



Name of Insurance Company
To Which Application Is Made: _____
(herein called the Company)

APPLICATION FOR HEALTHCARE FACILITY
PROFESSIONAL & COMMERCIAL GENERAL LIABILITY INSURANCE

Instructions:

- 1. Please type or print clearly.
- 2. Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do apply, print " N/A' in the space.
- 3. If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.
- 4. This form must be completed, dated and signed by a principal of your facility.

I. GENERAL INFORMATION

Producer Name: _____

Address: _____
Street City State Zip

Telephone Number: _____
(Area Code) Number

Applicant Name: _____

Business Address: _____
Street City State Zip

Mailing Address: _____

Years In Business: _____ Employer Federal Tax I.D. No.: _____ Telephone No.: _____

Requested effective date: _____ Retroactive date: _____

Current Form Of Insurance: Professional Liability: [] Occurrence [] Claims-made
Commercial General Liability: [] Occurrence [] Claims-made

Applicant is a:
[] Corporation [] Partnership
[] Professional Association [] Sole Proprietorship
[] Joint Venture [] Other (Please Explain) _____

Applicant operates: [] For Profit [] Not for Profit

Limits of Liability*

- \$100,000/\$300,000 \$200,000/\$600,000
 \$500,000/\$1,000,000 \$1,000,000/\$3,000,000 Other: _____

**Professional Liability and General Liability Limits must be the same, but apply separately*

Deductible (applies separately to Professional Liability and General Liability)

- None \$5,000 \$25,000
 \$2,500 \$10,000 Other _____

List below all subsidiaries, date acquired, description of operations & ownership in percentages

Subsidiaries	Date Acquired	Description of Operations	% Ownership

II. PROFESSIONAL LIABILITY

1. **Services Provided:** Indicate all services provided by your facility, giving requested information for each classification. Information given should be projected numbers for the next 12 months. "Visits" are defined as the number of patients entering your facility for health related services. DO NOT tally the number of departments visited or the number of procedures or treatments performed. "Beds" are defined as the average number of occupied beds.

Laboratory	Annual Receipts
X-Ray/Imaging	
Mobile X-Ray/Imaging	
Ocular	
Dental	
Medical	
Routine Clinical Pathology	
Quality Control/Reference Research Development	
Pharmaceutical	
Other:	

Surgical Center	# of Procedures	Overnight Beds
Emergicenter		
Surgicenter		

Schools for Health Care Providers	# of Students	# of Faculty
Chiropractic		
Dental		
Medical		
Nursing		
Other (<i>please describe</i>):		

Outpatient Clinic	Outpatient Visits	Beds
Multispecialty		
Other (<i>please describe</i>):		

Organ Banks	Annual Receipts
Organ or Tissue Procurement Center: No direct processing or contact	
Organ or Tissue Procurement Center: Direct processing or contact	

Rehabilitation Center	Outpatient Visits	Beds
Cardiac Rehabilitation		
Physical or Occupational Rehabilitation		
Trauma Rehabilitation Therapy		
Transitional Living		
Skilled Medical		

Treatment Center	Outpatient Visits	Beds
College or University Health Centers		
Community Health Centers		
Crisis Stabilization		
Mental Health & Counseling Services		
Municipal Health Department		
Urgicenter		
Other (please describe)		

2. **Professional Employees/Independent Contractors:** Please provide information requested for each physician/ surgeon providing services at your facility

Medical Director* Name	Specialty	Insurance Carrier & Policy Number	Type of Surgery**	Procedures/ Month***	Employee/ Contractor	Hours/ Month
Other Physicians & Surgeons Names	Specialty	Insurance Carrier & Policy Number	Type of Surgery	Procedures/ Month	Employee/ Contractor	Hours/ Month

* **A PHYSICIAN WILL ONLY BE COVERED IN HIS/HER CAPACITY AS A MEDICAL DIRECTOR FOR ACTIVITIES RELATING TO ADMINISTRATION OF THE FACILITY.**

** Surgery Definitions:

No Surgery - No surgical procedures performed other than circumcisions, incision of boils and superficial abscess or suturing of skin and superficial fascia. Includes closed fractures of the fingers and toes.

Minor Surgery - Assisting in surgery on physician' s own patients, including closed bone fractures, except those of the fingers and toes, and D&Cs or vasectomies performed under local anesthesia.

