HEALTHCARE*Pros*
Insurance Solutions for Healthcare Service Providers

U.S. Risk Underwriters
Boston (617.342.7116)
Dallas (800.232.5830)
Houston(800.833.8803)

MISCELLANEOUS HEALTH CARE PROFESSIONAL AND GENERAL LIABILITY APPLICATION

(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter you are working with.
For contact information please visit www.usrisk.com/healthcare.html

Effective date desired:______________________

1. Complete name of facility : ____
   Address: ____
   City: ______________________ State:______ Zip:__________ County: ______________________
   Contact name: ______________________ Title:________________ Email address: ______________________
   Phone: ________________ Web site Address: ______________________Fax: ____________________
   List all other locations **(use an additional sheet of paper if necessary):** ______________________
   ____
   ____

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

3. Date established: ______ /_____

4. List all states where you are licensed to practice: ______________________
   ____
   ____

5. Current accreditations or associations: ❑ NAHC ❑ TAHC ❑ JCAHO ❑ CHAP ❑ NHPCO ❑ Other: __________

6. 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): ______________________
   ____

7. 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: ______________________

8.. Do you provide any internet services? ❑ Yes ❑ No
   If yes, please attach an explanation, including confirmation of licensing in all states in which services are provided.
   ____

9. Does the applicant anticipate any facility expansions within the next year? ❑ Yes ❑ No
   If yes, please describe: ______________________
   ____

10. 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: ____

    ____

11. Hold Harmless (Indemnification) Agreements: -

    (a) In favor of the applicant: - if the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained: ______________________________

    ____

    (b) In favor of others: - has the applicant agreed to indemnity (hold harmless) others under written contract? ❑ Yes ❑ No

    If yes, please submit a copy of the agreement.

12. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule? ❑ Yes ❑ No

    If yes,

    (i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ❑ Yes ❑ No

    (II) Provide the name and title of the Applicant's Privacy Officer. ______________________________

13. **Professional Activities and Specialty (check one)**

❑ Adult Day Care **

❑ Ambulatory Surgery Center **

❑ Chiropractor

❑ Clinic **

❑ Counselor (Describe)

❑ Dental Hygienist

❑ Group Home **

❑ Hearing Aid Fitter

❑ Home Health Care Agency **

❑ Hospice

❑ Laboratory Technician

❑ Medical Staffing Agency **

❑ Mental Health Center **

❑ MRI Centers**

❑ Pharmacist**

❑ Nurse: Anesthetist ______, LPN**____, RN _____

❑ Optician_______, Optometrist______

❑ Paramedics_____, EMT**_____

❑ Perfusionist

❑ Personal Care Home **

❑ Psychologist

❑ Therapist: **
Inhalation___, Occupational ____
Physical ______, Speech _____

❑ Training School **

❑ Veterinarian

❑ X-ray: Lab_____, Technician _____

❑ Other (specify): ________

14. Is there a swimming pool on premises you own or occupy? ❑ Yes ❑ No

15. 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		
Percentage of services provided involving minors (persons under age 18) ______________%		

16. State sources and amounts of actual and projected gross revenue:

Source	**Amount this Fiscal Year**	**Amount Next Fiscal Year**
a. Charitable Contributions		
b. Government Funding		
c. Fee for Service		

17. Describe the type of procedures performed at or by this facility including imaging if applicable: ____________________________

____

____

18. Are all personnel performing these procedures certified? ❑ Yes ❑ No

19. Percentage of professional services performed: ____________ % on premises __________% off premises

20. 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	(k)	Pharmacist
(b)	Inhalation Therapist	(l)	Physical Therapist
(c)	Laboratory Technician	(m)	Certified Physicians Assistant
(d)	Licensed Midwife	(n)	Psychologist
(e)	Nurse Anesthetist	(o)	Registered Nurse First Assist
(f)	Nurse, License Practical	(p)	Social Worker
(g)	Nurse Practitioner	(q)	Speech Therapist
(h)	Nurse, Registered	(r)	Home Health Care Aide
(i)	Optician	(s)	Other (specify):
(j)	Optometrist	(t)	Other (specify):

a. Are all the above individuals licensed in accordance with applicable state and federal regulations? ❑ Yes ❑ No
If no, attach an explanation.

b. Does the applicant have any independent contractors? ❑ Yes ❑ No
If yes, list the number and type of independent contractors who provide professional services on behalf of the applicant: ____

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

d. Name of medical director, if any: ______________________________

(i) Is coverage provided for the medical director under any other insurance policy? ❑ Yes ❑ No

(ii) If yes, please provide type of policy and name of carrier: ______________________________

HIRING PRACTICES

21. a. Do you conduct a criminal background check? ❑ Yes ❑ No

b. Do you require signed applications on all prospective employees? ❑ Yes ❑ No

c. Do you verify all professional qualifications, licenses and certifications? ❑ Yes ❑ No

d. Do you require professional and personal references on each employee? ❑ Yes ❑ No

e. Do you provide training and orientation for new employees? ❑ Yes ❑ No

f. Do you verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities? ❑ Yes ❑ No

g. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? ❑ Yes ❑ No

h. Do you have written job descriptions? ❑ Yes ❑ No

i. Do you require drug/alcohol screening? ❑ Yes ❑ No

RISK MANAGEMENT/LOSS CONTROL

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

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

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

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

INSURANCE AND CLAIM INFORMATION

23. **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	**Policy Period To: MM/DD/YY**	**Insurance Company**	**Limit of Liability**	**Deductible**	**Policy Form: 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

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	**Carrier**	**Limit of Liability BI/PD**	**Deductible**	**Policy Form: Claims Made or Occur-rence?**	**Premium**

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

24. **CLAIMS HISTORY:**

a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ❑ Yes ❑ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS

IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ❑Yes ❑ No
If yes, provide full details. ____

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? ❑ Yes ❑ No
If yes, fully describe the circumstances and follow up action taken: ____________________________________
____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

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.

*Notice applicable in most 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.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____________________________________/____________________ ____________________________

Applicant's Signature **Title** **Date**

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

1. COPY OF 5 YEAR CURRENTLY VALUED HARD COPY COMPANY LOSS RUNS
2. COPY OF THE DECLARATION PAGE OF YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY
3. IF A START UP FIRM, COPY OF THE PROFORMA BUSINESS PLAN
4. COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS
5. COPY OF A SAMPLE CLIENT CONTRACT
6. RESUMES/CV'S FOR ALL KEY PERSONNEL, PRINCIPALS, EXECUTIVES, MEDICAL DIRECTORS AND/OR ADMINISTRATORS

Limits of Liability desired for Professional Liability:

❑ $100,000/$100,000 ❑ $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: _______________

MINIMUM AND MAXIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

YOU SHOULD SECURE PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS, DENTISTS, SURGEONS AND NURSE ANESTHETISTS