



- Ace American Insurance Company
- Illinois Union Insurance Company
- Westchester Surplus Lines Insurance Company

**Healthcare/Miscellaneous Facilities
Liability Application**

Instructions:

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

Supporting information:

Along with this completed and signed application, the applicant must also submit the following information:

1. Loss experience details:
 - a. A minimum of 5 years of loss runs.
 - b. Incurred loss amounts: Breakdown of paid and outstanding loss amounts for indemnity and expenses.
 - c. Loss descriptions: For all losses with incurred loss amounts.
 - d. Scope of Coverage: Loss experience for all applicants and coverages to be considered under this application.
2. Organizational chart including ownership percentage of each organization and relationship of each organization to one another.
3. Financial statements (audited, if available).

SECTION A. – PRODUCER CONTACT INFORMATION

Company Name:	<input type="text"/>	Surplus Lines Agent Name:	<input type="text"/>
Business Address:	<input type="text"/>	Surplus Lines Agent's Business Address:	<input type="text"/>
Telephone Number:	<input type="text"/>	Surplus Lines Agent's Telephone Number:	<input type="text"/>
Facsimile Number:	<input type="text"/>	Surplus Lines Agent's License Number:	<input type="text"/>



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Email Address:



SECTION B. – APPLICANT

1. Legal name of the parent entity to be the first named insured exactly as it shall be shown on the policy.

First Named Insured	Street Address
_____	_____
City, State, Zip Code	County
_____	_____

2. Applicant is:

- Individual
- Partnership
- Corporation
- Joint Venture
- Limited Liability Company
- Profit
- Non-Profit

3. List any subsidiary or affiliate to be insured exactly as it shall be shown on the policy. Include its relationship to the parent entity shown in item B.1. above, a description of operations, date of acquisition or creation, percentage of ownership by the applicant, and requested retroactive date. If the space below is inadequate, attach a list providing the same information for each applicant.

Loc. #	Business Legal Name & Address	Relationship to Parent Entity	Description of Operations	Date Acquired	Ownership %	Retroactive Date
_____	_____	_____	_____	_____	_____%	_____
_____	_____	_____	_____	_____	_____%	_____
_____	_____	_____	_____	_____	_____%	_____
_____	_____	_____	_____	_____	_____%	_____
_____	_____	_____	_____	_____	_____%	_____

4. Has any applicant acquired or sold another organization in the past 5 years? Yes No
If Yes, describe: _____

5. Has any applicant had a change in ownership or management in the past 12 months? Yes No
If Yes, describe: _____

6. Is any applicant managed by an independent management group? Yes No
If Yes, describe: _____

7. Provide contact information for the following:

	Insurance Buyer	Risk Manager	Claims Contact
Name:	_____	_____	_____
Title:	_____	_____	_____
Telephone Number:	_____	_____	_____
Email Address:	_____	_____	_____
Mailing Address:	_____	_____	_____

SECTION C. – COVERAGE REQUESTED

1. Coverage Period Requested From: _____ To: _____

2. Date Quotation Desired: _____



3. Coverage/Limits/Deductible Requested – Healthcare Facilities Professional Liability:

<input type="checkbox"/> Claims-Made Only Retroactive Date: _____	Limit of Liability Requested: <input type="checkbox"/> \$1,000,000 Each Professional Incident \$3,000,000 Aggregate <input type="checkbox"/> Other: _____
Is any applicant currently enrolled in a Patient Compensation Fund? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, in what state(s) and for what limits: State(s) - _____ Limits - \$_____ Each Professional Incident \$_____ Aggregate	Deductible (Each Professional Incident/Aggregate): <input type="checkbox"/> \$10,000/None <input type="checkbox"/> \$25,000/None <input type="checkbox"/> \$50,000/None <input type="checkbox"/> Other: \$_____

