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Miscellaneous Medical Facilities and Providers Insurance Application

Answer all questions completely. If any questions do not apply, print "NA" in the space.

Do not use this application for Hospitals or Long-Term Care facilities.

II. Applicant Profile

A. Applicant Name	B. Doing Business As:	C. State of Domicile
D. Mailing Address	E. City, State, Zip	F. County
G. Telephone Number / H. Facsimile Number	I. Website Address	J. Annual Revenues
K. Applicant's Legal Structure ☐ Individual ☐ Partnership ☐ LLC ☐ Corporation ☐ Joint Venture	L. Tax status ☐ For Profit ☐ Not for Profit	M. Do you conduct business over the Internet? If yes, please attach a detailed description of your services ☐ Yes ☐ No

N. List names, locations, and descriptions of all legal entities, including subsidiaries for which the Applicant is a part.

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

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

P. Number of years this facility has been: Operating: _____ Owned By Present Owners: _____ Managed by Present Management: _____	Q. List of licenses held by your facility including type and expiration dates:

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

S. Have you sold, discontinued, or acquired any operations in the past 5 years, or do you plan to in the upcoming year?

T. Do you plan to add any new procedures, products, or services in the upcoming year?

II. Coverage/Limits/Deductibles

A. Requested Policy Effective Date	B. Requested Policy Expiration Date	C. Are you currently enrolled in a Patient's Compensation Fund? ☐ Yes ☐ No	D. Are you requesting General Liability Coverage? ☐ Yes ☐ No

E. Limits of Liability Professional Liability:	F. Are you requesting Prior Acts?	G. Deductible (Event Deductible/Total Deductible)
☐ $1,000,000 Each Person/$3,000,000 Total Limit ☐ $_____ Each Medical Incident/$_____ Total Limit ☐ $_____ Umbrella Limits (Complete ACORD Application)	☐ Yes - Requested Retroactive Date Is _____ ☐ No	☐ No Deductible ☐ $10,000/None ☐ $25,000/None ☐ $50,000/None

III. Professional Liability Exposures

A. Health Care Services Provided: Check each box that applies and provide projected exposure information for the next 12 months. If you have multiple locations, provide exposure information for each location separately.

- ☐ Adult Day Care — Daily Census: _____
- ☐ Adult Group Home — Beds: _____

Ambulance
- ☐ Ambulance - Emergent — Transfers: _____
- ☐ Ambulance - Non-Emergent — Transfers: _____

- ☐ Blood/Plasma Bank — Donations: _____

- ☐ Cancer Treatment Centers (Non-Radiological) — Visits: _____

Cardiac Catheterization Labs
- ☐ Cardiac Catheterization Labs - Diagnostic — Visits: _____
- ☐ Cardiac Catheterization Labs - Intervention — Visits: _____

- ☐ Crisis Stabilization Center: _____
- ☐ Development Disability Rehabilitation: _____
- ☐ Dialysis Center: _____
- ☐ Emergicenter: _____
- ☐ Gammaknife: _____
- ☐ Health Department - Incl. Community Health Centers: _____

Home Health Center
- ☐ Home Health Center - Durable Medical Equipment — Visits: _____
- ☐ Home Health Center - Intravenous Therapy: _____
- ☐ Home Health Center - Personal: _____
- ☐ Home Health Center - Rehabilitaion: _____
- ☐ Home Health Center - Respiratory: _____
- ☐ Home Health Center - Skilled: _____
- ☐ Home Health Center - All Other: _____
- ☐ Hospice Care - Out Patient Only: _____

Imaging
- ☐ Imaging - CT Scans — Receipts: _____
- ☐ Imaging - MRI Facilities: _____
- ☐ Imaging - Non-Invasive Radiology Services: _____
- ☐ Imaging - PET Scans: _____
- ☐ Imaging - Therapeutic (Colbalt, X-Ray, Terahertz): _____
- ☐ Imaging - X-Ray (Diagnostic): _____

Laboratory
- ☐ Laboratory - All Other — Receipts: _____
- ☐ Laboratory - Dental: _____
- ☐ Laboratory - Medical/Pathology/X-Ray: _____
- ☐ Laboratory - Ocular: _____
- ☐ Laboratory - Pharmaceutical: _____
- ☐ Laboratory - Quality Control/Reference: _____
- ☐ Laboratory - Routine Clinical Pathology: _____

- ☐ Lithotripsy Centers — Visits: _____

- ☐ Med'l Registry/Staffing/Med'l Employee Contract — Hours: _____

- ☐ Mental Health Counseling Services - OP Only — Visits: _____

- ☐ Optical Establshment — Receipts: _____

Organ Bank
- ☐ Organ Bank - Direct Processing — Receipts: _____
- ☐ Organ Bank - No Direct Processing: _____

