APPLICATION FOR ALLIED HEALTH CARE PROFESSIONAL LIABILITY

THE COVERAGE IS ON A CLAIMS MADE AND REPORTED BASIS.
PLEASE READ THE COVERAGE CAREFULLY.

1. Complete name of facility (applicant) (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary):** _____

   _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Contact name: _____ Title: _____

   Phone: _____ Web site Address: _____ Fax: _____

   List all other locations **(use an additional sheet of paper if necessary):** _____

   _____

   _____

2. In what state is the facility domiciled? _____

3. Applicant is: a. ❑ Individual ❑ Partnership ❑ Corporation
   ❑ Professional Association ❑ Other: _____
   b. ❑ Not-for-profit ❑ For-profit ❑ Both

4. Current accreditations or associations: ❑ NAHC ❑ TAHC ❑ JCAHO
   ❑ CHAP ❑ NHPCO ❑ Other: _____

5. Is the firm engaged in, owned by or associated with or controlled by any other business? ..... ❑ Yes ❑ No
   If yes, give details (use an additional sheet of paper if necessary): _____

6. Date established: ____/ ____

7. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? ..... ❑ Yes ❑ No
   If yes, give details: _____

   _____

8. Limits of Liability desired for Professional Liability:
   ❑ $100,000/$300,000 ❑ $250,000/$250,000 ❑ $500,000/$500,000
   ❑ $1,000,000/$1,000,000 ❑ $1,000,000/$2,000,000 ❑ $1,000,000/$3,000,000
   ❑ Other: $_____/$_____

   Deductible desired:
   ❑ $2,500 ❑ $5,000 ❑ $10,000 ❑ $25,000 ❑ $50,000 ❑ Other: _____

   MAXIMUM AND MINIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

9. Effective date desired: _____

10. Please list the individual shareholders or partners of the facility:

_____ _____ _____

_____ _____ _____

11. Name of medical director, if any: _____

    a. Is coverage provided for the medical director under any other insurance policy? ❑ Yes ❑ No

    b. If yes, please provide type of policy and name of carrier: _____

12. Does the applicant anticipate any facility expansions within the next year? ❑ Yes ❑ No

    If yes, please describe: _____

    _____

13. List states in which applicant is licensed to do business: _____

14. Are any services provided outside of the United States? ❑ Yes ❑ No

    If yes, please explain, including what countries, what type of services are provided and what percentage of your revenues are derived from these services: _____

    _____

15.

Professional Activities and Specialty (check one)	Gross Revenues Prior Year	Gross Revenues Estimate for Current Year
❑ Ambulatory Surgery Center		
❑ Laboratory/Dialysis Center/X-Ray/MRI		
❑ Out-Patient Clinic		
❑ Clinical Trials		
❑ Home Health Care		
❑ Hospice		
❑ Other (specify):		

16. a. Percentage of gross revenues from applicant's largest client: _____ %

    Explain services provided for this client: _____

    b. Percentage of gross revenues from applicant's second largest client: _____ %

    Explain services provided for this client: _____

17. State percentage of revenues derived from:

Source	Percentage for Last Policy Year	Estimated Percentage for Current Year
a. Charitable Contributions	%	%
b. Government Funding	%	%
c. Fee for Service	%	%
d. Other (specify):	%	%

18. Does applicant have positive net worth? ❑ Yes ❑ No

19. Does applicant have sufficient working capital? ❑ Yes ❑ No

20. State the number of patient encounters and/or patient tests carried out as follows (patient encounters refer to number of visits—not number of patients):

Type of Encounters	Number for Last 12 Months	Estimated Number for Next 12 Months
Patient Encounters	%	%
Patient Tests	%	%

21. If the applicant is a training school, complete the following:

Specify Profession/ Qualifications for Which Students Are Being Trained (e.g. MD, RN, PHD)	Maximum Number of Students per Session	Number of Sessions per Year	Percentage of Time Involved in Clinical Setting	Number of Students
			%	
			%	