4. Coverage/Limits/Deductible Requested – General Liability

<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made If Claims-Made, Retroactive Date: _____	Limit of Liability Requested: <input type="checkbox"/> \$1,000,000 Each Occurrence \$3,000,000 Aggregate <input type="checkbox"/> Other: \$_____
Deductible (Each Occurrence/Aggregate): <input type="checkbox"/> \$10,000/None <input type="checkbox"/> \$25,000/None <input type="checkbox"/> \$50,000/None <input type="checkbox"/> Other: \$_____	

5. Coverage/Limits Requested – Employee Benefits Liability

<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made If Claims-Made, Retroactive Date: _____ Number of employees receiving benefits: _____	Limit of Liability Requested: <input type="checkbox"/> \$1,000,000 Each Employee \$3,000,000 Aggregate <input type="checkbox"/> Other: \$_____
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6. Coverage Requested – Non-Owned Automobile Liability

<input type="checkbox"/> Non-Owned Automobile Liability Coverage Requested Number of employees driving personal auto for work: _____

7. Coverage Requested – Stop Gap (Employer's Liability)

<input type="checkbox"/> Stop Gap (Employer's Liability) Requested Payroll: \$_____ State: _____

8. Underlying Coverages/Limits Requested – Excess Liability

Underlying coverages: <input type="checkbox"/> Healthcare Facilities Professional Liability Retroactive Date: _____ <input type="checkbox"/> General Liability If Claims-Made, Retroactive Date: _____ <input type="checkbox"/> Other: _____	Excess Limits of Liability Requested: <input type="checkbox"/> \$1,000,000 Each Occurrence or Each Professional Incident \$1,000,000 Aggregate <input type="checkbox"/> \$2,000,000 Each Occurrence or Each Professional Incident \$2,000,000 Aggregate <input type="checkbox"/> \$3,000,000 Each Occurrence or Each Professional Incident \$3,000,000 Aggregate <input type="checkbox"/> \$4,000,000 Each Occurrence or Each Professional Incident \$4,000,000 Aggregate <input type="checkbox"/> \$5,000,000 Each Occurrence or Each Professional Incident \$5,000,000 Aggregate <input type="checkbox"/> Other: \$_____
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SECTION D. – EXPOSURES

1. Provide census data for all exposures applicable to the applicants.

Service	Projections for Current or Expiring Year	Projections for Requested Coverage Period	Service	Projections for Current or Expiring Year	Projections for Requested Coverage Period
<input type="checkbox"/> Ambulatory Surgery Center (1)	_____ visits	_____ visits	<input type="checkbox"/> Hospice (in-patient services) (2)	_____ avg. occupied beds	_____ avg. occupied beds
<input type="checkbox"/> Clinic	_____ visits	_____ visits	<input type="checkbox"/> Imaging Center (1)	\$_____ receipts	\$_____ receipts
<input type="checkbox"/> Community Health Center or Health Department	_____ visits	_____ visits	<input type="checkbox"/> Laboratory (1)	\$_____ receipts	\$_____ receipts
<input type="checkbox"/> Dialysis (1)	_____ visits	_____ visits	<input type="checkbox"/> Lithotripsy (1)	_____ visits	_____ visits
<input type="checkbox"/> Durable Medical Goods (expendables such as bandages, hypodermic needles, etc.)	\$_____ receipts	\$_____ receipts	<input type="checkbox"/> Mental Health Counseling	_____ visits	_____ visits
<input type="checkbox"/> Durable Medical Goods (non-expendables – excluding diagnostic or treatment devices; includes beds, wheel chairs, etc.)	\$_____ receipts	\$_____ receipts	<input type="checkbox"/> Optical Establishment	\$_____ receipts	\$_____ receipts
<input type="checkbox"/> Durable Medical Goods (diagnostic or treatment devices; includes oxygen and medical gases, IV pumps, etc.)	\$_____ receipts	\$_____ receipts	<input type="checkbox"/> Pharmacy	\$_____ receipts	\$_____ receipts
<input type="checkbox"/> Durable Medical Goods (life sustaining or critical monitoring equipment; includes dialysis or heart lung machines, apnea monitors, etc.)	\$_____ receipts	\$_____ receipts	<input type="checkbox"/> Rehabilitation (physical, occupational, cardiac, trauma, etc.)	_____ visits	_____ visits
<input type="checkbox"/> Employee Health Center	_____ visits	_____ visits	<input type="checkbox"/> School (1)	Refer to Application Supplement	Refer to Application Supplement
<input type="checkbox"/> Health & Wellness Center	_____ visits	_____ visits	<input type="checkbox"/> Sleep Center	_____ visits	_____ visits
<input type="checkbox"/> Home Health (infusion therapy) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	<input type="checkbox"/> Staffing Agency (3)	Refer to Section F.	Refer to Section F.
<input type="checkbox"/> Home Health (professional care) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	<input type="checkbox"/> Student Health Center	_____ visits	_____ visits
<input type="checkbox"/> Home Health (homemaker/personal care/companion) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	<input type="checkbox"/> Substance Abuse (including counseling & rehab)	_____ visits	_____ visits
<input type="checkbox"/> Hospice (professional care) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	<input type="checkbox"/> Weight Loss Center	_____ visits	_____ visits
<input type="checkbox"/> Hospice (homemaker/personal care/companion) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	<input type="checkbox"/> Other – Describe: _____	_____	_____