Pharmacies
- ☐ Pharmacies - Contract — Receipts: _____
- ☐ Pharmacies - Infusion (No Administration): _____
- ☐ Pharmacies - Infusion and Delivery: _____
- ☐ Pharmacies - Retail: _____

Rehabilitation
- ☐ Rehabilitation - All Other (Speech, Art, Clay, etc.) — Visits: _____
- ☐ Rehabilitation - Cardiac: _____
- ☐ Rehabilitation - Physical/Occupational: _____

- ☐ Schools - Healthcare Providers Excl. Physicians — Hours: _____

- ☐ Sleep Center — Visits: _____

- ☐ Student Health Center — Visits: _____

Substance Abuse
- ☐ Substance Abuse - Counseling - Outpatient Only — Visits: _____
- ☐ Substance Abuse - Skilled Medical: _____

Surgicenter
- ☐ Cardiology — Visits: _____
- ☐ Colon and Rectal: _____
- ☐ Endoscopy/Colonoscopy: _____
- ☐ Dentist engaged in oral surgery: _____
- ☐ Dermatology: _____
- ☐ Endocrinology: _____
- ☐ Gastroenterology: _____
- ☐ General Surgery: _____
- ☐ Gynecology: _____
- ☐ Hand Surgery: _____
- ☐ Head and Neck Surgery: _____
- ☐ Neoplastic Surgery: _____
- ☐ Neurology: _____
- ☐ Opthalmology Surgery: _____
- ☐ Orthopedics, excluding back: _____
- ☐ Ear, Nose and Throat: _____
- ☐ Pain Management: _____
- ☐ Plastic Surgery: _____
- ☐ Podiatrists: _____
- ☐ Urology: _____
- ☐ Vascular: _____

Trauma Rehabilitation
- ☐ Trauma Rehabilitaion - Skilled Medical — Visits: _____
- ☐ Trauma Rehabilitaion - Therapy: _____

- ☐ Urgicenter — Visits: _____

- ☐ Weight Loss Control — Visits: _____

[1]Visits: Count each patient each time they enter your facility for healthcare related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.
[2]Annual Receipts: Use gross receipts. Do not adjust this figure for items such as profit, un-collectible accounts, or amounts billed but not paid

B. Medical / Dental / Surgical Equipment

1. Owned:

a. Briefly describe your preventive maintenance program:

b. If you use a vendor, what limits of liability do you require? $_____Each occurrence/$_____Aggregate

Do Not Require N/A

2. Leased:

a. Do you repair or sell used equipment of others?
If yes, please describe in the Comments Section. ☐ YES ☐ NO

b. Do you service the equipment you sell or lease? ☐ YES ☐ NO

If no, who provides preventive or corrective maintenance? _____
What limits do you require them to carry? $_____Each occurrence/$_____Aggregate
Do Not Require

c. Do you repackage or redesign the equipment you sell, rent, or lease?
If yes, describe in the Comments Section. ☐ YES ☐ NO

d. Is any of the equipment sold with your company's label?
If yes, describe in the Comments Section. ☐ YES ☐ NO

e. 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 Staff Training, Preventive Maintenance, and Patient Education.

Comments Section:

IV. General Liability Exposures — Complete this section if General Liability Coverage is requested.

1. Do you sell or lease any medical equipment or products to patients or others in connection with your operation?
☐ YES ☐ NO

If yes, please complete the following information:
Total Annual Sales: $_____ Total Annual Lease/Rental Receipts: $_____

a. Category I. Expendable Items – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)
Total Annual Sales: $_____ Total Annual Lease/Rental Receipts: $_____

b. Category II. Non-Expendable Items – Excluding diagnostic or treatment equipment or devices. This category includes but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc., and prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.
Total Annual Sales: $_____ Total Annual Lease/Rental Receipts: $_____

c. 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.
Total Annual Sales: $_____ Total Annual Lease/Rental Receipts: $_____

d. 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.
Total Annual Sales: $_____ Total Annual Lease/Rental Receipts: $_____

2. Are you included under the Manufacturer's Products Liability Coverage? ☐ YES ☐ NO

V. General Liability Exposures — *Continued*

3. Employee Benefits Liability Coverage? ☐ Yes (Number of Employees:_____) ☐ No
4. Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Business Name and Address	Interest

VI. Administration and Staff

A. Medical Director

Does the Medical Director provide direct patient care? ☐ Yes ☐ No ☐ N/A

Name of Medical Director	Specialty	Insurance Carrier/Policy Number/Policy Period	Check One:	Hours Per Month*:	Financial Interest**:
			☐ Employee ☐ Contractor		

B. Physicians/Surgeons

Name	Specialty	Insurance Carrier/Policy Number/Policy Period	Check One:	Hours Per Month*:	Financial Interest**:
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		
			☐ Employee ☐ Contractor		

***Hours/Month** - Indicate the total number of hours per month, on average, that each individual works for your facility.
****Financial Interest** – Provide the percent of Financial Interest in the Facility (Owner, Stock, etc.)

