



PROFESSIONAL INSURANCE®

Medical Facilities and Providers Liability Application

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.

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

I. PRODUCER PROFILE		
A. Company Name	B. Telephone Number	C. Contact Person
D. Business Address	E. City, State, Zip	F. Email Address
G. Surplus Lines Agent name and Telephone #	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

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. Contact Person	I. Website Address			
J. Applicant's Legal Structure <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Corporation <input type="checkbox"/> Joint Venture		K. Tax Status <input type="checkbox"/> For Profit <input type="checkbox"/> Not for profit		L. Do you conduct business over the internet? If yes, please attach a detailed description of your services. <input type="checkbox"/> Yes <input type="checkbox"/> No	
M. List names, locations and descriptions of all legal entities, including subsidiaries for which the Applicant is a part.					
Loc. #	Business Name & Address	Description	Date Acquired	Ownership %	Retroactive Date
N. Please describe any acquired or sold entities in the past 5 years:					
O. Number of years this facility has been: Operating: _____ Owned by Present Owners: _____ Managed by Present Management:			P. List of licenses held by your facility including type and expiration dates:		
Q. Is applicant owned by or operated by a hospital, whether main location or branch <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, do you lease a distinct area: <input type="checkbox"/> Yes <input type="checkbox"/> No					
R. Is applicant owned or operated by any person holding an MD or DO degree? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe involvement. "					
S. List all accreditations (JCAHO, DHHS, etc.) and association memberships held by your facility and include a copy of the most recent report:					

T. Please describe any new procedures, products, or services in the upcoming year:

U. Gross Receipts for the past twelve months _____

Anticipated gross receipts for the next twelve months _____

V. Percentage of receipts for the following payer categories:

Medicare _____% Medicaid _____% Other public aid _____% Private Pay _____%

III. COVERAGES/LIMITS/DEDUCTIBLES

A. Effective Date of Coverage Requested: _____

B. Coverage Requested:

- Professional Liability
 - Claims-Made Retroactive Date: _____
 - Occurrence
- General Liability
 - Claims-Made Retroactive Date: _____
 - Occurrence
- Employee Benefit Administration Liability 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
- \$2,000,000 per Claim/\$4,000,000 Aggregate
- \$2,000,000 per Claim/\$6,000,000 Aggregate
- Other: _____

D. Deductible Requested:

- \$0
- \$5,000
- \$10,000
- \$25,000
- \$50,000
- \$100,000
- Other: _____

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

IV. 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.

Counseling/Rehabilitation	Visits	Beds	Laboratory:	Receipts
<input type="checkbox"/> Adolescent/Child Residential Care	_____	_____	<input type="checkbox"/> Dental Lab	\$ _____
<input type="checkbox"/> Cardiac Rehabilitation	_____	_____	<input type="checkbox"/> Medical Lab	\$ _____
<input type="checkbox"/> Developmental Disability	_____	_____	<input type="checkbox"/> Ocular Lab	\$ _____
<input type="checkbox"/> Mental Health/Counseling	_____	_____	<input type="checkbox"/> Optical Establishment	\$ _____
<input type="checkbox"/> Physical /Occupational Rehabilitation	_____	_____	<input type="checkbox"/> Organ/Tissue Bank (direct processing)	\$ _____
<input type="checkbox"/> Substance Abuse			<input type="checkbox"/> Organ/Tissue Bank (no direct processing)	\$ _____
Counseling	_____	_____	<input type="checkbox"/> Pathology Lab	\$ _____
Residential	_____	_____	<input type="checkbox"/> Pharmacy	\$ _____
Skilled Medical Services	_____	_____	<input type="checkbox"/> Quality Control/Reference Lab	\$ _____
<input type="checkbox"/> Trauma Rehabilitation			<input type="checkbox"/> X-ray/Imaging Center	\$ _____
Therapy	_____	_____	<input type="checkbox"/> Blood/Plasma Banks	Donations _____
Transitional Living	_____	_____	<input type="checkbox"/> Other Lab	_____
Skilled Medical Services	_____	_____	Describe: _____	
<input type="checkbox"/> Weight Loss Center	_____	_____		
<input type="checkbox"/> Other Counseling/Rehabilitation	_____	_____	Treatment Centers:	Visits
Describe: _____			<input type="checkbox"/> College or University Health Center	_____
Other Residential Facilities			<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Group Homes	_____	_____	<input type="checkbox"/> Community Health Center	_____
<input type="checkbox"/> Halfway Houses/Shelters	_____	_____	<input type="checkbox"/> Crisis Stabilization	_____
Surgical:			<input type="checkbox"/> Dialysis	_____
<input type="checkbox"/> Abortion Clinic	_____	_____	<input type="checkbox"/> Health Department	_____
<input type="checkbox"/> Birthing Center	_____	_____	<input type="checkbox"/> Medical/Health Spas	_____
<input type="checkbox"/> Urgent Care Centers	_____	_____	<input type="checkbox"/> Surgicenter	_____
<input type="checkbox"/> Outpatient Surgery Centers	_____	_____	<input type="checkbox"/> Other Treatment	_____
<input type="checkbox"/> Other Surgical	_____	_____	Describe: _____	
Describe: _____			<input type="checkbox"/> Radiation Therapy	Receipts \$ _____
Hospice:			<input type="checkbox"/> Telemedicine: Preliminary Reads	_____
<input type="checkbox"/> Hospice Care Facility	_____	_____	<input type="checkbox"/> Telemedicine: Final Reads	_____
<input type="checkbox"/> Hospice Home Care	_____	_____	Services: (Complete Section VI. C Health Care Professionals and appropriate Supplemental Application.)	
Complete Home Healthcare			<input type="checkbox"/> Air Ambulance Service	
Supplemental: _____			<input type="checkbox"/> Ground Ambulance Service	
Schools for Medical Professionals:			<input type="checkbox"/> Home Health	
<input type="checkbox"/> Dental			<input type="checkbox"/> Medical Registry Services/Medical Personnel	
<input type="checkbox"/> Medical			Pools	
<input type="checkbox"/> Optometry			<input type="checkbox"/> Adult Day Care	
<input type="checkbox"/> Other Healthcare Provider				
Describe: _____				
		Receipts		
Clinical Trials/Research/Consulting: (If yes, please attach details of clinical Trials)		\$ _____		
<input type="checkbox"/> Pharmaceuticals		\$ _____		
<input type="checkbox"/> Medical Devices		\$ _____		
<input type="checkbox"/> Medical/Surgical Procedures				
Other Facility:				