22. Please list the licenses/certifications held by the facility:

Agency: _____ Agency: _____

Issue date: _____ Issue date: _____

Expire date: _____ Expire date: _____

23. Describe the type of procedures performed at or by this facility: _____

_____

_____

_____

_____

24. Are all personnel performing these procedures certified and properly trained to perform these procedures? ..... ❑ Yes ❑ No

25. Percentage of professional services performed: _____% on premises _____% off premises

26. Do you provide imaging services? ..... ❑ Yes ❑ No

If yes, please explain types of imaging performed and what percentage of applicant's revenues is derived from each:

_____

_____

27. Do you perform specimen collection services? ..... ❑ Yes ❑ No

If yes, please explain types of specimens collected and what percentage of applicant's revenues is derived from each:

_____

_____

28. a. List the number and type of applicant's employees and volunteers (if none, state "none"):

Number	Type of Profession	Number	Type of Profession
(a)	Acupuncturist	(n)	Pharmacist
(b)	Cardiac Perfusionist	(o)	Physical Therapist
(c)	Dentist	(p)	Certified Physicians Assistant
(d)	Inhalation Therapist	(q)	Physician—minor surgery

(e)	Laboratory Technician	(r)	Physician—no surgery
(f)	Licensed Midwife	(s)	Psychologist
(g)	Nurse Anesthetist	(t)	Physiotherapist
(h)	Nurse, License Practical	(u)	Registered Nurse First Assist
(i)	Nurse Midwife	(v)	Social Worker
(j)	Nurse Practitioner	(w)	Speech Therapist
(k)	Nurse, Registered	(x)	Home Health Care Aide
(l)	Optician	(y)	Other (specify):
(m)	Optometrist	(z)	Other (specify):

b. Does the applicant have any independent contractors employed? ..... ❑ Yes ❑ No

If yes, list the number and type of independent contractors who provide professional services on behalf of the applicant: _____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations? .... ❑ Yes ❑ No

If no, attach an explanation.

d. Is continuing education or staff development required for your employees? ..... ❑ Yes ❑ No

e. Total annual payroll amount for all employees: _____

HIRING PRACTICES

29. Do you require signed applications on all prospective employees? ..... ❑ Yes ❑ No
30. Do you verify all professional qualifications, licenses and certifications? ..... ❑ Yes ❑ No
31. Do you conduct a personal interview with prospective employees and non-employees? ..... ❑ Yes ❑ No
32. Do you require professional and personal references on each employee? ..... ❑ Yes ❑ No
33. Do you conduct a criminal background check? ..... ❑ Yes ❑ No
34. Do you provide training and orientation for new employees? ..... ❑ Yes ❑ No
35. Do you check on hospital privileges for physicians and dentists? ..... ❑ Yes ❑ No
36. Do you verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities? ..... ❑ Yes ❑ No
37. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? ..... ❑ Yes ❑ No
38. Do you have written job descriptions? ..... ❑ Yes ❑ No
39. Do you require drug/alcohol screening? ..... ❑ Yes ❑ No

INTERNAL PROCEDURES

40. **Is anesthesia used?** ..... ❑ Yes ❑ No

If yes, answer the following questions:

a. Type of anesthesia used: _____

b. Who administers anesthesia? _____

c. What monitoring equipment is used for anesthesia administration? _____

d. Is there a crash cart on the premises? ..... ❑ Yes ❑ No

e. What is the distance to the nearest hospital in the event of an emergency? _____

f. How long are patients kept after the surgery/procedure? _____

g. Who monitors patients during recovery? _____

41. Are patients ever kept overnight? ..... ❑ Yes ❑ No

42. Are signed patient consent forms required for the following:

a. Admission? ..... ❑ Yes ❑ No ❑ N/A

b. Surgery? ..... ❑ Yes ❑ No ❑ N/A

c. Against medical advice? ..... ❑ Yes ❑ No ❑ N/A

d. Any other medical treatment or dispensing of drugs? ..... ❑ Yes ❑ No ❑ N/A

43. Do records reflect that the patient was advised of surgical procedures and possible risks associated with such procedures (informed consent)? ..... ❑ Yes ❑ No ❑ N/A

