Premium Indication Request for Healthcare Facilities

Please read carefully before completing:

This is a premium indication request only. It is not an application for medical malpractice insurance coverage and does not, in any way, bind coverage. The information contained in this request will be used to acquire premium indications from one or more insurance carriers as appropriate and will otherwise be held in the strictest confidence.

SIGNATURE
After completing the premium indication request, the signature of an authorized representative of the facility is required, along with the date. Please complete the request completely.

CLAIMS INFORMATION
If you have any claims, suits, or incidents alleging malpractice brought against you within the past ten (10) years, complete a claim information sheet for each claim. Each Claim Information Sheet must be completed, signed and dated.

RETROACTIVE ("NOSE") COVERAGE
If you wish to obtain nose coverage, a copy of your most recent declarations page from your current carrier indicating the original effective date of coverage and a current paid through date must be attached.

Tegner-Miller Insurance Brokers - CAMM
2001 Wilshire Boulevard Suite 101
Santa Monica, CA 90403
Phone: 800.775.8642
Fax: 310.453.7971
E-mail: insure@tmib.com

OFFICE USE ONLY

Account No. ________________

Policy No. ________________

Group No. ________________

DATE RECEIVED

If multiple locations exist, please complete a separate application for each location.

SECTION I — GENERAL INFORMATION

1. Name of Applicant ______________________
2. Primary Facility Address ______________________

   City ______________ State ______________ Zip ______________
3. Phone No. (_____) ______________ Fax No. (______) ______________
4. Do you lease or rent this location? ☐ Yes ☐ No Do you own this location? ☐ Yes ☐ No Sq. Ft. ______
5. E-Mail Address ______________________
6. Mailing/Billing Address ______________________

   City ______________ State ______________ Zip ______________
7. Contact Person ______________________
8. Phone No. (_____) ______________ Fax No. (______) ______________
9. Federal Tax I.D. No. ______________ Social Security No. ______________
10. Additional Location ______________________
11. Street Address ______________________

    City ______________ State ______________ Zip ______________
12. Phone No. (_____) ______________ Fax No. (______) ______________
13. Do you lease or rent this location? ☐ Yes ☐ No Do you own this location? ☐ Yes ☐ No Sq. Ft. ______

    List additional names and/or locations in the Remarks Section, Page 15. Also attach a copy of any fictitious name permits or licenses if applicable.

NOTE: A LOCATION MAY BECOME AN "INSURED PREMISES" UNDER THE POLICY ONLY IF IT IS LISTED.

14. Name of Director ____________________ M.D.? ☐ Yes ☐ No

15. Name of Assistant Director ____________________ M.D.? ☐ Yes ☐ No

16. Name of Owner ____________________

17. Ownership

a. The applicant is a (check the appropriate box):

☐ Corporation ☐ Professional Association

☐ Partnership ☐ Sole Proprietorship

☐ Other (Explain) ____________________

b. Applicant operates:

☐ For Profit ☐ Not For Profit

Please list names of all Partners and/or Shareholders in the Remarks Section, Page 15.

SECTION II — APPLICANT INFORMATION

18. Type of organization (Please check ***all*** appropriate boxes):

☐ Birthing Center

☐ Cardiac Rehabilitation Center

☐ College/University Health Center

☐ Community Health Center

☐ Crisis Stabilization Center

☐ Detoxification Facility

☐ Developmental Disability Center

☐ Dialysis Center

☐ Drug/Alcohol & Substance Abuse Center

☐ Emergicenter

☐ Group Home

☐ Halfway House

☐ Health Department

☐ Home Health Agency

☐ Hospice

☐ Laboratory; Type ____________________

☐ Medical Registry Service

☐ Mental Health Clinic

☐ Optical Establishment

☐ Physical/Occupational Rehabilitation Center

☐ Surgicenter

☐ Trauma Rehabilitation Center

☐ Urgicenter

☐ Visiting Nurses Association

☐ X-Ray Imaging Center

☐ Other ____________________

19. Description of Operations: ____________________

____

____

PLEASE SUBMIT A COPY OF YOUR LICENSE FOR EACH LOCATION.