C. Allied Health Care Professionals (indicate number of personnel in each applicable category)

	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Aides						
Chiropractors						
Counselors						
Dentists						
Dietitians						
EMT's/Paramedics						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/Clinics						
Occupational Therapists						
Oral Surgeon						
Pharmacists						
Physical Therapist						
Physician/Surgeon/First Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Speech Therapists						
Technicians						
Other (describe):						

D. Insurance Requirements - Please explain any 'No' answers in the comments Section.

1. Indicate if employed or contracted healthcare professionals carry professional liability insurance:
   a. Physicians or 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 or surgeons: $_____Each occurrence/$_____Aggregate
   b. 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 Section:

E. 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 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/alcohol/abuse screening ☐ YES ☐ NO

2. If an individual has had a previous claim, license suspension, or revocation, how does that impact your procedures for hiring that person? Are any additional criteria applied? ☐ YES ☐ NO

3. Are each of the above procedures followed and documented?
If no, please explain in the Comments Section. ☐ YES ☐ NO

4. What training is provided for new staff (e.g., aides, volunteers, technicians)? ☐ YES ☐ NO

5. Are written job descriptions established for all employees and volunteers? ☐ YES ☐ NO

6. Before staff can provide care, is a competency-based checklist used to assess and document their skills? ☐ YES ☐ NO

Comments Section:

VII. Contractual Agreements

1. Does Legal Counsel review all contractual agreements? ☐ Yes ☐ No
2. Have you agreed to hold harmless or indemnify others under contract? ☐ Yes ☐ No
3. Please describe any services provided to other entities:

4. Please describe any contracted services provided to you:

VIII. Admission/Discharge Criteria

Please describe any 'No' answers in the Comments Section.

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 ☐ N/A

Comments Section:

IX. Risk Management/Quality Management

1. Is there a written, formalized Risk Management/Quality Management program? ☐ Yes ☐ No
2. Does the governing body periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No
3. Who coordinates your Risk Management program?
   Name: _____
   Title: _____
   Telephone Number: _____
   Email Address: _____
4. Is the Risk Manager accountable and solely responsible for Risk Management? ☐ Yes ☐ No
   If no, describe other responsibilities: _____
5. Is the Risk Manager responsible for reviewing incident reports? ☐ Yes ☐ No

X. Policy and Loss Information

A. Losses - Please include loss runs and attach a detailed explanation to any 'Yes' answers.

1. Are you 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. Have you had any professional claims or suits made against your facility during the last 5 years? ☐ Yes ☐ No
3. 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
4. Has any insurance company ever canceled, non-renewed, or declined to accept your professional or general liability insurance? ☐ Yes ☐ No
5. Have you been the subject of any license suspension or revocation or been placed under probation? ☐ Yes ☐ No

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

Policy Period	Carrier	Limits	Ded/SIR	CM or OCC	Retro Date	Premium

PLEASE INCLUDE THE FOLLOWING INFORMATION:

1. COPY OF ALL MARKETING OR ADVERTISING BROCHURES USED BY FACILITY.
2. LOSS HISTORY:
   a. CURRENT EVALUATED 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)
   c. FULL DETAILS OF ALLEGATION ON ALL LOSSES PAID OR OUTSTANDING IN EXCESS OF $50,000
3. CURRENT ACCREDITING AGENCY (JCAHO, AOA, CARF, ETC.) REPORT WITH RECOMMENDATIONS AND THE FACILITY'S RESPONSE TO ANY CONTINGENCIES
4. CURRENT AUDITED FINANCIAL STATEMENT
5. RISK MANAGEMENT AND QUALITY IMPROVEMENT PLAN

XI. Notice to Applicant

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE, OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ARKANSAS, LOUISIANA, AND NEW MEXICO 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 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 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 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 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 claims 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.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an 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 PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps, or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) no more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three , or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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.

NOTICE TO 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 benefit.

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Miscellaneous Medical Facilities and Providers Insurance Application

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 the company 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 provides coverage on a claims made and reported basis and, subject to the policy provisions, will apply only to claims or suits that are first made and reported in writing to the company during the policy period unless an extended reporting period applies.

I. Producer Profile

A. Company Name	B. Telephone Number	C. Facsimile Number
D. Business Address	E. City, State, Zip	F. Email Address
G. Surplus Lines Agent Name & Telephone Number	H. Surplus Lines Agent's License Number	I. State in which Surplus Lines Tax is Filed
J. Surplus Lines Agent's Business Address	K. City, State, Zip	L. New Jersey - Surplus Lines Trans Number

Applicant Signature:	Producer Signature:
Print Name:	Print Name:
Title:	Date:
Date:	

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