44. Are written post-operative orders submitted and signed by the surgeon? ..... ❑ Yes ❑ No ❑ N/A

45. Are sponge, needle and instrument counts performed before and after surgery? ..... ❑ Yes ❑ No ❑ N/A

46. Are nursing charts maintained, including patient's condition at discharge? ..... ❑ Yes ❑ No ❑ N/A

STAFF PRIVILEGES

47. Are credentials for new staff members checked and approved prior to granting staff privileges? ..... ❑ Yes ❑ No ❑ N/A

By whom? _____

48. Staff member's Medical Professional Liability Insurance:

a. Are all medical staff members/independent contractors required to maintain Medical Professional Liability Insurance? ..... ❑ Yes ❑ No

b. What limits are required? _____

c. What evidence of compliance is required? _____

RISK MANAGEMENT/LOSS CONTROL

49. Is there a written, formalized Risk Management Program? ..... ❑ Yes ❑ No

50. Is there a written, formalized Quality Assurance Program? ..... ❑ Yes ❑ No

51. Do you have a standard system to handle a patient's complaints or suggestions? ..... ❑ Yes ❑ No

52. Do qualified personnel inspect and maintain the equipment on a regular basis? ..... ❑ Yes ❑ No

53. Do you practice universal precautions? ..... ❑ Yes ❑ No

54. Do you have a Quality Assurance Department? ..... ❑ Yes ❑ No

55. In case of an emergency is management available 7 days a week, 24 hours a day? ..... ❑ Yes ❑ No

CLINICAL TRIALS (Complete the following questions if you are involved in clinical trials. If not, indicate "none.")

56. a. **What percentage of clinical trials are: Phase I ____ % Phase II ____% Phase III _____% Phase IV _____ %**

b. **Are all clinical trials FDA approved?** ..... ❑ Yes ❑ No

If no, please explain: _____

GENERAL LIABILITY

57. Please indicate if you desire General Liability coverage ..... ❑ Yes ❑ No

If you answered yes, please answer Questions 58. through 62.

If you answered no, please skip to Question 63.

58. Complete the following for any owned or leased premises (use a separate sheet of paper if needed):

LOCATION ADDRESS	OCCUPANCY	SQUARE FOOTAGE
	❑ Owned ❑ Leased	
	❑ Owned ❑ Leased	
	❑ Owned ❑ Leased	

59. Are you required to name your landlord or any other business as an additional insured? ..... ❑ Yes ❑ No
(If yes, please list name and address of each and state interest. Use separate sheet if required.)

NAME	ADDRESS	INTEREST

60. Do you supply or sell any medical supplies or equipment to patients or clients? ..... ❑ Yes ❑ No

61. Do you rent or lease or supply any medical or therapeutic equipment to patients or clients? ..... ❑ Yes ❑ No
If the answer to Question 60. or 61. above is yes, please complete the following:

Category I	Expendable Items—intended for one time use and then disposed	Annual Sales:	$
Category II	Non-Expendable Items—including hospital beds, bathroom safety bars, portable toilets, lifts or hoists, ambulatory aids (excludes diagnostic treatment equipment devices)	Annual Sales:	$
		Annual Rental Receipts:	$
Category III	Diagnostic or Treatment Devices—including oxygen and other medical gasses used in conjunction with respiratory therapy (excluding ventilators)	Annual Sales:	$
		Annual Rental Receipts:	$
Category IV	Life Sustaining or Critical Monitoring Equipment or Devices—including dialysis or heart/lung machines, all monitors	Annual Sales:	$

62. Do you install, service or demonstrate products or equipment? ..... ❑ Yes ❑ No

INSURANCE AND CLAIM INFORMATION

63. **Do you currently carry the following:**

a. **Professional Liability Insurance?** ..... ❑ Yes ❑ No

List the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage.

