MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY and GENERAL LIABILITY APPLICATION

(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I - GENERAL INFORMATION

1) Full Name of Applicant:
(Include all DBAs and subsidiaries seeking coverage under the policy for which you are applying)

2) Mailing & Location Address (If multiple locations, include an attachment with a complete list of locations)
Mailing:

Location:

3) Website Address(es) (if applicable):

4) Date Established (mm/dd/yy):

5) FEIN:

6) Type of Entity: Corporation Partnership Professional Association Sole Proprietor
Government Entity Other (describe):

7) Description of Operations:

8) Is this entity owned by, associated with or controlled by any other entity or are you part of a franchise? Yes No
If Yes, describe:

9) Are any of your services provided in, or under contract to a facility or entity that you own, operate or are somehow affiliated with? Yes No
If Yes, describe:

10) Does the Applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? Yes No

If Yes, provide complete details including name of entity, your ownership interest or contractual relationship, and information on their insurance program(s):

11) Within the next 12-month period, does the applicant plan to:

a. Obtain another operation or entity? Yes No

b. Add to the number of employees? Yes No

c. Expand the number of locations? Yes No

d. Eliminate current services or add new services? Yes No

e. Operate in other states? Yes No

If Yes to any of the above questions, describe:

12) Organization Accreditations/Certifications/Licensures:

a. Accredited:

b. Certified:

c. Licensed:

d. Has the applicant's accreditation, certification or license been suspended or revoked? Yes No

If Yes, describe:

SECTION II – EXPOSURES [PROFESSIONAL ACTIVITIES & SPECIALTIES]

13) Describe in detail all of your professional services and indicate the percentage of gross receipts/revenues derived from each activity:

Description of Professional Services	Percentage of Revenue
	%
	%
	%
	%

14) Does your practice include Pain Management? Yes No

If Yes, specify the percentage of your practice derived from Prescription Only Pain Management. %

15) Does your practice include prescribing of opioids? Yes No

If Yes, provide the following details:

a. Specify the percentage of your practice derived from opioid prescriptions: %

b. Do you fully comply with the CDC Guideline for Prescribing Opioids? Yes No

c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? Yes No

d. Do you also dispense the opioids? Yes No

16) Complete all sections that apply:

	Revenue	# of Outpatient Visits	# of Inpatient Beds	# of Non-Emergency Transports	# of Emergency Transports	# of Students
Next 12 Months						
Last 12 Months						
Two Years Ago						

17) Provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of the Applicant:

	Employee or Volunteer	Independent Contractors	Insured on Own Med Mal Policy	Current Carrier & Limits of Liability
Physicians (no surgery)			Yes No	
Physicians (surgical)			Yes No	
Physicians Assistants			Yes No	
Surgical Technicians			Yes No	
Certified Nurse Anesthetists			Yes No	
Nurse Practitioners			Yes No	
Registered Nurses			Yes No	
LPNs or Nurse Aides			Yes No	
X-Ray Technicians			Yes No	
Medical Assistants			Yes No	
Optometrists			Yes No	
Opticians			Yes No	
Pharmacists			Yes No	
Pharmacy Technicians			Yes No	
Chiropractors			Yes No	
Massage Therapists			Yes No	
Laboratory Technicians			Yes No	
Paramedics			Yes No	
EMTs			Yes No	
Social Workers			Yes No	
Aestheticians			Yes No	
Other:			Yes No	

18) Do you have a Medical Director? Yes No

If Yes, provide the following details:

a. What is the name of your Medical Director?

b. What is the specialty of your Medical Director?

c. Does the Medical Director provide good faith exams or develop treatment plans? Yes No

d. Does the Medical Director have direct patient care? Yes No

If Yes, does the Medical Director carry a medical malpractice policy? Yes No

What limits of liability are carried and what is the name of the insurance carrier?

e. Does the Medical Director have supervisory duties over allied healthcare professionals? Yes No
If Yes, describe:

f. Are you seeking coverage for the Medical Director's direct patient care under this policy? Yes No
If Yes, provide a Physician's Short Form Application.

