HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

NEW ENGLAND EXCESS EXCHANGE

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800-548-4301 • www.neee.com

APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER) PROFESSIONAL AND GENERAL LIABILITY INSURANCE

(CLAIMS MADE AND REPORTED BASIS)

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

I. GENERAL INFORMATION:

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

   _____

   Address: _____

   City: _____ State: _____ Zip:_____ County: _____

   Contact name: _____ Title:_____ Email address: _____

   Phone: _____ Web site Address: _____ Fax: _____

   Location: Stand alone _____ Hospital _____ School _____ Correctional Facility _____ Other _____

2. List all Locations, by name and address where Applicant is registered and licensed to operate:

   Location 1: _____

   Location 2: _____

   Location 3: _____

   Location 4: _____

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

4. Date established: _____ / ____

5. List all states where you are licensed to practice: _____

   _____

6. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered? ❑ Yes ❑ No
   If Yes, provide details._____

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

8. 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):_____

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

   _____

10. Does the applicant or any partner, owner or director own (wholly or in part), operate or administer, any hospital, nursing home or other institution where medical services are customarily rendered? ❑ Yes ❑ No
    If yes, give details: _____

11. Name(s) of all partners or members of the clinic who provide professional services: _____

12. Does the Applicant participate in any state patient compensation fund? ❑ Yes ❑ No

13. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")? ❑ Yes ❑ No
    If Yes, what percentage of services are provided under the FTCA? _____

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. 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.
    _____

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

17. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory? ❑ Yes ❑ No
    If yes, please attach a copy of ALL of the advertisements.

18. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advise is offered to the public? ❑ Yes ❑ No

19. 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.

20. 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. _____

II. OPERATIONS:

1. Days/hours of operation: _____

2. (a) Provide the name and specialty of the Applicant's Medical Director: _____
   (b) Does the Applicant's Medical Director have direct patient contact? ❑ Yes ❑ No
   (c) Is the Applicant's Medical Director ❑ full-time or ❑ part-time?

3. Applicant's professional specialty: _____

4. Provide the percentage of patients/clients:

Bariatrics	_____%	Holistic medicine	_____%	Sleep Disorders	_____%
Communicable Disease	_____%	Obstetrical	_____%	Stress Testing	_____%
Correctional Medicine	_____%	Oncology	_____%	Students	_____%
Dental	_____%	Pain Management	_____%	Substance Abuse	_____%
Disability Evaluation	_____%	Pediatric	_____%	Surgical	_____%
Family Planning	_____%	Physical Rehabilitation	_____%	Urgent Care	_____%
Free Clinic	_____%	Psychiatric	_____%		
Hemodialysis	_____%	Research or Experimental	_____%	**Must Total 100%**	

5. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: _____
   _____

6. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.? ..... ❑ Yes ❑ No

7. Applicant's Gross Revenues:

	Last Twelve Months	Next Twelve Months
Fee for Service	$_____	$_____
Medicare/Medicaid Funds	$_____	$_____
Research	$_____	$_____
Other (describe)	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

8. Number of outpatient/client visits:

	Last Twelve Months	Next Twelve Months
Clinics	_____	_____
Laboratory	_____	_____
X-ray/Imaging	_____	_____
Pharmacy	_____	_____
TOTAL VISITS:	_____	_____

9. Does the Applicant maintain any beds for overnight occupancy:
   (a) On the Applicant's premises? ❑ Yes ❑ No
   If Yes,
   (i) No. of beds: ____
   (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.
   (b) Off the Applicant's premises? ❑ Yes ❑ No
   If Yes,
   (i) No. of beds: ____
   (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

III. STAFF:

1. Indicate the number of professional employees, independent contractors and volunteers. If None, state None

	Employees		**Independent Contractors**		**Volunteers**	
	Full-Time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures						
Physicians: Minor surgery or obstetrical procedures not constituting major surgery						
Anesthesiologists						
Obstetrics-Gynecologists						
Oncologists						
Ophthalmologists						
Urologists						
Dentists						
Chiropractors						
Nurse Anesthetists						
Nurse Practitioners						
Optometrists						
Pharmacists						
Physician Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Other(describe):						

2. Are all of the above persons licensed in accordance with applicable state and federal regulation? ❑ Yes ❑ No
If No, attach explanation.