OneBeacon

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B. Does the Applicant provide Medical Staffing services to others? If yes, complete the Medical Staffing Supplemental.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total revenues derived from Supplemental Staffing services? \$ _____		
C. Does the Applicant provide Mental Health Program Services and utilization?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Outpatient Group Counseling Number of Groups per week: _____ Number of persons per group: _____ How often does each group meet per week: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Individual Counseling Number of clients seen weekly: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Partial Hospitalization/Day Treatment Program Number of patients attending per day _____ Number of hours attended daily _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Weekend DUI Intervention Program Number of groups per year: _____ Average number of patients attending per day: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Testing/Collections Services Number of drug tests or collections done annually: _____ If Yes, please attach a copy of procedures for collection.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Methadone Maintenance Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Visits – Count each patient each time they enter your facility for healthcare related services, regardless of the number or departments visited or the number of procedures/treatments performed within each department.

Beds – Use the total number of beds

Donations – Use the number of units received from a donor whether paid or not.

Annual Receipts – Use gross receipts. Do not adjust this figure for items as profits, un-collectible accounts or amounts billed but not paid.

V. ADMINISTRATION AND STAFF						
A. Is there an employed or contracted medical director on staff? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Does the Medical Director provide direct patient care?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Name of Medical Director	Specialty	Insurance Carrier/ Policy Number/Policy Period	Check One; <input type="checkbox"/> Employee <input type="checkbox"/> Contractor	Hours per Month:	Financial Interest:	
B. Physicians/Surgeons						
Names	Specialty	Insurance Carrier/ Policy Number/Policy Period	Check One: <input type="checkbox"/> Employee <input type="checkbox"/> Contractor	Hours per month:	Financial Interest**:	
			<input type="checkbox"/> Employee <input type="checkbox"/> Contractor			
			<input type="checkbox"/> Employee <input type="checkbox"/> Contractor			
			<input type="checkbox"/> Employee <input type="checkbox"/> Contractor			
			<input type="checkbox"/> Employee <input type="checkbox"/> 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 Professional (indicate number of personnel in each applicable category)						
	Full – Time	Part – Time	Full – Time	Part – Time	Full – Time	Part - Time
	Employees		Contractors		Volunteers	
Aides						
Chiropractors						
Counselors						
Dentists						
Dieticians						
EMTs/Paramedics						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/Clinicians						
Occupational Therapists						
Oral Surgeons						
Pharmacists						
Physical Therapists						
Physicians/Surgeon/First Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Speech Therapists						
Technicians						
Other (Describe):						

VIII. CONTRACTUAL AGREEMENTS

-
1. Does Legal Counsel review all contractual agreements: Yes No
2. Are you required to name any other entity as an Additional Insured? Yes No
 If so, list name and address of each entity and the business relationship.
- _____
- _____
- _____
3. Do you contract with others to provide medical services to your patients? If so, please describe.
- _____
- _____

IX. Medical/Dental/Surgical Equipment

-
1. Owned:
- a. Briefly describe your preventative 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? Yes No
If yes, please describe in the Comments Section.
- 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? Yes No
If yes, please describe in the Comments Section
- d. Is any of the equipment sold with your company's label? Yes No
If yes, please describe in the Comments Section
- 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:

X. 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

Please provide premises information for all locations to be insured:

Address/Occupancy	Square Footage	Age	Type of Construction	Number of Floors	Type of Fire Protection*
Medical Facilities locations:					
Other Buildings	None				

*Fire Protection Key: AS=Automation Sprinkler, H=Heat Detector, S=Smoke Detector, A=Automatic Alarm

XI. 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:

XII. 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

XIII. 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 five 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:

<u>Policy Period</u>	<u>Carrier</u>	<u>Limits</u>	<u>Ded/SIR</u>	<u>CM or Occ</u>	<u>Retro Date</u>	<u>Premium</u>

THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER’S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE OR ISSUE A POLICY.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

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 KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD 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.

NOTICE TO MINNESOTA, OHIO, AND ARKANSAS APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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, WHICH IS A CRIME.

NOTICE TO OKLAHOMA APPLICANTS: 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 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.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

Applicant		
By (<i>CEO/President/Chairman</i>)	Title	Date

NOTE: This Application must be signed by the Chief Executive Officer, President or Chairman of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

REQUIRED INFORMATION

Produced By (<i>Insurance Agent</i>) Please print and sign name <hr/> <hr/>	
Insurance Agency	
Insurance Agency Taxpayer ID or Social Security No.	Agent License No.
Address (<i>No., Street, City, State and ZIP</i>)	
E-Mail Address	

Submitted By (<i>Insurance Agency</i>)	
Insurance Agency Taxpayer ID or Social Security No.	Agent License No.
Address (<i>No., Street, City, State and ZIP</i>)	