Major Surgery - Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen or pelvis; any other operation which, because of the condition of the patient or length or circumstances of the operation presents a distinct hazard to life. It also includes removal of tumors, open bone fractures, amputations, abortions, cesarean sections, the distinct hazard to life. It also includes removal of tumors, open bone fractures, amputations, abortions, cesarean sections, the removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies and any operations done using general anesthesia.

*** Procedures - Indicate the number of times per month, on average, each doctor performs the following techniques. Give total number for all procedures:

Acupuncture-other than anesthesia

Angiography

Arteriography

Catherization-arterial, cardiac, or diagnostic, other than:

- a) Occasional emergency insertion of pulmonary wedge, pressure recording catheters, or temporary pacemakers.
- b) Urethral catherization
- c) Umbilical cord catherization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen.

Colonoscopy/Sigmoidoscopy

Cryosurgery-other than use on benign or premalignant dermatholgical lesions

Discograms

ERCP (Endoscopic retrograde cholangiopancreatography)

Laser-used in therapy

Lymphangiography

Myelography

Needle biopsy-including lung and prostate but not including liver, kidney or bond marrow biopsy.

Pneumatic or mechanical esophageal dilation (not with bougie or lolive)

Pneumoencephalography

Radiation therapy

Radiopague due injections into blood vessels, lynphatics, sinus tracts and fistulae

Shock Therapy

NOTE: If any physician/surgeon is to be provided coverage under this policy, a supplemental application must be completed and an additional charge will be applied

3. Other Health Care Professionals: Indicate the number in each category, full-time and part-time

	Employees		Contractors		Volunteers	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
Dentists						
Emergency Medical Technicians						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/Clinicians						
Occupational Therapists						
Oral Surgeons						
Physical Therapists						
Physician Assistants						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Technicians						
Other (define)						

4. Do you currently comply with any state licensing requirements for your facility? Yes No
If yes, describe. If no, state reasons for non-compliance and corrective actions being taken.

5. Is the facility a member of any professional organizations or associations? Yes No

If yes, please name: _____

6. Is the facility accredited by any governmental body or other organization (JCAHO, CARF, AAAHC)? Yes No

- No Accreditation available
- Accreditation available, facility not accredited

If yes, please describe and include a copy of the accreditation report. _____

7. Do you have written requirements that the following providers carry Professional Liability Insurance? Please indicate the limits required.

	Yes	No	Limits
Physicians			
Surgeons			
Oral Surgeons			
Dentists			
Nurse Anesthetists			
Nurse Midwives			

8. Has any outside organization (JCAHO, government, insurance company) conducted an inspection of your facility within the past 3 years? Yes No

If yes, please indicate the name of the organization and type of inspection (physical plant, nursing protocols) and include a copy of the report.

_____ Name

_____ Type of Inspection

III. RISK MANAGEMENT/LOSS CONTROL

1. Does your facility have a formalized Risk Management Program? Yes No

2. Who coordinates your Risk Management Program?

Name: _____

Title: _____

Phone Number: _____

3. Does the facility own any biomedical or other equipment used for diagnosis, monitoring or treatment purposes? Yes No
- If yes, who is responsible for inspection and maintenance of the equipment?
 Employees Independent Contractor
- Do qualified personnel inspect and maintain the equipment on a regular basis? Yes No
- Are manufacturers recommendations followed for all maintenance and repair of equipment? Yes No
4. Do you have any contractual agreements with independent contractors/providers to provide services at your facility? Yes No
- If yes, please provide a copy of a sample contract.
- Are certificates of insurance obtained from all contracted providers? Yes No
5. Does the facility provide services to others on a contractual agreement? Yes No
- If yes, please describe services provided and include a copy of the contract. _____

6. Has the facility agreed to hold harmless or indemnify others under contract? Yes No
- If yes, please describe and include a copy of the contract. _____

7. Does the facility rent or lease any biomedical or other equipment? Yes No
- If yes, please describe: _____

8. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:
- Check of educational background, or residency program, when applicable.
- Check of previous employers In writing By telephone
- Check of personal references In writing By telephone
- Check on hospital privileges for physicians, oral surgeons and dentists
- How often do you update your list of specific privileges? _____
- Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
- Require information on any professional liability or work-related claim that has previously been made against any individual.
9. Does your facility have written job descriptions? Yes No

IV. COMMERCIAL GENERAL LIABILITY INFORMATION

1. Please provide physical plant information as requested:

Address/Occupancy	Square Footage	Age	Type of Construction	# of Floors	Type of Fire Protection*
Patient Care Buildings					
Other Buildings					

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

2. Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

3. 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: \$ _____

Category I. EXPENDABLE ITEMS - Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)

Annual Sales: \$ _____

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 IV stands including medical and surgical instruments unless considered diagnostic or treatment, etc....