3. Do all professional staff maintain a Professional Liability Insurance Policy? ❑ Yes ❑ No
If Yes, what are the minimum limits of liability that the Applicant requires?
$_____each claim / $_____ aggregate

IV. PROFESSIONAL SERVICES:

1. Does the Applicant's employees or independent contractors:
   (a) Perform any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? ❑ Yes ❑ No
   If Yes, list all minor/invasive procedures _____
   (b) Perform any anti-aging procedures, including Botox or other injectables? ❑ Yes ❑ No
   (c) Perform abortions and/or menstrual extractions? ❑ Yes ❑ No
   (d) Perform any experimental procedures or research testing? ❑ Yes ❑ No
   If Yes, are they FDA approved? ❑ Yes ❑ No
   If No, attach a description.
   (e) Perform any chelation therapy services? ❑ Yes ❑ No
   If Yes, explain: _____
   (f) Administer anesthesia other than topical or local infiltration? ❑ Yes ❑ No
   If Yes, attach detailed explanation.
   (g) Use drugs for weight reduction for patients? ❑ Yes ❑ No
   (h) Administer any methadone treatment? ❑ Yes ❑ No
   If Yes,
      (i) Provide the number of treatments during the:
      Last 12 months _____ Next 12 months _____
      (ii) Attach a description of treatment and controls used.
   (i) Provide teleradiology services? ❑ Yes ❑ No
   If Yes, provide description of services and for whom services are provided _____
   (j) Offer professional advice to the public via the internet, newspapers or broadcasts? ❑ Yes ❑ No
   If Yes, provide details _____
   (k) Advertise professional services in any manner other than a simple listing in a telephone directory? ..... ❑ Yes ❑ No
   If Yes, attach a copy of all advertisements.

2. Does the Applicant use a collection agency: ❑ Yes ❑ No
If Yes,
   (a) Name of agency: _____
   (b) Does the agency have authority to file a collection suit on behalf of the Applicant? ❑ Yes ❑ No

V. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1.					
2.					
3.					
4.					

2. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:
   (a) Complete Sprinkler System? ❑ Yes ❑ No
   (b) At least two clearly marked exits on each floor? ❑ Yes ❑ No
   (c) Self-closing fire doors on each floor? ❑ Yes ❑ No
   (d) Automatic fire alarm system connected to a local fire department? ❑ Yes ❑ No
   (e) Smoke detectors? ❑ Yes ❑ No
   (f) Emergency electrical system? ❑ Yes ❑ No
   (g) Heat sensors? ❑ Yes ❑ No
   (h) Fire escape(s)? ❑ Yes ❑ No
   (i) Posted emergency evacuation procedures? ❑ Yes ❑ No
   (j) Properly maintained fire extinguishers? ❑ Yes ❑ No
   If any of the above are answered No, provide details by attachment.

4. Does the Applicant have a written safety program in place? ❑ Yes ❑ No
   If Yes, attach a copy of the written safety program.

5. Does the Applicant have written procedures for incident reporting? ❑ Yes ❑ No

6. Do any of the Applicant's locations have any:
   (a) Exposure to flammables, explosive, chemicals? ❑ Yes ❑ No
   (b) Catastrophe exposure? ❑ Yes ❑ No
   (c) Exposure to radioactive materials? ❑ Yes ❑ No

7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? ❑ Yes ❑ No

8. Does the Applicant sell or lease any medical equipment or products to patients/clients or others in connection with Applicant's operation? ❑ Yes ❑ No
   If Yes, Total Annual Sales $_____
   Total Annual/Lease Rental Receipts $_____

9. Does the Applicant:
   (a) Loan or rent machinery or equipment to others? ❑ Yes ❑ No
   (b) Own any elevators or escalators? ❑ Yes ❑ No
   (c) Own or rent any parking facility? ❑ Yes ❑ No
   (d) Provide any recreational facility? ❑ Yes ❑ No
   (e) Have a swimming pool on the premises? ❑ Yes ❑ No
   (f) Sponsor any sporting or social events? ❑ Yes ❑ No

VI. INSURANCE INFORMATION:

1. **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 Occurrence?	Premium

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

VII. HISTORY:

1. Has the Applicant or any of its employees ever:
   (a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency? ❑ Yes ❑ No
   (b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses? ❑ Yes ❑ No
   If Yes, provide details. _____
   _____
   (c) Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders? ❑ Yes ❑ No
   If Yes, provide details. _____
   _____
   (d) Had any professional license or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license? ❑ Yes ❑ No
   If Yes, provide details. _____
2. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years? ❑ Yes ❑ No
   If Yes, attach a copy of such insurer's notice.

VIII. CLAIMS HISTORY:

1. 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

2. 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. _____
3. 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**

IX. ADDITIONAL INFORMATION:

As part of this Application attach the following:

1. A CV of Medical Director including specialty and board certification.
2. A list of any activities or procedures performed that are not otherwise described in this Application.
3. Complete an Additional Insured Supplement for any additional insured that coverage is being requested for under General Liability Coverage.