SECTION III — ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS

20. Is your organization accredited by:

- Commission on the Accreditation of Rehabilitation Facilities (CARF)? ☐ Yes ☐ No
- Community Health Accreditation Program (CHAP)? ☐ Yes ☐ No
- Joint Commission on Accreditation of Healthcare Organizations (JCAHO)? ☐ Yes ☐ No
- Any other accrediting organization(s)? ☐ Yes ☐ No

IF YES, PLEASE SPECIFY ____________________

21. Is your organization a member of The National Association for Home Care (NAHC)? ☐ Yes ☐ No

22. Is your organization a member of The Health Industry Distributors Association (HIDA)? ☐ Yes ☐ No

IF YES, YOUR HIDA MEMBERSHIP NUMBER ____________________

23. Are you a member of any state association(s)? ☐ Yes ☐ No

IF YES, NAME OF THE STATE ASSOCIATION(S) ____________________

24. Are you a member of any other industry association(s)? ☐ Yes ☐ No

IF YES, PLEASE SPECIFY ____________________

SECTION IV — HIRING/SCREENING AND EMPLOYMENT PROCEDURES

25. Are employees' references contacted before hiring? ☐ Yes ☐ No

26. How are references checked? ☐ Written ☐ Verbal ☐ Both

IF VERBAL ONLY, PLEASE EXPLAIN ____________________

____

27. Do you screen prospective employees for criminal records? ☐ Yes ☐ No

IF NO, PLEASE EXPLAIN ____________________

____

28. Do you verify certification and/or professional licensure status of employees? ☐ Yes ☐ No

29. Do you screen employees to rule out drug, alcohol and sexual abuse? ☐ Yes ☐ No

30. Do you verify the following when hiring professionals and clinical support staff to provide patient care services at your facility:

- Check of educational background, or residency program, when applicable. ☐ Yes ☐ No
- Confirm hospital privileges for physicians, oral surgeons and dentists. ☐ Yes ☐ No
  How often do you update your list of specific privileges? ____________________
- Confirm that they have no pending license suspensions or revocations, or any pending disciplinary actions by other facilities. ☐ Yes ☐ No
- Require information on any claim previously made against any individual resulting from the performance of or failure to perform professional services while working within the scope of his or her duties. ☐ Yes ☐ No

31. Are written job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No

SECTION V — RISK MANAGEMENT/QUALITY ASSURANCE

32. Does the applicant have a formal written Quality Assurance Program in place? ☐ Yes ☐ No
    IF NO, PLEASE EXPLAIN ______________________________

33. Does the applicant have a formal written Risk Management Program in place? ☐ Yes ☐ No
    IF NO, PLEASE EXPLAIN ______________________________

34. Is the overall responsibility for Risk Management activities assigned to one individual in your organization? ☐ Yes ☐ No
    IF YES, PLEASE LIST NAME AND TITLE ______________________________

    IF NO, PLEASE DESCRIBE HOW THESE FUNCTIONS ARE MONITORED ______________________________

35. Does the applicant conduct patient/client surveys? ☐ Yes ☐ No

    IF YES, PLEASE ATTACH A SAMPLE.

36. Are the results of patient/client surveys used to improve day-to-day operations? ☐ Yes ☐ No

SECTION VI — COVERAGE INFORMATION

LIMITS DESIRED

NOTE: PROFESSIONAL AND GENERAL LIABILITY LIMITS SHOULD BE THE SAME.