Annual Sales: \$ _____ Annual Lease/Rental Receipts: \$ _____

Category III. DIAGNOSTIC OR TREATMENT DEVICES - This category includes oxygen and other medical gasses used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV. pumps, portable EKG machines, or sending devices.

Annual Sales: \$ _____ Annual Lease/Rental Receipts: \$ _____

Category IV. LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES - This category includes dialysis or heart/lung machines, apnea monitors, SIDA monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.

Annual Sales: \$ _____ Annual Lease/Rental Receipts: \$ _____

Have any of the products that you distribute ever been recalled? Yes No

4. Do you provide preventive maintenance or repairs on medical equipment leased to others? Yes No

If yes, please provide details: _____

V. POLICY AND LOSS INFORMATION

1. Please provide past policy information as requested. List all General Liability and Professional Liability policies for each of the past five years. Begin with the current policies on the top line.

	Policy Period	Insurer	Policy Limits	Deductibles	Total Premium	Claims made or Occurrence
Commercial General Liability Professional Liability						
Commercial General Liability Professional Liability						
Commercial General Liability Professional Liability						
Commercial General Liability Professional Liability						
Commercial General Liability Professional Liability						

If claims-made, indicate retroactive date. _____

2. Are you aware of any circumstance, accident or loss which has occurred after the retroactive date, which may result in a claim? Yes No

If yes, provide complete details. _____

3. Have any claims ever been made against you? Yes No

If yes, please give dates, allegations and disposition of each claim or suit in the comments section.

4. Has the facility ever had any Insurance Company or Lloyd's Syndicate decline, cancel, refuse to renew or accept only on special terms any Professional Liability Insurance?
(NOTE: MISSOURI APPLICANTS DO NOT REPLY.) Yes No

If yes, please provide explanation: _____

VI. FACILITY SPECIFIC INFORMATION

REHABILITATION FACILITIES

1. Are patients referred to you by a physician? Yes No

If no, please describe referral procedures: _____

2. What is the length of the orientation and training period for new employees and volunteers? _____

Does it include training for the proper use of equipment and special training for high tech areas? Yes No

INPATIENT FACILITIES

1. Was the facility designed or built for this occupancy? Yes No

If no, what was the original occupancy? _____

2. What is the construction? _____ Fire Protection Class? _____ Number of Stories? _____

3. What are the number of exits per floor? _____

4. Are the electrical, heating and plumbing systems up to code and regularly inspected? Yes No

5. Fire Protection:

Are there smoke detectors and fire extinguishers? Yes No

Number and Location _____

Is the building completely sprinklered? Yes No

If partially sprinklered, identify those areas that are sprinklered: _____

Are there fire alarms? Yes No

Number and type (local, central station, etc.) _____

6. Are there evacuation plans posted and drills held regularly? Yes No

7. Are there non-slip surfaces in bathing areas and handrails? Yes No

8. How are the beds licensed? (nursing home, ambulatory facility, etc.) _____

9. What is the minimum number of staff on duty at night? _____

10. What level of care is provided for the beds maintained?

Is skilled nursing care provided including medication administration, injections, catheterizations or other procedures ordered by physicians? Yes No

Is assistance with daily living activities and some medication administration provided but no skilled nursing care? Yes No

Are patients responsible for their own medication but some daily living activities planned, such as meals and social activities? Yes No

11. Do you provide residential care to children or adolescents? Yes No

Please include the following information with the completed application:

1. Previous Insurance Company loss runs for the past five years.
2. Current audited financial statement.
3. Brochures, pamphlets or other advertising material utilized by your facility.
4. Copies of any inspection reports/surveys conducted by outside organizations within the past three years.
5. Copies of any contracts for professional services provided to your facility or by your facility.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS* APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE /SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

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 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 KENTUCKY APPLICANTS:

“Any person who knowingly and with 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 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 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 ARKANSAS 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 policy holder 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 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 MINNESOTA APPLICANTS:

“Any person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.”

Name of Applicant: _____

Title: _____

Date: _____

Agency: _____
NAME

ADDRESS

Agent: _____
PRINT NAME

SIGNATURE

DATE