Policy Period From: MM/DD/YY	To: MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Claims Made or Occurrence?	Premium
/ /	/ /					
/ /	/ /					
/ /	/ /					

/ /	/ /					
/ /	/ /					

If claims made what is the retroactive date/prior acts date on your current policy? _____

b. Commercial General Liability Insurance? ..... ❑ Yes ❑ No

List the Commercial General Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Claims Made or Occurrence?	Premium

If claims made what is the retroactive date/prior acts date on your current policy? _____

CLAIMS HISTORY

64. a. **Have there been any professional liability/general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance, in the last five years?** ..... ❑ Yes ❑ No

If yes, how many? _____

If yes, please complete a Claim/Circumstance Supplement for <u>each</u> claim.

b. **Are you or anyone proposed for this insurance aware of any facts or circumstances which might give rise to a professional liability claim or complaint?** ..... ❑ Yes ❑ No

If yes, how many? _____

If yes, please complete a Claim/Circumstance Supplement for <u>each</u> incident.

c. **Are you or anyone proposed for this insurance aware of any charges, inquiries, investigations, grievances or other administrative hearings in the last five years or currently?** ..... ❑ Yes ❑ No

If yes, how many? _____

If yes to any, please complete a Claim/Circumstance/Administrative Hearings Supplement for <u>each</u>.

d. **Was prior Professional Liability/General Liability coverage ever canceled or nonrenewed (OTHER THAN BEING NONRENEWED DUE TO THE CARRIER NO LONGER WRITING THESE COVERAGES) (NOT APPLICABLE TO MISSOURI APPLICANTS)?** ..... ❑ Yes ❑ No

IF YES, PLEASE EXPLAIN REASON FOR NONRENEWAL OR CANCELLATION: _____

_____

_____

NOTE: THE APPLICANT UNDERSTANDS AND AGREES THAT IF ANY FACTS, INCIDENTS OR CIRCUMSTANCES EXIST WHICH MAY REASONABLY GIVE RISE TO A CLAIM UNDER THIS PROPOSED POLICY, THEN ANY CLAIMS ARISING FROM SUCH FACTS, INCIDENTS OR CIRCUMSTANCES ARE EXCLUDED FROM COVERAGE.

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. **COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS**
2. **COPY OF A SAMPLE CLIENT/PATIENT SERVICES CONTRACT**

3. **RESUMES/CVs FOR ALL KEY PERSONNEL, PRINCIPALS, EXECUTIVES, MEDICAL DIRECTORS AND/OR ADMINISTRATORS IF ESTABLISHED LESS THAN THREE YEARS**
4. **MOST CURRENT FINANCIAL STATEMENT**
5. **CURRENTLY VALUED LOSS RUNS FOR PAST FIVE YEARS**
6. **FULLY COMPLETED CLAIM SUPPLEMENTS FOR ALL CLAIMS**
7. **PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS AND NURSE ANESTHETISTS**
8. **IF SEXUAL ABUSE COVERAGE IS DESIRED—COMPLETE SEXUAL ABUSE SUPPLEMENTAL APPLICATION**
9. **COPY OR DESCRIPTION OF THE STEP-BY-STEP PROCEDURE THAT IS FOLLOWED TO OBTAIN CRIMINAL BACKGROUND INFORMATION ON PROSPECTIVE EMPLOYEES**

SIGNATURE SECTION AND OTHER INFORMATION

NOTE: Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY BE ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

FRAUD WARNING: 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.

FRAUD WARNING (Applicable in Tennessee and Washington): 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.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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.

_____

Name of Applicant

_____ _____

Signature and Title of Principal (must be owner, partner or officer) Date

_____

Print Name and Title of Principal Signing Above