

## Health Care Organizations and Providers Liability Insurance Application

### APPLICATION INSTRUCTIONS

**NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.**

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application where indicated.
- All information requested must be fully and accurately completed.
- If changes or corrections must be made to the completed application, strike out or line through the incorrect information, write in the modification, and initial and date the change.
- If a particular question does not apply, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a six-year experience period. This applies to open and closed claims and to any incidents reported to a previous carrier. It is important to provide complete and detailed claims information, including current carrier loss runs.

### ACCOUNT INFORMATION

1. Applicant Name			
2. Mailing Address	Street:		
	City: <span style="float: right;">State:      Zip:</span>		
	County: <span style="float: right;">Website Address:</span>		
3. Risk Management Contact	Name/Title:		
	Email Address:		
	Telephone Number:		
4. Applicant's Legal Structure	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> LLC <input type="checkbox"/> Other: _____		
5. Tax Status	<input type="checkbox"/> For Profit – Private <input type="checkbox"/> For Profit – Publicly Traded <input type="checkbox"/> Not for Profit <input type="checkbox"/> Governmental		
6. Type of Risk (check all that apply)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Acute care hospital  <input type="checkbox"/> Behavioral health hospital  <input type="checkbox"/> Rehabilitation hospital  <input type="checkbox"/> Chemical dependency/substance abuse facility  <input type="checkbox"/> Senior living / LTC facility  <input type="checkbox"/> Accountable care organization </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Critical access hospital  <input type="checkbox"/> Long term acute care hospital (LTAC)  <input type="checkbox"/> Children's hospital  <input type="checkbox"/> Research hospital  <input type="checkbox"/> Specialty hospital: _____  <input type="checkbox"/> Other: _____ </td> </tr> </table>	<input type="checkbox"/> Acute care hospital <input type="checkbox"/> Behavioral health hospital <input type="checkbox"/> Rehabilitation hospital <input type="checkbox"/> Chemical dependency/substance abuse facility <input type="checkbox"/> Senior living / LTC facility <input type="checkbox"/> Accountable care organization	<input type="checkbox"/> Critical access hospital <input type="checkbox"/> Long term acute care hospital (LTAC) <input type="checkbox"/> Children's hospital <input type="checkbox"/> Research hospital <input type="checkbox"/> Specialty hospital: _____ <input type="checkbox"/> Other: _____
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7. Number of years in operation: \_\_\_\_\_ Number of years under current ownership: \_\_\_\_\_

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8. List all states where the Applicant is operating and providing services:

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9. Does the Applicant have any operations outside of the United States of America?  Yes  No  
 If "Yes," please provide details:

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10. Is the Applicant owned, controlled or managed by another entity?  Yes  No  
 If "Yes," please provide details:

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11. Within the past 36 months or within the next 12 months, has the Applicant or does the Applicant expect to:

- a. Merge, acquire or consolidate with another entity?  Yes  No
- b. Sell or divest another entity or facility?  Yes  No
- c. Discontinue any operations or services?  Yes  No
- d. Enter into any new business activities or services (including new procedures or products being offered)?  Yes  No

If "Yes," describe the essential terms of each such transaction.

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12. Please list below all subsidiaries, including a description of operations, relationship to the Applicant, ownership and retroactive date.

Name & Address	Description of Operations	Relationship	Ownership %	Retroactive Date

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

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13. Does the Applicant own, operate or manage any business or facilities other than the operations described in this Application?  Yes  No  
 If "Yes," please provide details, including name of entity and the Applicant's ownership interest/management role.

