

Miscellaneous Medical Professional Liability and General Liability Insurance Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.

This application for Professional Liability and General Liability Insurance is intended to be used for the preliminary evaluation of a submission. When completed in its entirety, this application will enable the Underwriter to decide whether or not to authorize the binding of insurance. Please type or print clearly and answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplemental forms/applications. "You" and "Your", as used in this application, means the Applicant.

1. GENERAL INFORMATION			
Name of Applicant			
Street Address		Phone	
City, State, Zip Code		County	
Website		Contact e-mail	
No. of Locations	If multiple names and locations, please attach a list.		
2. FORM OF BUSINESS/OPERATIONS			
a. Applicant is a(an): <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Professional Association <input type="checkbox"/> Individual <input type="checkbox"/> For Profit <input type="checkbox"/> Not for Profit			
b. Date established:			
c. Where is the Applicant registered and licensed to practice (number of states)?			
d. Please specify any professional societies or associations of which you are a member:			
e. If the Applicant is an entity: (1) is the entity engaged in, owned or controlled by, or associated with, any other business? (2) is the entity owned by any physician? (3) is the entity owned by any hospital or are any services hospital-based? (4) have there been any changes in ownership since the date the entity was established? If "YES" to any of the above, please provide details on a separate page.			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
3. COVERAGE DESIRED			
a. Proposed Effective Date:			
b. Retroactive Date:			
c. Limit(s):			
d. Deductible(s):			
4. REVENUES			
a. Please describe the sources and amount of the Applicant's total revenue:			
Source	Amount Last Policy Year	Estimated Amount This Policy Year	
(1) Charitable Contributions	\$	\$	
(2) Government Funding	\$	\$	
(3) Fee for Services	\$	\$	
(4) Product Sales (attach a list of products)	\$	\$	
(5) Other: _____	\$	\$	
TOTAL GROSS REVENUE:	\$	\$	

b. For PHARMACIES, please describe the sources and amounts of total revenue:

Source	Amount Last Policy Year	Estimated Amount This Policy Year
(1) Prescription Sales	\$	\$
(2) Non-Prescription Sales	\$	\$
(3) Other: _____	\$	\$

c. Are all drugs dispensed by the Applicant approved by the Food and Drug Administration (FDA)? Yes No
If "NO", attach explanation.

5. PROFESSIONAL ACTIVITIES AND SPECIALTY (attach narrative description, if necessary)

CHECK ALL THAT APPLY:

<input type="checkbox"/> Acupuncturist/Naturopathic Medicine	<input type="checkbox"/> Medical Spa (Please complete Medical Spa Supplemental)
<input type="checkbox"/> Alcohol/Drug/Psychiatric Rehabilitation	<input type="checkbox"/> Medical Testing/Laboratory
<input type="checkbox"/> Ambulance Services	<input type="checkbox"/> Nurse Registry
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Optometry
<input type="checkbox"/> Diagnostic Imaging	<input type="checkbox"/> Out-Patient Medical Clinic
<input type="checkbox"/> Dialysis Center	<input type="checkbox"/> Out-Patient Mental Health Clinic
<input type="checkbox"/> Health/Fitness Center	<input type="checkbox"/> Pharmacy (Please complete Pharmacy Supplemental)
<input type="checkbox"/> Home Healthcare Agency	<input type="checkbox"/> Residential Facility
<input type="checkbox"/> Hospice	<input type="checkbox"/> Speech Therapy
<input type="checkbox"/> Other (Please specify): _____	

6. PATIENT BREAKDOWN

State approximate division of Applicant's patients among:

a. Alcoholics	%	k. Obstetrical	%
b. Counseling/Family Planning	%	l. Pediatric	%
c. Communicable Disease	%	m. Prisoners	%
d. Dental	%	n. Psychiatric	%
e. Drug Addicts	%	o. Research or Experimental	%
f. General	%	p. Senile or Aged	%
g. Hemodialysis	%	q. Stress Testing	%
h. Holistic Medicine	%	r. Surgical	%
i. Medical	%	s. Tubercular	%
j. Intellectually Disabled	%	t. Other: _____	%

7. SERVICES PROVIDED BREAKDOWN

State approximate division of services being provided among the following settings:

a. Assisted Living Facilities	%	e. Nursing Homes	%
b. Clinics	%	f. Physician Offices	%
c. ER/ICU/Labor, Delivery	%	g. Private Homes	%
d. Hospitals	%	h. Other: _____	%

8. EMPLOYEES AND VOLUNTEERS

a. List the number of the Applicant's employees and volunteers in each profession below. If None, state "0" by the designated profession.