19) Has the applicant or any of the above employees and/or independent contractors:

a. Ever been subject to a disciplinary or investigative proceeding or been reprimanded by a government or administrative agency, hospital or professional association? Yes No

b. Ever been convicted of a criminal act other than traffic offenses? Yes No

c. Ever been treated for alcoholism or drug addiction? Yes No

d. Ever had any professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered such license? Yes No

If Yes to any of the above questions, describe:

20) If you offer any of the following substance abuse or behavioral health services, complete the table below: N/A

Service	# of Annual Visits	Service	# of Annual Visits
Methadone		MAT (Medication Assisted Treatment)	
Suboxone		IOP (Intensive Outpatient Program)	
Vivitrol		TMS (Transcranial Magnetic Stimulation)	
Detoxification		Ketamine Therapy	
Detoxification under anesthesia		Counseling (Marriage, Individual, Family)	
PHP (Partial Hospitalization Program)		Other:	

21) For inpatient services, provide the following, if applicable: N/A Yes No

a. Do you provide rapid detox under anesthesia services? Yes No

b. For inpatient beds, provide the average length of stay:

c. Provide the medical staff to bed ratio breakdown along with the shift structure and hours below:

8-Hour Shift Structure	Staff: Resident Ratio	12-Hour Shift Structure	Staff: Resident Ratio
7:00am – 3:00pm		7:00am – 7:00pm	
3:00pm – 11:00pm		7:00pm – 7:00am	
11:00pm – 7:00am			

22) Is anesthesia (other than topical or by means of local infiltration) administered by, for or at the Applicant's facility? Yes No

If Yes, what percentage of procedures require general anesthesia? %

What procedures require general anesthesia?

Who administers the general anesthesia?

23) Does the Applicant have a training school or provide internships? Yes No
If Yes, answer the following questions:

a. What profession or topic are the students being trained on?

b. How many students are trained per year?

c. Does their training include clinical training involving direct patient care? Yes No

If Yes, are you requesting coverage for students under this policy? Yes No

d. What are the qualifications of the faculty providing the training?

24) Does the Applicant participate in any clinical trials? Yes No
If Yes, describe:

25) Are you under contract with any non-owned entity? Yes No
If Yes, provide the entity's name, services performed and a copy of the specimen of the contract including the scope of services:

26) Do you provide any services to long term care facilities including but not limited to nursing homes, assisted living facilities, and/or senior homes? Yes No

What percentage of overall services are performed to long term care facilities? %
Provide a brief explanation of these services:

27) Do you provide any correctional care services? Yes No

What percentage of overall services are correctional care? %
Provide a brief explanation of your correctional care services:

SECTION III – RISK MANAGEMENT

28) Are background checks performed on all employees, independent contractors and volunteers? Yes No

If Yes, what level or type of criminal background checks?

County State Federal Sexual Offender Registry

If No, describe:

29) Are all employees, independent contractors and volunteers screened for drugs and alcohol? Yes No

If Yes, how often are screens performed?

30) How are patients referred to the Applicant?

31) Do you have a policy to prevent sexual abuse or allegations of sexual abuse? Yes No
If Yes, describe and advise how often it is reviewed:

SECTION IV – NETWORK SECURITY AND DATA PRIVACY PROCEDURES

32) Do you currently purchase a standalone cyber policy? Yes No

If Yes, provide the following information:

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

33) Do you employ the following tools to protect private sensitive data?

a. Anti-Virus and Firewalls Yes No

b. Encryption Yes No

c. Formal Password Management Procedures Yes No

34) Are you compliant with the Health Information Portability and Accountability Act (HIPAA) and Health Information Technology for Economic Critical Health Act (HITECH)? Yes No

35) Have you ever experienced a security breach, data loss or denial of service attack? Yes No

If Yes, complete a Supplemental Claim Information Form for each and every claim.

SECTION V – ADDITIONAL COVERAGES INFORMATION

36) Do you publish or broadcast any material other than for your own advertising activities? Yes No
If Yes, describe:

37) Do you develop or sell software to third parties for a fee? Yes No
If Yes, describe:

38) Do you do medical billing services for others for a fee? Yes No

If Yes, do you have a separate Professional Liability policy for these services? Yes No
Describe:

39) Do you do your own medical billing? Yes No
If No, who does your medical billing?