37. Health Care Facility Professional Liability

Claims Made Coverage

☐ $1,000,000 Each Loss — $3,000,000 Aggregate Limit

☐ $_________ Each Loss — $_________ Aggregate Limit

Commercial General Liability

Occurrence Coverage

☐ $1,000,000 Each Loss — $3,000,000 Aggregate Limit

☐ $_________ Each Loss — $_________ Aggregate Limit

38. **FLAT DEDUCTIBLES: (Applicable to both professional and general liability.)**

☐ None	☐ $10,000
☐ $1,000	☐ $15,000
☐ $2,500	☐ $20,000
☐ $5,000	☐ $25,000

39. **PARTICIPATING DEDUCTIBLES: (Applicable to both professional and general liability.)**

☐ None	☐ $10,000
☐ $1,000	☐ $15,000
☐ $2,500	☐ $20,000
☐ $5,000	☐ $25,000

40. **DESIRED EFFECTIVE DATE:** ____

RETROACTIVE DATE REQUESTED: ____

PLEASE ATTACH A COPY OF YOUR MOST RECENT DECLARATIONS PAGE FROM YOUR PRESENT CARRIER INDICATING THE ORIGINAL EFFECTIVE DATE OF COVERAGE AND A CURRENT PAID THROUGH DATE.

SECTION VII — DESCRIPTION OF SERVICES

41. Services Provided

Check each box that applies. Please provide requested information for each classification. (Provide projected information for the next 12 months.)

Counseling/Rehabilitation	**Visits**[1]
☐ Cardiac Rehabilitation	______
☐ Crisis Stabilization	______
☐ Developmental Disability	______
☐ Mental Health/Counseling	______
☐ Physical or Occupational Rehab	______
☐ Substance Abuse	
Counseling	______
Skilled Medical Services	______
☐ Trauma Rehabilitation	
Therapy	______
Transitional Living	______
Skilled Nursing	______
☐ Weight Loss Center	______

Laboratory	**Annual Receipts**[3]
☐ Dental	__________
☐ Medical	__________
☐ Ocular	__________
☐ Optical Establishment	__________
☐ Pathology	__________
☐ Pharmaceutical	__________
☐ Quality Control/Reference	__________
☐ Research/Development	__________
☐ X-Ray/Imaging Center	__________

Surgical Center	**Visits**[1]
☐ Abortion Clinic	______
☐ Birthing Center	______
☐ Surgicenter	______

Organ-Blood Tissue	**Annual Receipts**[3]
☐ Organ or Tissue Procurement (No Direct Processing or Contact)	__________
☐ Organ or Tissue Procurement (Direct Processing or Contact)	__________

FOR THE FOLLOWING SERVICES, DESCRIBE YOUR OPERATIONS IN THE REMARKS SECTION, PAGE 15.

Home Care/Hospice	**Visits**[1]	**Beds**[2]
☐ Hospice Care	______	______
☐ Intravenous Therapy	______	______
☐ Personal/Companion Care	______	______
☐ Rehabilitation Therapy	______	______
☐ Respiratory Therapy	______	______
☐ Skilled Care	______	______

Schools For Home Healthcare Professionals	*No. Of Students*
☐ Dental	__________
☐ Medical	__________
☐ Nursing	__________
☐ Optometry	__________
☐ Other	__________

Treatment	**Visits**[1]
☐ College or University Health Center	______
☐ Dialysis	______
☐ Emergicenter	______
☐ Health Department	______
☐ Urgicenter	______

Ambulance Companies	*No. Of Staff*
☐ Air Ambulance	__________
☐ Ambulance Service Company	__________
☐ **Medical Registry Services/Medical Personnel Pools**	__________

Examinations

- ☐ Health Examinations — Annual Exams ______
  (Diagnosis and Inoculations/No Follow-up)
- ☐ Insurance Physicals — Annual Physicals ______
- ☐ **Pharmacy** — Annual Receipts ______
- ☐ **Blood or Plasma Bank** — Annual Donations ______

Community Health Center (Non-Profit)

- ☐ Visits __________
- ☐ Physician Hours __________
- ☐ Surgical Procedures[4] __________
- ☐ Deliveries __________
- ☐ Abortions __________

Board & Care Facilities — Beds[2]

- ☐ Detoxification Facility ______
- ☐ Group Home ______
- ☐ Halfway House ______

[1] Use a threshold count. Count each patient each time they enter the healthcare facility for health related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.