<u>Number</u>	<u>Type of Profession</u>	<u>Number</u>	<u>Type of Profession</u>
i) _____	Acupuncturist	xv) _____	Opticians
ii) _____	Counselor	xvi) _____	Optometrist
iii) _____	Chiropractor	xvii) _____	Paramedics
iv) _____	Dentist	xviii) _____	Perfusionist
v) _____	Dental Assistant	xix) _____	Pharmacist
vi) _____	EMT	xx) _____	Pharmacist Tech
vii) _____	Home Health Aide	xxi) _____	Physician Assistant
viii) _____	Inhalation Therapist	xxii) _____	Physician/Surgeon
ix) _____	Laboratory Technician	xxiii) _____	Physiotherapist
x) _____	Licensed Practical, Nurse	xxiv) _____	Psychologist
xi) _____	Massage Therapist	xxv) _____	Registered Nurse
xii) _____	Medical Director	xxvi) _____	Social Worker
xiii) _____	Nurse Anesthetist	xxvii) _____	Speech Therapist
xiv) _____	Nurse Practitioner	xxviii) _____	Other _____

b. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet of paper, if necessary. If None, state "None" here: _____

c. Are all of the individuals listed **8.a.** and **8.b.** licensed in accordance with applicable state and federal regulations?
If "NO", please attach and explanations. Yes No

d. Are all employed/contracted physicians board-certified in their specialty? Yes No

e. Do all physicians, surgeons and dentists who provide professional services on behalf of the Applicant maintain their own Medical Malpractice coverage with limits of at least \$1million/\$3million? Yes No

f. Are criminal background checks conducted on all employees, volunteers and independent contractors?
If "NO", attach explanation. Yes No

g. Does the Applicant conduct pre-employment screenings and background investigations prior to hiring all employees, volunteers and independent contractors? Yes No

h. Has the Applicant or any of the individuals listed in question **8.a.** and **8.b.:**

(1) ever been the subject of a disciplinary proceeding, investigation or reprimand by a governmental or administrative agency, hospital or professional association? Yes No

(2) ever been convicted of a violation of any law or ordinance other than traffic offenses? Yes No

(3) ever been treated for alcoholism or drug addiction? Yes No

(4) ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered any such license? Yes No

If "YES" to any of the above, attach explanation.

i. Does the Applicant:

(1) have a written/formalized risk management/quality assurance program? Yes No

(2) have a written credentialing process for all staff? Yes No

(3) have written procedures for reporting all incidents? Yes No

If "NO" to any of the above, attach explanation.

9. ADDITIONAL REQUIRED INFORMATION			
a. If the Applicant provides AMBULANCE/TRANSPORT SERVICES, please answer the following:			
(1) Number of Ground Ambulances		Number of Emergency Calls (per year)	
		Number of Non-Emergency Calls (per year)	
(2) Number of Air Ambulances		Number of Transport Calls (per year)	
		Number of Body Transports (per year)	
(3) Radius of Services		Is the Applicant part of a Fire Department?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. For AMBULATORY SURGERY CENTERS, please answer the following:			
(1) Number of Surgical Procedures in the next 12 months			
(2) Percentage of procedures using general anesthesia			
c. Do you perform obstetric surgeries, bariatric surgeries or abortions?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
d. For DIALYSIS CENTERS, please answer the following:			
(1) Number of hemodialysis treatments in the next 12 months			
(2) Number of peritoneal treatments in the next 12 months			
(3) Hours of service in the next 12 months for in-home treatments			
(4) Number of stations			
e. For ALCOHOLIC/DRUG/PSYCHIATRIC REHABILITATION CENTERS, please answer the following:			
(1) Number of total licensed beds			
(2) Do you provide off-site counseling services?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(3) Are all counselors licensed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(4) Number of intern counselors			
f. For HEALTH/FITNESS CENTERS, please answer the following:			
(1) Is there a pool?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(2) Are there tanning beds?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
g. Does the Applicant perform: (attach detailed explanation for any "YES" answers to the following.)			
(1) any surgeries other than incision of superficial boils or suturing superficial fascia?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(2) circumcisions?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(3) dilation and curettage?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(4) insertion of temporary pacemakers?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(5) tonsillectomies and/or adenoidectomies?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(6) caesarean sections?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(7) cosmetic plastic surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(8) excision of large cysts and/or I&D of deep-seated boils or carbuncles?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(9) hysterectomies?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(10) open reduction of fractures?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(11) surgery for weight reduction of patients?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(12) abortions and/or menstrual extractions? (If "YES", include trimester, method and number of abortions performed per month in description.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(13) silicone implants?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
(14) sterilization procedures/		<input type="checkbox"/> Yes <input type="checkbox"/> No	