(1) A separate ACE Application Supplement is required if the applicant provides this service.

(2) Complete SECTION E. for Home Health Care and/or Hospice services.

(3) Complete SECTION F. for Staffing Agency services.



2. Provide historical and prospective annual gross revenue as follows:

	3 Years Prior	2 Years Prior	1 Year Prior	Projections for Current or Expiring Year	Projections for Requested Coverage Period
Gross Revenue:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

3. Indicate all locations where the applicant(s) provides services. (Total of all locations must equal 100%.)

<input type="checkbox"/> Applicants' Locations: _____ %	<input type="checkbox"/> Hospital: _____ %	<input type="checkbox"/> Long Term Care Facility: _____ %
<input type="checkbox"/> Patients' Homes: _____ %	<input type="checkbox"/> Prison/Jail Facility: _____ %	<input type="checkbox"/> Mobile Facility: _____ %
<input type="checkbox"/> Other: _____ %	<input type="checkbox"/> Other: _____ %	<input type="checkbox"/> Other: _____ %
Describe location: _____	Describe location: _____	Describe location: _____

4. Indicate the percentage of the applicants' patients in the following age groups. (Total of all age groups must equal 100%.)

18 and younger: _____ %	19 to 65: _____ %	65 and older: _____ %
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5. Does any applicant provide management services to others? Yes No
If Yes, describe: _____

6. Does any applicant engage in the following services?

a. Formal clinical research under the auspices of an institutional review board: Yes No
If Yes, describe: _____

b. Administration or distribution of non-FDA approved pharmaceuticals (experimental drugs): Yes No
If Yes, describe: _____

c. Biomedical device research and development: Yes No
If Yes, describe: _____

7. Does any applicant sell, rent or lease medical supplies and/or equipment to others? Yes No
If Yes, describe: _____

8. Does any applicant perform maintenance or repairs on equipment sold or leased? Yes No
If Yes, describe: _____

9. Is all equipment checked and documented as to its condition prior to release? Yes No
 Not Applicable

10. Do all applicants perform preventive maintenance on all equipment according to a written schedule?
 Yes No
 Not Applicable

11. Does any applicant modify products in any way from their original use/form? Yes No
If Yes, describe: _____

12. Does any applicant repackage or re-label any items obtained from suppliers? Yes No
If Yes, describe: _____

13. Is any equipment sold under the applicants' name? Yes No
If Yes, describe: _____



14. Does the applicant have a sales staff? Yes No
If Yes, is the sales staff trained by the manufacturer? Yes No
15. Does any applicant repair or sell used equipment to others? Yes No
If Yes, describe: _____
16. Does any applicant distribute oxygen cylinders? Yes No
If Yes, are the oxygen cylinders pre-filled? Yes No
If Yes, does any applicant fill oxygen cylinders at the applicants' premises? Yes No
17. Do all applicants follow FDA and DOT regulations for the sterilization and transportation of oxygen?
 Yes No
 Not Applicable
18. Does any applicant prescribe medications for patients? Yes No
If Yes, describe: _____
19. Is methadone utilized in the treatment of patients? Yes No
If Yes, describe: _____
20. Does any applicant own or manage any residential facilities? Yes No
If Yes, describe: _____
21. Does any applicant offer recreational activities in the treatment of patients? Yes No
If Yes, describe: _____
22. Will any new services be offered in the next 12 months? Yes No
If Yes, describe: _____
23. Will any services be discontinued in the next 12 months? Yes No
If Yes, describe: _____
24. Have any services been discontinued in the last 24 months? Yes No
If Yes, describe: _____

SECTION E. – COMPLETE THIS SECTION ONLY IF THE APPLICANT PROVIDES HOME HEALTH CARE AND/OR HOSPICE SERVICES. IF THESE SERVICES DO NOT APPLY, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION F.

1. Who/what are the referral sources by which patients are directed to the applicant: _____
2. Are patients accepted for health care services only after receipt of a written plan by the attending physician?
 Yes No
If No, explain any exceptions: _____
3. Do all patients receiving any level of skilled care have a current and regularly updated physician treatment plan on file? Yes No
4. Does the applicant have protocols when:
- a. patients no longer meet criteria for home/hospice care? Yes No
- b. providers should contact a physician? Yes No



c. patients should be transferred to a hospital? Yes No

5. In-Home Services.

a. Does any applicant provide 24-hour services? Yes No
If yes, describe: _____

b. Does any applicant provide "live-in" services? Yes No
If yes, describe: _____

c. Percentage of patients that are bed-bound: _____%
 Not Applicable

d. Do all visiting employees have training in transfer/lifting bed-bound patients? Yes No
 Not Applicable

e. Are employees required to complete daily work reports? Yes No

f. Does the applicant maintain a written clinical record showing the total number of visits by each category of staff for each patient? Yes No

g. Does the staff supervisor make regular and unannounced audit visits of staff in the field? Yes No

h. Estimate the percentage of services attributable to each of the following.

AIDS Therapy: _____%	IV Therapy: _____%
Chemotherapy: _____%	Pediatric/Infant Childcare including Babysitting: _____%
High Tech Critical Care: _____%	Tracheotomy/Ventilator Dependent – Adult: _____%
Infant Monitoring (SIDS, etc.): _____%	Tracheotomy/Ventilator Dependent – Pediatric: _____%

SECTION F. - COMPLETE THIS SECTION ONLY IF THE APPLICANT PROVIDES STAFFING AGENCY SERVICES. IF THESE SERVICES DO NOT APPLY, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION G.

1. Total projected annual revenues for the requested coverage period derived from supplemental staffing services: \$_____

2. Indicate the percentage of total projected annual revenues by specialized service. (Total services must equal 100%).

Adult Day Care Facilities: _____%	Industrial Facilities: _____%
Correctional Facilities: _____%	Long Term Care Facilities: _____%
Clinics: _____%	Physician Offices: _____%
Hospice: _____%	Psychiatric Facilities: _____%
Hospitals: _____%	Other: _____%
	Describe services: _____

3. If supplemental staffing is provided to hospitals, specify services:

Coronary Care Unit: _____%	Neonatal: _____%
Emergency Department: _____%	Obstetrical: _____%
Intensive Care Unit: _____%	Pediatric: _____%
Medical/Surgical Unit: _____%	Psychiatric: _____%
	All Other Units: _____%
	Describe services: _____



SECTION G. – PROFESSIONAL EMPLOYEES AND STAFF

1. Provide the following for Employed or Contracted Medical Directors.

Not Applicable

Name	Specialty	Employed	Contracted	Number of Hours Worked Per Week for the Applicant	Number of Years of Experience as Medical Director
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours per week	_____ years
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours per week	_____ years
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours per week	_____ years

2. Provide the following for Employed or Contracted Physicians.

Not Applicable

Name	Specialty	Employed	Contracted (4)	Number of Hours Worked Per Week for the Applicant	Does Physician carry own Professional Liability insurance? If Yes, indicate limits.
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours per week	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, limits: \$ _____ / \$ _____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours per week	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, limits: \$ _____ / \$ _____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours per week	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, limits: \$ _____ / \$ _____
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours per week	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, limits: \$ _____ / \$ _____

(4) These independent contractors will not be Insureds and will not have coverage under the policy for which the applicants are applying. Such independent contractors should obtain their own insurance.



3. Provide the following for Professional Employees/Independent Contractors.

Professional Classification	Number of Employees		Number of Contractors (5)		Number of Volunteers	
	FTEs (6)	Hours (annual)	FTEs (6)	Hours (annual)	FTEs (6)	Hours (annual)
Aides/Assistants Indicate type: _____	_____	_____	_____	_____	_____	_____
Companion/Personal Care Asst/ Homemaker	_____	_____	_____	_____	_____	_____
Dentist	_____	_____	_____	_____	_____	_____
Dialysis Technician	_____	_____	_____	_____	_____	_____
Dietician/Nutritionist	_____	_____	_____	_____	_____	_____
Mental Health Counselor	_____	_____	_____	_____	_____	_____
Nurse Practitioner	_____	_____	_____	_____	_____	_____
Nurse/R.N./L.P.N.	_____	_____	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____	_____	_____
Pastoral Counselor	_____	_____	_____	_____	_____	_____
Pharmacist	_____	_____	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____	_____	_____
Physician Assistant	_____	_____	_____	_____	_____	_____
Psychologist	_____	_____	_____	_____	_____	_____
Radiological Technologist	_____	_____	_____	_____	_____	_____
Rehabilitation Counselor/ Therapist	_____	_____	_____	_____	_____	_____
Respiratory Therapist	_____	_____	_____	_____	_____	_____
Social Worker	_____	_____	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____	_____	_____
Technicians	_____	_____	_____	_____	_____	_____
Other (specify) _____	_____	_____	_____	_____	_____	_____
Other (specify) _____	_____	_____	_____	_____	_____	_____
GRAND TOTAL:	_____	_____	_____	_____	_____	_____

- (5) These independent contractors will not be Insureds and will not have coverage under the policy for which the applicants are applying. Such independent contractors should obtain their own insurance.
- (6) FTE means Full Time Equivalents. 1 Full Time Equivalent = 2,000 annual hours.

SECTION H. – LICENSE/CERTIFICATION INFORMATION

- Licensed Specialty: _____
- Licensing Agency(ies): _____
- Applicant Accreditation: _____
Date Surveyed: _____
Score: _____
- Has any applicant's license or certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? Yes No
If Yes, describe: _____
- Are there any charges pending against any applicant? Yes No
If Yes, describe: _____



6. Has any applicant ever been investigated by a state health department, state licensing board or other governmental body? Yes No
If Yes, describe: _____
7. Are all applicants licensed in all states in which they are operating? Yes No
If No, explain: _____
8. List all memberships in professional organizations: _____

SECTION I. – RISK MANAGEMENT

1. Are patient records protected in accordance with HIPPA (Health Insurance Portability and Accountability Act of 1996)? Yes No
If No, explain: _____
2. Has any applicant ever had an incident that resulted in an allegation of sexual abuse? Yes No
If Yes, explain: _____
3. Is an informed consent process in place? Yes No
4. Are copies of informed consent forms maintained in patient files? Yes No
5. Does the applicant conduct patient/client surveys? Yes No
6. Is a formal written Quality Assurance and Risk Management program in place? Yes No
7. Are written policies and procedures in place regarding the following:

Advance Directives/Living Wills:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Acceptance of Verbal Physician Orders:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chain of Command:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Administration Procedures:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employee Training:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emergency Management:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food Preparation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Handling of Complaints:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Incident Reporting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lifting Requirements:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Equipment Training:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical Record Documentation:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient Acceptance:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient Discharge Procedures:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Patient Rights:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Reporting Suspected Abuse:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is compliance with these policies and procedures enforced and monitored? Yes No

8. Do all contracts for clinical services include mutual hold harmless and indemnification agreements? Yes No
If No, describe the contracted services where these provisions do not exist: _____
9. Do all contracts for clinical services contain minimum Professional Liability insurance requirements for the other party? Yes No
If Yes, what is the minimum amount required? \$_____ Each Professional Incident/\$_____ Annual Aggregate
If No, describe the contracted services where this provision does not exist: _____



10. Does the applicant require certificates of insurance from all independent contractors: Yes No

SECTION J. – EMPLOYMENT PRACTICES

1. Does the applicant perform criminal background checks on prospective employees? Yes No

2. Are job descriptions provided for all professional and nonprofessional employees? Yes No

3. Do employees actively participate in continuing educational programs? Yes No

4. Does the applicant verify employment related references? Yes No

5. Does the applicant verify certification and/or professional licensure status of employees and independent contractors? Yes No

6. Are independent contractors and volunteers subject to employment screening practices including criminal background checks and reference checks? Yes No
If No, explain: _____

7. Does the applicant confirm in writing any of the following related to prospective employees:

Whether their medical Professional Liability insurance has been denied or canceled? (Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Whether they have been involved in any Professional Liability claims or litigation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Whether any action has ever been taken on their clinical privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Does the applicant screen employees for drug and alcohol abuse? Yes No

9. Does the applicant screen employees for any previous allegations against them involving sexual abuse or molestation? Yes No

10. Does the applicant have a written crisis management plan for dealing with staff, victims, family, authorities, and the media if there is an incident of abuse? Yes No

SECTION K. – GENERAL LIABILITY EXPOSURES

1. Provide the following information for each area owned, occupied, or leased by the applicant.

Location	Square Footage	Year Built	Construction	Number of Floors	Type of Fire Protection (7)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

(7) Fire Protection Key: AS = Approved Sprinkler; H = Heat Detector; S = Smoke Detector; A = Automatic Alarm

2. Has the applicant planned any new construction and/or abatement for the prospective coverage period? Yes No
If Yes, describe: _____

3. Does any applicant sponsor sporting or social events? Yes No
If Yes, describe: _____



4. Does any applicant own, operate or control a day care facility? Yes No
 If Yes, are day care services open to the public? Yes No
 If Yes:
- a. Number of Children: _____
 - b. Number of Adults: _____
 - c. Days and hours of operation: _____

SECTION L. – NON-OWNED/HIRED AUTOMOBILE LIABILITY EXPOSURES - COMPLETE THIS SECTION ONLY IF PRIMARY NON-OWNED/HIRED AUTOMOBILE LIABILITY COVERAGE IS REQUESTED. IF THIS COVERAGE IS NOT REQUESTED, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION M.

- 1. Is Hired and Non-Owned Automobile Liability coverage provided by the applicants' primary Automobile coverage? Yes No
- 2. Does the applicant have a policy and procedures to secure motor vehicle records for all drivers who frequently use their personal autos for business use? Yes No
- 3. Does the applicant secure evidence of personal Automobile Liability insurance from all drivers who frequently use their personal automobile for business use? Yes No

SECTION M. – EXCESS LIABILITY UNDERLYING SCHEDULE - COMPLETE THIS SECTION ONLY IF EXCESS LIABILITY COVERAGE IS REQUESTED. IF THIS COVERAGE IS NOT REQUESTED, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION N.