[2] Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.

[3] This figure can be found on your financial statement. Do not adjust this figure for items such as profit, uncollectible accounts or amount billed but not paid by third party payers.

[4] Surgical procedures are defined as all procedures cutting beyond the subcutaneous layer, hemorrhoidectomies and all other procedures limited to the anal ring, herniorraphies (including inguinal, femoral, epigastric, ventral and umbilical), myringotomies, tonsillectomies and adenoidectomies.

SECTION VIII — SERVICES

42. Locations Where Services Are Provided — In Percentages (%) (Total must equal 100%)

- ☐ Private Homes ________%
- ☐ Nursing Homes ________%
- ☐ Hospitals ________%
- ☐ Clinics ________%
- ☐ Doctor's Office ________%
- ☐ Other Locations ________%
  PLEASE SPECIFY: ____________________
  ____

43. Types Of Services Provided — In Percentages (%) (Total must equal 100%)

- ☐ Personal Care Chore or Companion ________%
- ☐ Rehabilitation ________%
- ☐ Infusion Therapy ________%
- ☐ Hospice ________%
- ☐ Supplemental Staffing ________%
  PLEASE COMPLETE SECTION X — SUPPLEMENTAL STAFFING
- ☐ Obstetrical Services ________%
- ☐ Adult Daycare ________%
- ☐ Child Daycare ________%
- ☐ Medical Equipment Supplier ________%
- ☐ Meals On Wheels ________%
- ☐ Respiratory Therapy ________%
  CIRCLE ONE:
  Trachea Care/Ventilator Care
- ☐ Radiation ________%
- ☐ Radiation Therapy ________%
- ☐ Skilled Nursing Care ________%
- ☐ Training Consultants ________%
- ☐ Infant Care ________%
- ☐ Pediatric Care ________%
- ☐ Retail Pharmacy ________%
- ☐ Closed Pharmacy ________%
- ☐ Clinics Owned/Operated ________%
- ☐ Other Services ________%
  PLEASE SPECIFY: ____________________
  ____

44. Services Of Healthcare Professionals — Indicate Number In Each Category

HEALTHCARE PROFESSIONALS	EMPLOYEES		CONTRACTORS		VOLUNTEERS	
	FULL TIME	PART TIME	FULL TIME	PART TIME	FULL TIME	PART TIME
Acupuncturists						
Chiropractors						
Dentists						
Dietitians						
Emergency Medical Technicians						
Hearing Aid Dispensers						
Home Health Aides						
L.P.N.s/L.V.N.s						
Marriage and Family Therapists						
Mental Health Counselors						
Nurses (R.N.s)						
Nurse Anesthetists						
Nurse Midwives						
Nurse Practitioners/Clinicians						
Nutritionists						
Occupational Therapists						
Opticians						
Orthopedic Technicians						
Oral and Maxillofacial Surgeons						
Perfusionists						
Pharmacists						
Physical Therapists						
Physicians						
Physician Assistants						
Podiatrists						
Psychologists						
Respiratory Therapists						
Social Workers						
Speech Therapists						
Technicians						
Other (Describe in the Remarks Section, Page 15.)						
TOTALS						

SECTION IX — SALARIED EMPLOYEES/INDEPENDENT CONTRACTORS

45. Physicians Who Are Salaried Employees Of Or Independent Contractors For The Facility.

EACH PHYSICIAN MUST COMPLETE A SEPARATE PHYSICIAN APPLICATION

NOTE: IF APPLICANT IS A SURGICENTER, PHYSICIAN APPLICATIONS SHOULD NOT BE COMPLETED.

PHYSICIAN'S NAME	NUMBER OF HOURS WORKED PER MONTH

If additional space is needed, please use the Remarks Section, Page 15.

SECTION X — SUPPLEMENTAL STAFFING

46. Supplying Healthcare Providers To Other Facilities For A Fee

- ☐ Clinics ________%
- ☐ Hospitals ________%
- ☐ Other Facilities ________%
  PLEASE SPECIFY: ________________________
  ____

- ☐ Nursing Homes ________%
- ☐ Physicians' Offices ________%
- ☐ Other Facilities ________%
  PLEASE SPECIFY: ____________________
  ____

IF THERE IS NO SUPPLEMENTAL STAFFING, PLEASE CHECK HERE: ☐

SECTION XI — GENERAL LIABILITY COVERAGE

Owned Or Leased Premises

47. Are any bed or board or overnight services provided? ☐ Yes ☐ No

    IF YES, PLEASE EXPLAIN ____

48. Do you provide any "high tech" services (i.e.: trachea care, ventilator care, chemotherapy, etc.)? ☐ Yes ☐ No

    IF YES, PLEASE EXPLAIN ____

49. Does the applicant enter into any contractual agreements (i.e.: with hospitals, nursing homes or other healthcare facilities)? ☐ Yes ☐ No

    IF YES, LIST AND ATTACH COPIES OF ALL AGREEMENTS ____________________________________

    ____

    a. Do these agreements contain hold harmless or indemnification clauses favorable to the applicant? ☐ Yes ☐ No

50. Are certificates of insurance obtained from all subcontractors? ☐ Yes ☐ No

51. List all entities to be named as additional insureds, including names and insurable interest.

PLEASE ATTACH A COPY OF EACH CONTRACTUAL AGREEMENT — EXCLUDING LANDLORDS

#	Field
1	**NAME**
	ADDRESS
	INSURABLE INTEREST
2	**NAME**
	ADDRESS
	INSURABLE INTEREST

52. Has the applicant sold, acquired, or discontinued any operations in the past five (5) years? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ____

53. Is the applicant considering any changes in operations or products handled in the next twelve (12) months? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ____

SECTION XII — PRODUCTS LIABILITY/MEDICAL EQUIPMENT/SUPPLIES

PLEASE ATTACH PRODUCT LISTING OF ALL PRODUCTS SOLD, LEASED OR RENTED.

54. Does the applicant **SELL** any medical supplies and/or equipment? ☐ Yes ☐ No

a. Total Annual Sales $ __________________

b. Of the amount indicated as "Total Annual Sales", what portion, if any, applies to pharmaceutical products? $ __________________

55. Does the applicant rent or lease any medical supplies and/or equipment? ☐ Yes ☐ No

a. Total Annual Lease or Rental Receipts $ __________________

56. Does the applicant repair or do maintenance on any medical supplies or equipment? ☐ Yes ☐ No

a. Total Annual Repair or Maintenance Receipts $ __________________

IF YOU HAVE ANSWERED "NO" TO BOTH 54. AND 55., PLEASE SKIP THE "CATEGORY" SECTION
IF YOU ANSWERED "YES" TO EITHER 54. OR 55., PLEASE COMPLETE THE REMAINDER OF THIS CATEGORY SECTION.

CATEGORY I — Expendable Items — Intended for one time usage and then disposed (i.e., adhesive tape, bandages, 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 gases 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, SIDS 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. (Please attach a list of Category IV equipment or devices.)

Annual Sales $ _____________ Annual Lease/Rental Receipts $ _____________

NOTE: TOTAL AMOUNT OF ANNUAL SALES IN CATEGORIES I-IV MUST EQUAL AMOUNT IN 54.; TOTAL AMOUNT OF ANNUAL LEASE RENTAL RECEIPTS MUST EQUAL 55.

57. Does the applicant manufacture any products? ☐ Yes ☐ No

58. Is the applicant named as an additional insured/vendor on the manufacturer's policy for any/all products? (Required for any Category IV products.) ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ______________________________

59. Does the applicant obtain certificates of insurance from its products suppliers? ☐ Yes ☐ No

60. Does/has the applicant ever distributed or directly imported products from a foreign manufacturer? ☐ Yes ☐ No

a. IF YES, PLEASE DESCRIBE ______________________________

b. IF YES, DOES THE FOREIGN MANUFACTURER HAVE A U.S. LOCATION? ☐ Yes ☐ No

c. IF YES, WHERE? ______________________________

61. Are written instructions for the use of the products provided to the user? ☐ Yes ☐ No

62. Are these instructions reviewed and required to be signed off by users? ☐ Yes ☐ No

63. Does the applicant modify any product in any way from its intended use? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ______________________________

64. Does the applicant repackage or relabel any of the items obtained from suppliers? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ______________________________

65. Is any of the equipment sold with the applicant's label? ☐ Yes ☐ No

66. Does the manufacturer's label remain on the equipment? ☐ Yes ☐ No

67. Does the applicant maintain a written quality control program? ☐ Yes ☐ No

68. Is all equipment checked and their condition documented prior to their release? ☐ Yes ☐ No

69. Are serial numbers of the finished product shown on shipment invoices? ☐ Yes ☐ No

70. Are complete records kept of inventory shipments? ☐ Yes ☐ No

71. Does the applicant use the services of an EPA approved contractor for disposal of hazardous waste materials? ☐ Yes ☐ No

IF YES, WHAT ARE THESE PRODUCTS? ______________________________

____

72. Are any products flammable or explosive? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ______________________________

____

73. Does the applicant have any exposure to nuclear or radioactive materials? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ______________________________

____

74. On oxygen, oxygen related equipment, life sustaining or critical life monitoring equipment or devices, describe the twenty-four (24) hour services, three hundred sixty-five (365) day/year program that exists. If extra space is needed, please use the Remarks Section, Page 15.

____

____

____

75. Does the applicant distribute oxygen cylinders? ☐ Yes ☐ No

IF YES, ARE THEY PRE-FILLED ☐ Yes ☐ No

OR

ARE THEY FILLED AT THE APPLICANT'S FACILITY? ☐ Yes ☐ No

76. Does the applicant follow FDA and DOT regulations for the sterilization and transportation of oxygen? ☐ Yes ☐ NO

SECTION XIII — PRODUCTS LIABILITY/MAINTENANCE AND/OR REPAIR OF EQUIPMENT

77. Does the applicant perform maintenance on all equipment according to a written schedule? ☐ Yes ☐ No

78. Does the applicant repair or sell other suppliers' used equipment? ☐ Yes ☐ No

IF YES, PLEASE EXPLAIN ____

IF YES, GIVE PERCENTAGE OF TOTAL SALES/RECEIPTS Repair __________% Sales __________%

79. If repairs are made, are separate records kept? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE REPAIR PAYROLL $ ______________

80. Does the applicant subcontract labor for installation, service or repair of any products? ☐ Yes ☐ No

IF YES, PLEASE INDICATE WHICH CATEGORY OF EQUIPMENT THIS APPLIES TO ______________________________

____

81. The applicant performs maintenance and/or repairs on the following types of equipment: ____________________

____

____

82. Are manufacturers' recommendations followed for all maintenance and repair of equipment? ☐ Yes ☐ No

83. Are certificates of insurance obtained from those entities that provide the maintenance and repair of equipment? ☐ Yes ☐ No

SECTION XIV — CLAIMS/LOSS HISTORY

Insurance History

84. Prior **PROFESSIONAL LIABILITY** coverage for the past five (5) years:

INSURANCE CARRIER	LIMITS OF LIABILITY	EFFECTIVE DATES	ANNUAL PREMIUM	CLAIMS MADE FORM OR OCCURRENCE	RETRO DATE CLAIMS MADE ONLY

85. Prior **GENERAL LIABILITY** coverage for the past five (5) years:

INSURANCE CARRIER	LIMITS OF LIABILITY	EFFECTIVE DATES	ANNUAL PREMIUM	CLAIMS MADE FORM OR OCCURRENCE	RETRO DATE CLAIMS MADE ONLY

86. If a current loss summary is available from present or previous carriers, please attach a copy.

87. Has a claim, incident or suit for alleged malpractice been brought against the applicant within the last ten (10) years? ☐ Yes ☐ No

IF YES, COMPLETE A CLAIM INFORMATION SHEET (PAGE 14) FOR EACH CLAIM.

88. Is there knowledge of any incident(s) that might provide a basis for any claim or suit to be brought against the applicant? (Include any non-billing or non-record transfer related requests for medical records.) ☐ Yes ☐ No

IF YES, DESCRIBE IN REMARKS SECTION, PAGE 15.

89. For renewal business, has the applicant reported any losses to its prior carrier during the last year? ☐ Yes ☐ No

IF YES, DESCRIBE IN REMARKS SECTION PAGE 15.

90. Has any insurance company canceled, declined coverage or modified (i.e. reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal for any professional liability insurance? ☐ Yes ☐ No

IF YES, DESCRIBE IN REMARKS SECTION, PAGE 15. INCLUDE COMPANY NAME AND POLICY NUMBER.

SECTION XV — SURVEY DATA

91. Please name the individual whom our Risk Management representative may contact for an on-site review of the applicant's facility:

____________________________ Name and Title

____________________________ Telephone Number

SECTION XVI — CLAIMS INFORMATION

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED.

NOTE: Please provide sufficient information for underwriters to evaluate the medical aspects of the case especially relating to your involvement.

1. Name of Patient/Resident ________________________________ 2. Age ______ 3. ☐ Male ☐ Female
4. Allegation ____

____

____

____

5. Date claim was made or filed ______________ 6. Date of incident leading to allegation ____________
7. Insurance company ____
8. Additional defendants ____
9. Location of occurrence ____
10. Disposition of claim ☐ OPEN ☐ CLOSED
    a. Exact date closed ________________________
    b. Total settlement or judgment $ ______________
    c. Amount paid on your behalf $ ______________

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of the claimant's office and hospital records, laboratory reports and any other information that would be appropriate. Attach additional sheets as required.

11. Condition and diagnosis at time of incident (**Include dates of visits**) ______________________________

____

____

____

12. Date and description of treatment rendered (**Include dates of visits**) ______________________________

____

____

____

____

13. Condition of patient/resident subsequent to treatment (**Include dates of follow-up treatment**)____________

____

____

____

____

I understand information submitted herein may become part of the Healthcare Facility's Professional and General Liability Application as submitted.

Date ______________________ Signed ____

SECTION XVII — REMARKS (INDICATE QUESTION NUMBER REFERRED TO)

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED.

SECTION XVIII — SIGNATURE

THIS IS THE SIGNATURE SECTION.

FALSE INFORMATION

Any person who knowingly and with intent to defraud any insurance company or other person, files false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

DECLARATION AND SIGNATURE

The undersigned declares that to the best of his or her knowledge and belief the statements set forth herein are true. The undersigned authorizes the release and exchange of information involving past and future underwriting and claims matters between the Company and the present and any past professional association/society of each of the healthcare facility's members or employees, the county association/society in the county in which the healthcare facility operates or operated, its respective committees and insurance consultants, any prior insurance company, and any state licensing board or other governmental agency. The undersigned warrants that he or she is authorized and has the power to complete and execute this request, including the Warranty Statement on behalf of the Healthcare Facility, its subsidiaries and their Directors, Officers, or Insured persons.

THE HEALTHCARE FACILITY UNDERSTANDS THAT THIS IS NOT A BINDER OF INSURANCE, BUT IS INSTEAD A REQUEST FOR A PREMIUM INDICATION ONLY.

NOTE: This application must be signed by the authorized representative of the Healthcare Facility, acting as the authorized agent of the person(s) and entity(ies) proposed for this insurance.

____
Authorized Representative Signature

____
Title

____
Full Legal Name of Healthcare Facility

____
Date