40) Are you HIPAA compliant? Yes No

SECTION VI – COVERAGE HISTORY

41) Provide the following information as respects the last five years of PROFESSIONAL LIABILITY coverage beginning with the most current coverage: (If none, state NONE)

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

42) Are you interested in a quote for General Liability? Yes No

If Yes, complete the General Liability Supplemental Application below.

SECTION VII – CLAIMS HISTORY

43) Has any application for professional liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, cancelled or have any policies been non-renewed? Yes No

If Yes, provide details including name of carrier and date:

44) Has any claim ever been made against the Applicant or any of its employees? Yes No

If Yes, complete a Supplemental Claim Information Form for each and every claim.

45) Is the applicant aware of any errors, omissions, circumstances or incidents which may result in a claim being made against them or their employees, or are there any claims that have not yet been reported? Yes No

If Yes, provide complete details:

46) Have any of the Applicant's employee(s) or independent contractors been the subject(s) of alleged or actual incidents regarding sexual abuse or molestation or child abuse/neglect? Yes No

If Yes, provide details on a separate attachment.

GENERAL LIABILITY SUPPLEMENTAL APPLICATION

SECTION I – YOUR LOCATIONS

IF YOU HAVE MORE THAN FIVE (5) LOCATIONS, PROVIDE A SPREADSHEET WITH THE INFORMATION BELOW FOR EACH LOCATION.

1)

Loc #	Facility Name	Address	Description / Use	Square Footage
1				
2				
3				
4				
5				

	Location 1	Location 2	Location 3	Location 4	Location 5
Own or Lease	Own Lease	Own Lease	Own Lease	Own Lease	Own Lease
% occupied by applicant	%	%	%	%	%
Are there other occupants?	Yes No	Yes No	Yes No	Yes No	Yes No
# of beds / units (if applicable)					

SECTION II – MAINTENANCE

2) Does the Applicant have a full-time maintenance staff? Yes No

Confirm the type of maintenance, service and repair performed by the Applicant (Direct) or subcontracted (Subbed) by completing the table below.
NOTE: Direct is a percentage of total direct payroll and Subbed is a percentage of total subcontractor cost.

Type	Direct	Subbed
Snow & Ice Removal	%	%
Janitorial/Cleaning Services	%	%
General Maintenance & Repairs	%	%
Landscaping	%	%
Other:	%	%

3) Does the Applicant have written procedures for routine inspections of the premises to identify and address potential liability hazards? Yes No

If Yes, are records of the completed inspections and repairs retained for at least five years? Yes No

4) Are there any construction projects planned for the upcoming policy term? Yes No

If Yes, provide full details of project, location, total costs, payroll and sub costs:

a. Will the construction be subbed out? Yes No

b. Are signs clearly posted to warn the third party of construction and/or during routine Maintenance? Yes No

SECTION III – FIRE-LIFE SAFETY INFORMATION

5) Are all of your locations equipped with:

a. Complete sprinkler system? Yes No

b. At least two clearly marked exits on each floor? Yes No

c. Smoke detectors? Yes No

d. Emergency electrical system? Yes No

e. Heat sensors? Yes No

f. Fire escape(s)? Yes No

g. Posted emergency evacuation procedures? Yes No

h. Properly maintained fire extinguishers? Yes No

Attach a separate sheet detailing any No answers.

SECTION IV – OTHER PREMISES EXPOSURES

6) Are any of the following provided:

a. Sale of any food or drinks? Yes No

b. Recreational facilities? Yes No

c. Gym or exercise equipment available to members or the public? Yes No

d. Swimming pool on any premises? Yes No

e. Daycare or childcare services? Yes No

f. Sponsor any sporting or social events? Yes No

g. Hold any fundraising events? Yes No

h. Provide alcohol with any of your events or services? Yes No

i. Participation in trade shows, exhibits or conventions? Yes No

j. Any plans for new construction or renovations during the next twelve (12) months? Yes No

Attach a separate sheet detailing any Yes answers.

SECTION V – PRODUCTS AND EQUIPMENT SOLD OR LEASED

7) Do you loan, lease or rent equipment to others? Yes No

a. Annual gross revenue **for equipment rental**? $

b. With or without operator (technician)? With Without
Provide details:

c. Who is responsible for equipment maintenance?