1. Provide the following information for each coverage to be included as scheduled underlying insurance.

Coverage	Company	Policy Number	Policy Period	Limits of Liability	Premium
Automobile Liability Attach loss runs.	_____	_____	_____	\$_____/_____ \$_____/_____	\$_____
Employer's Liability	_____	_____	_____	\$_____/_____ \$_____/_____ \$_____/_____	\$_____
General Liability	_____	_____	_____	\$_____/_____ \$_____/_____	\$_____
Professional Liability	_____	_____	_____	\$_____/_____ \$_____/_____	\$_____
Other (specify): _____	_____	_____	_____	\$_____/_____ \$_____/_____	\$_____

- 2. Does any applicant own motor vehicles? Yes No
 If Yes, provide a schedule by vehicle type and principal garaging location.
- 3. Does any applicant own or operate ambulances or provide emergency patient transport services? Yes No
 If Yes:
 - a. Annual number of emergency runs: _____
 - b. Annual number of non-emergency runs: _____
- 4. Does the applicant have a policy and procedures to secure motor vehicle records for all drivers? Yes No



5. Does any applicant own, lease or operate any aircraft? Yes No
If Yes, describe: _____
6. Does any applicant have employees flying owned or non-owned aircraft? Yes No
If Yes, describe: _____
7. Are any fuel services provided for aircraft? Yes No
If Yes, describe: _____
8. Does any applicant own or lease watercraft? Yes No
If Yes, describe: _____
9. Has any applicant rejected a state Workers' Compensation Act? Yes No
If Yes, indicate organization name and state: _____

SECTION N. – PREVIOUS INSURANCE

1. Professional Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
_____	_____	\$ _____ / \$ _____	\$ _____ / \$ _____	\$ _____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$ _____ / \$ _____	\$ _____ / \$ _____	\$ _____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$ _____ / \$ _____	\$ _____ / \$ _____	\$ _____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence

2. General Liability Insurance Coverage Information: Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
_____	_____	\$ _____ / \$ _____	\$ _____ / \$ _____	\$ _____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$ _____ / \$ _____	\$ _____ / \$ _____	\$ _____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$ _____ / \$ _____	\$ _____ / \$ _____	\$ _____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence



3. Excess Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence

4. Missouri Applicants Disregard This Question and Proceed to Section O.

Has any Primary or Excess Liability insurer refused, canceled or non-renewed insurance for any applicant in the past? Yes No

If Yes, explain: _____

SECTION O. – PRIOR ACTS WARRANTY

1. If this application is for new Claims-Made coverage including prior acts with ACE, will all current Primary and Excess Claims-Made policies accept claims for (a) a written notice, demand or service of suit against any applicant, and (b) specific circumstances reasonably likely to give rise to a written notice, demand or service of suit against any applicant? Yes No

If Yes, does the applicant have a process to identify claims and specific circumstances regarding loss events reasonably likely to give rise to a written notice, demand or service of suit, for purposes of timely reporting to the applicants' Claims-Made insurers before expiration? Yes No

2. Have all such claims or specific circumstances reasonably likely to give rise to a claim been made under all the applicants' current Claims-Made policies and accepted by all current insurers for coverage there under? Yes No

If No, explain: _____

Note: Written notice, demand, service of suit, and specific circumstances reasonably likely to give rise to a written notice, demand or service of suit, known to any applicant or any insurer prior to the requested effective date for any applicant will be excluded.



SECTION P. – FRAUD WARNING, DECLARATION & CERTIFICATION, AND SIGNATURE

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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 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 TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE & VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claims for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS ATTACHED HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS



WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE APPLICANT AGREES TO COOPERAT WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant

Signature of Broker/Agent

Title

Date

Date

Signed by Licensed Resident Agent
(Where Required By Law)