsylvania residents: "Any person who knowingly and with intent to defraud any insurance company or other person files a 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 residents: "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 Texas residents: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Notice to Vermont residents: "Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law."

Notice to New York residents: "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 violation."

The undersigned represents that he or she is authorized to sign this application on behalf of the **Applicant** and further represents and acknowledges that all information contained in this Application, including any supplements and attachments, is true accurate, and complete; will be relied upon by this Insurer in determining whether to insure the **Applicant** and at what rate to insure it; and will be considered part of any policy that is issued. The undersigned further represents and acknowledges that the policy applied for may provide coverage on a claims made and reported basis, and subject to the policy provisions, may apply to claims or suits that are first made and reported in writing to this Insurer during the policy period unless an extended reporting period applies.

Producer Profile and Applicant Signature

Company Name:	Telephone Number:	Facsimile Number:
Business Address:	City, State, Zip:	Email Address:
Surplus lines Agent Name & Telephone Number:	Surplus Lines Agent's License Number:	
State in which Surplus Lines Tax is Filed:	Surplus lines Agent Business Address:	
Surplus lines Agent City, State, Zip:		
Producer Signature: Producer Printed Name:		Date:
Applicant (Signature): By:	Title:	Date: