



APPLICATION - HEALTH CARE PROVIDER

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
Street
City
County
State
ZIP Code
3. Location of Premises: Same as mailing address
 Other _____
4. Telephone () _____ Fax () _____
5. Contact person/phone #: Inspection _____
Accounting/Records _____
6. Business type: Individual Partnership Corporation LLC
 Trust Other (specify) _____
7. Operating as: For Profit Nonprofit Other _____
8. Interest of Named Insured in premises: Owner General Lessee Tenant Other _____
9. Part occupied by Named Insured: Entire Portion (____ %) Other (Lessor's Risk Only)
10. Date business established _____

DESIRED TERMS AND CONDITIONS

1. Coverage Desired: General Liability Professional Liability
2. Limit of Liability Desired: \$100,000/\$300,000 \$300,000/\$600,000 \$500,000/\$1,000,000
 \$1,000,000/\$1,000,000 Other _____

Note: Standard coverage includes the following:

Damage to Premises Rented to You	\$100,000
Personal and Advertising Injury	Same as Occurrence Limit
Medical Payments	\$5,000

3. Contractual Liability
4. Effective Date Desired _____ Term Desired _____

TYPE OF FIRM

1. Check your specific professional occupation:
 - Aide/Homemaker
 - Artificial Limb Fitter
 - Audiologist *Do you operate a mobile unit?* Yes No
 - Counselor Psychiatrist Psychologist Social Worker

Indicate type of services performed and percentage:

- | | | |
|---|--|---|
| <input type="checkbox"/> Abortion/Family Planning _____ % | <input type="checkbox"/> Crisis Intervention _____ % | <input type="checkbox"/> Occupational _____ % |
| <input type="checkbox"/> Alcohol/Drug _____ % | <input type="checkbox"/> Family/Marital _____ % | <input type="checkbox"/> School/Youth _____ % |
| <input type="checkbox"/> Child Abuse/Sexual Offenders _____ % | <input type="checkbox"/> General Guidance _____ % | <input type="checkbox"/> Other _____ % |
| <input type="checkbox"/> Criminal _____ % | <input type="checkbox"/> Hot Line _____ % | _____ % |

Do you utilize shock and/or drug therapy? Yes No

- Dental Hygienist
- Dietician/Nutritionist *Do you market products under your own label?* Yes No
- Druggist/Pharmacist *Do you prescribe medications?* Yes No
- Hearing Aid Specialist
- Massage Therapist

Nurse: Type _____

Check if appropriate: X-ray specialist Midwife
 Nurse anesthetist

- Occupational Therapist
- Optician
- Optometrist
- Physical Therapist

- Respiratory Therapist
- Speech Therapist
- X-Ray Technician
- Other _____

2. Description of operations _____

OPERATIONS

- 1. Do you treat children exclusively? Yes No
- 2. Indicate percentage of time spent in the following work locations:
Administrative Office _____ % Hospice _____ % Professional Office _____ %
Classroom _____ % Outpatient Clinic _____ % Nursing Home _____ %
Emergency Dept. of Hosp. _____ % Laboratory _____ % Other _____ %
Hospital Ward (Specify) _____ % Patient's Home _____ %
- 3. Are you engaged in, associated with, or involved in any other enterprises? Yes No
If yes, explain. _____

4. Are you self-employed? Yes No
If no, provide name of employer. _____

5. Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following?		Yes	No	N/A
General Liability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Liability		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization? Yes No
If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy? Yes No

7. Have you entered into any contractual agreements? Yes No
If yes, is legal advice sought to write and approve? Yes No
Does the agreement require you to hold any third party harmless? Yes No

8. Indicate: Receipts _____ Payroll _____ Outpatient Visits _____
(Number of patient encounters per year)

9. How are funds obtained? (i.e. Medicare, donations, fees, government grants, etc.) _____

10. Do you have recordkeeping procedures? Yes No

11. Do you practice: Full Time (30+ hours/week) Part Time (30 hours or less/week)

12. Do you have independent contractors working for you? Yes No
Describe, including number of contractors, type, total hours per month worked by all contractors, and in what capacity the independent contractor is working. _____

13. Do you require independent contractors working for you to carry their own professional insurance and provide proof of this coverage? Yes No

14. Do you use the services of volunteers or students? Yes No
If yes, describe selection, duties, training, and extent to which they are used. _____

EMPLOYEE PROCEDURES & STAFFING

1. Check the highest level of education you have completed relating to practice in your field:
- | | | |
|---|--|---|
| <input type="checkbox"/> None required | <input type="checkbox"/> Bachelor's Degree | <input type="checkbox"/> Other |
| <input type="checkbox"/> Associate Degree | <input type="checkbox"/> Doctorate Degree | School where degree was obtained: _____ |
| <input type="checkbox"/> Master's Degree | <input type="checkbox"/> Post-Doctorate Degree | _____ |
- For multiple employees, attach list with names, degree(s), and school(s).*
2. Describe any professional training, licensing, or certification needed for this operation. _____
3. Are you certified/licensed? Yes No
If yes, name of board/licensing body. _____
- | | Yes | No | N/A |
|--|--------------------------|--------------------------|--------------------------|
| 4. Has your license ever been: Restricted? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Suspended? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Revoked? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Have you ever been denied a license or board certification? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you ever been a patient in any chemical dependency program? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have your privileges ever been restricted, suspended, or revoked by any health care facility? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you prescribe drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Do you participate in any peer review or utilization review activities? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Explain all YES answers.* _____
5. Years practicing current professional occupation _____
6. Years in business under the above name _____
7. List any professional association or organization of which you are a member. Show complete name.
 None _____
- | | Yes | No |
|--|--------------------------|--------------------------|
| 8. Do you have employees? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you conduct criminal background checks of employees?
If yes, are copies kept on file? | <input type="checkbox"/> | <input type="checkbox"/> |
10. Check all procedures you use when hiring professional, paraprofessional, or any other employee providing patient care services at your facility:
- | | None | Written | Verbal |
|--|--------------------------|--------------------------|--------------------------|
| a. Educational background or residency program check, when applicable. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Previous employers check. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Personal references check. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PREVIOUS EXPERIENCE

1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities? Yes No
If yes, explain. _____

2. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**

Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years?

Yes No *If yes, give name of company, date and reason.*

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years.

Attach separate sheet if necessary.

Dates (Month/Year)	Allegations	Amount	Paid	Reserve
			<input type="checkbox"/>	
			<input type="checkbox"/>	
			<input type="checkbox"/>	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address