(15) biopsies and/or endoscopies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(16) therapeutic optometry (implantation of prosthetic ocular devices)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(17) sex change operations? (If "YES", please advise the number performed per year _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
(18) other surgery (please describe): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Does the Applicant perform: (attach detailed explanation for any "YES" answers to the following.)	
(1) acupuncture or acupuncture anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) angiography/arteriography/venography?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(3) cardiac catheterization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(4) catheterization (other than cardiac, urinary or umbilical)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(5) closed reduction of compound fractures?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(6) normal deliveries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(7) microdermabrasion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(8) injection of radioisotopes and/or use of irradiated substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(9) IV/infusion therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(10) AIDS therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(11) radiation therapy and/or chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(12) psychiatric shock therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(13) silicone injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(14) spinal anesthesia (other than saddle blocks or caudals)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(15) botox injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(16) Chelaton therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(17) DNA testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(18) genetic testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(19) environmental testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(20) pharmaceutical testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(21) testing of any weapons?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(22) blood banking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(23) clinical trials or research using animal or human test subjects?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(24) teleradiology?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(25) telemedicine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Does the Applicant perform hospital emergency room care:	
(1) for its own patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(2) for patients of other providers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
(3) If answer to question 9.i)(2) above is "YES", please specify: The percentage of time devoted to this work = _____% The number of hours per month devoted to this work = _____ hours	

j) Does the Applicant prescribe or dispense weight reduction drugs? If “YES” , list drugs used and indicate the percentage of the Applicant’s practice (1) devoted to weight reduction, (2) frequency and duration of prescriptions for weight reduction drugs and (3) quantity dispensed by the Applicant.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
k) Does the Applicant administer any methadone treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
l) Is anesthesia (other than topical or by means of local infiltration) administered by either the Applicant or others working on behalf of the Applicant? If “YES”, attach detailed explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
m) Does the Applicant maintain any beds for overnight occupancy? If “YES”, provide number of licensed beds by location:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
n) State number of x-ray machines owned or operated by the Applicant and indicate whether they are used for diagnosis or treatment or both: State by whom treatment is given and number of procedures:				
o) Does the Applicant own (wholly or in part), operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? If “YES”, provide details, including name, location, size and number of beds:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
p) Does the Applicant sell or lease any equipment for use by any other persons or entities? If “YES”, provide details, including name, location, size and number of beds:	<input type="checkbox"/> Yes <input type="checkbox"/> No			
r) Number of estimated patient encounters and patient tests in the next 12 months (Note: “patient encounters” refers to number of visits; not number of patients): Patient encounters: _____ Patient tests: _____				
10. INSURANCE				
a. Please describe the Applicant’s Professional Liability coverage for the last five (5) years:				
Insurance Carrier	Limit	Deductible	Premium	Policy Period
If the expiring Professional Liability policy is claims-made, what is the retroactive date? _____				

b. Has any insurer cancelled or refused to renew any similar insurance during the past five (5) years? If "YES", please explain.					<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Is the Applicant currently insured under a Commercial General Liability Policy? If "YES", please provide details:					<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Carrier	Limit	Deductible	Claims-Made or Occurrence	Premium	Policy Period
d. Has any application for Professional Liability or General Liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, or has such insurance ever been cancelled, non-renewed or accepted only on special terms? If "YES", please provide details on a separate page.					<input type="checkbox"/> Yes <input type="checkbox"/> N
11. LOSS HISTORY					
If the answer to any question in 11.a. through 11.b. below is "YES", please complete a Claim Supplemental Form for each claim, allegation or incident, and submit a currently valued loss runs for the past five (5) years.					
a. In the past five (5) years, has any claim been made, or legal action been brought, against you, any of your current or former officers, directors, owners, partners or employees, or any other person or entity proposed for this insurance?					<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Are you or any other person or entity proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in any professional liability or general liability claim(s) being made against any person or entity proposed for this insurance?					<input type="checkbox"/> Yes <input type="checkbox"/> No
NOTICE TO APPLICANT					
The insurance for which you are applying will not respond to incidents about which any person proposed for coverage had knowledge prior to the effective date of the policy, nor will coverage apply to any claim or circumstance identified or that should have been identified in question 11. of this application.					
NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.					
The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by claim expenses and, in such event, the Insurer shall not be liable for claim expenses or any judgment or settlement that exceed the limit of liability.					
I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact, and that I agree that this application shall be the basis of the contract with the Underwriters.					
CERTIFICATION AND SIGNATURE					
The Applicant has read the foregoing and understands that completion of this application does not bind the Underwriter or the Broker to provide coverage. It is agreed, however, that this application is complete and correct to the best of the Applicant's knowledge and belief, and that all particulars which may have a bearing upon acceptability as a Professional Liability and General Liability Insurance risk have been revealed.					
It is understood that this application shall form the basis of the contract should the Underwriter approve coverage and should the Applicant be satisfied with the Underwriter's quotation. It is further agreed that, if in the time between submission of this application and the requested date for coverage to be effective, the Applicant becomes aware of any information which would change the answers furnished in response to any question of this application, such information shall be revealed immediately in writing to the Underwriter.					
This application shall be deemed attached to and form a part of the Policy should coverage be bound.					
Must be signed by an officer of the company.					
Print or Type Applicant's Name			Title of Applicant		
Signature of Applicant			Date Signed by Applicant		