



Professional Liability Application for Health Care Services

(TO BE COMPLETED ONLY IF A MORE SPECIFIC APPLICATION IS NOT APPLICABLE)

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

Tax ID: _____

1.2 Mailing Address: _____

1.3 Location Address(es): _____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____) _____ Fax (_____) _____

Email: _____

Website: _____

1.6 Person to contact for Survey: Name: _____ Title: _____

Email: _____ Telephone Number: (_____) _____

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) or B) below:

A. The **APPLICANT** is an: INDIVIDUAL Employee Student Sole Practitioner

B. The **APPLICANT** is a: Sole Proprietorship Partnership Corporation Limited Liability

Other –Please Describe _____

1.9 Entity is: For Profit Non-Profit

Please describe source of funds: _____

1.10 Proposed Effective Date: _____

___	___	Medical Technicians	___	___	X-Ray or Radiologist Technicians
___	___	Nurse Midwives	___	___	X-Ray or Radiologist Therapists
___	___	Nurse Practitioners	___	___	Other, describe _____
___	___	Occupational Therapists			

* Attach list and indicate specialty.

2.6 If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors and annual estimated Out Patient Visits by professional category. _____

2.7 Do you require:

A) Contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? _____

B) Employed or contracted physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? _____

2.8 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? Yes No

2.9 What minimum limits of Professional Liability are required? _____

2.10 What was your total number of patient/client visits last year? _____

Estimated next year? _____

2.11 **Adult Day Care** Yes No

If YES, please provide average occupancy: _____

2.12 Breakdown of patient services:

___% Pediatric	___% Gynecological
___% Dental	___% Emergency Medical
___% Obstetric	___% General Exams
___% Psychiatric	___% Occupational Medical
___% Rehabilitative Therapy	___% Optometry/Ophthalmology
___% Minor Surgery	___% Nutrition (Diet)
___% Major Surgery	___% Other(describe) _____
___% Orthopedic	_____

2.13 Are any of the following performed?

Administer anesthesia (general or local)? Yes No

Surgery (major or minor including Face Peel, Dermabrasion,

Silicone Injection, and Needle Biopsies)? Yes No

Cardiac Catheterization Yes No

Diagnostic tests Yes No

- Chemotherapy Yes No
- X-Rays Yes No
- Radiation Therapy Yes No
- Reduction of Fracture Yes No
- Shock Therapy Yes No
- Prescribe medication Yes No
- Obstetric procedures Yes No

For all "yes" answers, please give detailed description on separate page or back of application.

PART III. RISK MANAGEMENT

3.1 Give name of Administrator/Supervisor and describe his/her training and experience. _____

3.2 Do you enter into contractual agreements? Yes No
 IF **YES**, please enclose copies of all such contracts.

3.3 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? Yes No
 If **NOT**, are you agreeable to instituting this procedure? Yes No

3.4 Enclose a copy of all brochures or advertising materials distributed by you.

3.5 Describe any "fund raising" or other special events activities conducted. _____

3.6 Describe any swimming pool, playground or amusement exposure. _____

3.7 Do you rent, sell, or otherwise provide any equipment or products to others? Yes No
 IF **YES**, complete our Products Supplement.

3.8 Do you provide 24 hour bed and board care for any patients, or do you (wholly or in part) own, operate or administer any facility which does provide such services? Yes No
 IF **YES**, complete our Residential Facilities Application.

- 3.9 Do you provide any of the following services?
- A) Blood Bank/Plasma Centers Yes No
 - B) Cemeteries/Funeral Homes/Morticians Yes No
 - C) Medical Arts Schools and Colleges Yes No

D) Pharmacies Yes No

E) Nursing Homes Yes No

IF **YES**, please complete the appropriate supplement application.

3.10 Do you have any other premises or operations exposures not stated in this application? Yes No

IF **YES**, enclose complete description and underwriting/rating information.

PART IV. HISTORY

3.1 List prior professional liability insurers for the past five years, starting with the most recent year.

If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

3.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? Yes No

IF **YES**, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary). _____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? Yes No

IF **YES**, describe the event and indicate the reason for anticipation of a claim. _____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant

Title



Drug and Substance Abuse Testing Supplemental Questionnaire

1. Type specimens taken / tested: ___Urine ___ Blood ___ Other: Please Describe _____

TESTING _____ or COLLECTION ONLY _____

2. Who does the testing?

_____ Insured's own laboratory / staff

_____ Laboratory insured contracts with for this service (include copy of contract and confirmation that lab carries own insurance and at what limits, provide example of letterhead results are sent out on)

_____ Independent Laboratories chosen by others (describe who selects lab facility, include copy of any contracts between the parties, confirm lab's own insurance and limits, and confirm letterhead results sent out on)

3. Describe exactly who reads and interprets the test results:

4. Describe the "protocols" in place to prevent reporting of "false positive" results:

5. Describe the "policy" regarding "confidentially" of reports and records.

6. In the past year:

(a) How many positive test results? _____

(b) How many employees:

(1) Treated? _____

(2) Counseled? _____

(3) Terminated from employment? _____

7. Is portable equipment used in any on-site testing operations? Describe fully the equipment including its exact use, who manufactures, any lease involving use of same, include brochure if available.