8) Do you sell durable medical equipment? Yes No
If Yes, complete the following table for Medical Equipment Suppliers Revenue:

	Annual Sales	Annual Lease/Rental
Category I: Expendable Items (i.e. adhesive tape, bandages, hypodermic needles)	$	$
Category II: Non-Expendable Items (i.e. hospital beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.)	$	$
Category III: Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, transmitting devices)	$	$
Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.)	$	$

SECTION VI – ADVERTISING

9) Do you obtain proper consents and utilize contractual agreements prior to using the image/oral/written publication of any person/celebrity? N/A Yes No

10) Are you making any structure/function claims for your products on labels, websites or other marketing materials? Yes No

Do you maintain documentation that substantiates each claim you make? Yes No
If Yes, explain the documentation and length of time records are retained:

SECTION VII – ADDITIONAL INSUREDS

11) List all parties that should be considered for Additional Insured status under the General Liability.
Include a copy of the contract for each entity and a certificate of insurance evidencing GL coverage in place.

Name and Address	Relationship to Applicant

SECTION VIII – PRODUCTS & COMPLETED OPERATIONS

Attach a separate sheet detailing any Yes answers, along with a list of products sold.

If product labels cannot be found on your website, include copies with this application.

12) Do you sell any products? Yes No
If No, skip to question 29.

If Yes, answer the following questions and include product brochures.

Describe the types of products you sell:

13) Total gross revenue **from product sales**:

a. Last twelve (12) months: $

b. Next twelve (12) months: $

14) Any herbal supplements, homeopathic remedies, and/or nutraceuticals? Yes No

15) Do any of your products include:

a. Caffeine exceeding 300 mg per servicing (all sources)? Yes No

b. Cannabidiol (CBD) hemp products? Yes No

c. Class I & Class II Medical Products / Devices? Yes No

16) Do you mix or compound any ingredients? Yes No

17) Is a prescription required for any of the products you sell? Yes No

18) Are products of others sold or re-packaged under your label? Yes No

19) Do all of your labels include a disclaimer that the FDA has not evaluated the claims on your labels and that your products are not intended to diagnose, treat, cure or prevent any diseases? Yes No

20) Do you obtain Certificates of Insurance from all suppliers evidencing Product Liability Insurance? Yes No

21) Are foreign products sold, distributed, or used as components? Yes No

22) Have any of your products been recalled, discontinued or changed? Yes No

23) Do you offer training or instruction to the user of your products? Yes No

24) Do you offer guarantees, warranties or Hold Harmless agreements with your products? Yes No

25) Do you install, service of demonstrate products? Yes No

26) Is research and development conducted or new products? Yes No

27) Are any new products planned in the next year? Yes No
If Yes, provide explanation:

28) Are you a manufacturer, wholesaler or importer of products to others? Yes No

If Yes, answer the following questions and attach a separate sheet detailing any No answers, along with copies of product labels (if not available on website).

a. Are all warning labels and instructions for use reviewed by outside legal counsel? Yes No

b. Has legal counsel reviewed your labeling and confirmed it is in compliance with regulations established by the FDA and FTC? Yes No

c. Have you conducted or are you planning to conduct human clinical trials to substantiate your product claims? Yes No

SECTION IX – PRIOR GENERAL LIABILITY COVERAGE HISTORY

29) List prior General Liability insurance carried for each of the past five (5) years. If NONE, check this box

Insurance Company	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form?	Retro Date
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

SECTION X – CLAIMS

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

30) Has any General Liability claim or suit been brought against you and/or any of your employees? Yes No
If Yes, complete a Supplemental Claim Information Form for each and every claim or suit.

31) Are any persons or entities proposed for this insurance aware of any fact, circumstance, or situation which may result in a GL claim, and has not been reported to your current GL insurance carrier? None to Report Yes No
If Yes, provide details:

32) Are you aware of any incident, condition, circumstance, defect or suspected defect in any product, which may result in a claim or claims against you that are not listed above? None to Report Yes No
If Yes, provide details:

Attach the following information:

- 5 years currently valued carrier loss runs
- A complete roster of physicians that are contracted with your facility
- Copies of informed consent documents

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or 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. *Applies in MD only.

Applicable in CO: 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.

Applicable in FL and OK: 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)*. * Applies in FL only.

Applicable in KS: 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 commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: 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.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.