HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

NEW ENGLAND EXCESS EXCHANGE
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RENEWAL APPLICATION

FOR
MISCELLANEOUS HEALTH CARE
PROFESSIONAL LIABILITY OR PROFESSIONAL & GENERAL LIABILITY

CLAIMS MADE AND REPORTED BASIS.

PLEASE TYPE OR PRINT IN INK

1. Full name of Renewal Applicant: _____

   _____

   Expiring Policy No:_____ Expiration Date:_____

   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. 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): _____

3. 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: _____

4. Does the applicant anticipate any facility expansions within the next year?_____ ❑ Yes ❑ No

   If yes, please describe: _____

   _____

5. 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: _____

6. 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.

7. 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. _____

8. Is there a swimming pool on premises? _____ ❑ Yes ❑ No

9. **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): _____

10. 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		

11. Please state the percentage of services provided involving minors (persons under age 18) _____ %

12. Describe the type of procedures performed at or by this facility: _____

13. Are all personnel performing these procedures certified and properly trained to perform these procedures? _____ ❑ Yes ❑ No

14. Percentage of professional services performed: _____ % on premises _____ % off premises

15. 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

16. Have there been any changes in your hiring practices since you completed the application for the prior policy, for which this is a renewal application?_____ ❑ Yes ❑ No

If so, please advise: _____

RISK MANAGEMENT/LOSS CONTROL

17. Have there been any changes in your risk management/loss control practices since you completed the application for the prior policy, for which this is a renewal application?_____ ❑ Yes ❑ No

If so, please advise: _____

MATERIAL CHANGES

18. Have there been any material changes in your operations since you completed the application for the prior policy, for which this is a renewal application?_____ ❑ Yes ❑ No

If so, please advise: _____

CLAIMS HISTORY

19. **Since completion of the application for the policy identified in Question 1 above:**

a. Have there been any judgments, settlements, or dismissals of any previously reported claims to any prior insurer?

❑ Yes ❑ No

If so, please advise:_____

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s), offense(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: _____

NOTE TO THE APPLICANT – PLEASE READ CAREFULLY

This renewal application and any materials submitted herewith are supplemental to all prior application(s) and renewal application(s) and any materials submitted therewith for all policies for which this policy would be a renewal. All such application(s) and renewal application(s) and any materials submitted therewith, together with this renewal application and any materials submitted therewith, shall be deemed attached thereto as if physically attached hereto, and shall constitute the complete renewal application. The renewal application shall be the basis of the contract should a renewal policy be issued and will be attached to and become part of the renewal policy. The information provided by the applicant within this renewal application shall be deemed material to the issuance of the policy and Underwriters will have relied upon this application and attachments in issuing any policy.

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**