**CURRENT AND REQUESTED COVERAGE**

14. Requested policy period: \_\_\_\_\_

15. Retroactive date: \_\_\_\_\_

16. Coverage requested:  Primary  Excess  Both

Primary limits of liability requested:	Each claim: _____	Aggregate: _____
Excess limits of liability requested:	Each claim: _____	Aggregate: _____
Deductible/SIR requested:	Each claim: _____	Aggregate: _____
	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR	

17. Please provide current insurance information:

	Carrier	Policy Period MM/DD/YY- MM/DD/YY	Limits	Ded/SIR	CM or Occ	Retroactive Date	Premium
Professional Liability							
General Liability							
Excess Liability							
Auto Liability							
Employers Liability							
Helipad Liability							
Other (describe): _____							

18. Please describe any additional insureds to be included, a description of their operations, their interest and requested coverage:

Name & Address	Description of Operations	Interest	Coverage Desired
			<input type="checkbox"/> PL <input type="checkbox"/> GL
			<input type="checkbox"/> PL <input type="checkbox"/> GL
			<input type="checkbox"/> PL <input type="checkbox"/> GL

19. MISSOURI RESIDENTS - DO NOT ANSWER THIS QUESTION.

Has any professional liability insurer ever cancelled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant or any other entity for which coverage is requested?  Yes  No

If "Yes," please provide details:

**EXPOSURE DETAILS**

20. Please provide the following information:

Total number of licensed beds: \_\_\_\_\_

Inpatient Services (Number of Occupied Beds)	Projected Next 12 Months	Current Year	1 <sup>st</sup> Prior Year	2 <sup>nd</sup> Prior Year	3 <sup>rd</sup> Prior Year
Acute Care Beds					
Bassinets/Cribs					
Pediatric Beds					
ICU					
CCU Beds					
NICU					
Long Term Acute Care Beds (LTAC)					
Behavioral Health Beds					
Rehabilitation Beds					
Hospice Beds					
Substance Abuse Beds					
Swing Beds					
Skilled Nursing Care Beds					
Independent Care Beds					
Residential/Assistant Living Beds					

Total Number of Deliveries					
Total Number of Inpatient Surgeries					

Outpatient Services (Do not include Lab, X-Ray, and Radiology Units)	Projected Next 12 Months	Current Year	1 <sup>st</sup> Prior Year	2 <sup>nd</sup> Prior Year	3 <sup>rd</sup> Prior Year
Emergency Department Visits					
Urgent Care Visits					
Outpatient Clinic Visits					
Outpatient Surgeries (include colonoscopies and endoscopies)					
Physician Office Visits					
Home Health Care Visits					
Rehabilitation Visits (occupational, speech and physical)					
Behavioral Health Visits					
Other (describe): _____					

21. Is the Applicant requesting employed physicians/interns/residents be included in the proposed health care professional liability insurance?  Yes  No

If "Yes," please attach a schedule which includes physician name, specialty and retroactive date.

**Allied Health Care Providers:**

22. Please provide the number of health care professionals described below who are employed by or work under the control of the Applicant:

_____ Certified Nurse Midwives	_____ Paramedics	_____ Podiatrists
_____ Lay Midwives	_____ Pharmacists	_____ Psychologists
_____ Certified Registered Nurse Anesthetists	_____ Physician Assistants	_____ Social Workers
_____ Emergency Medical Technicians	_____ Surgical Assistants	
_____ Therapists: Occupational, Physical, Speech and Respiratory	_____ Advanced Practice Registered Nurses	
	_____ Other (describe): _____	

<b>Hiring/Credentialing:</b>	
23.	Total number of medical staff: _____ Board Certified: _____% Board Eligible: _____%
24.	Are midlevel practitioners (advanced practice registered nurse, certified registered nurse anesthetist, physician assistant) full members of the medical staff (governed by medical staff bylaws)? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span>
25.	Are midlevel practitioners credentialed using the same processes as physicians? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span>
26.	Is final credentialing for staff members approved by a formal credentialing committee prior to granting staff privileges? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span>
27.	Are medical staff re-credentialed at least every 2 years? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span>
28.	In the past 5 years, has any member of the medical staff had his/her appointment to the medical staff or privileges revoked, restricted or suspended? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span> If "Yes," please explain:
29.	Do the Applicant's bylaws require physicians to carry health care professional liability insurance? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span> If "Yes," what limit is required? _____
30.	Please indicate all of the screening/hiring procedures used for professionals and others who provide patient care services for the Applicant's operations. <ul style="list-style-type: none"> <li>a. Verification of educational background <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span></li> <li>b. Verification of previous employers/employment history <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span></li> <li>c. Verification of personal references <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span></li> <li>d. Verification of any pending license suspensions or revocations, or any pending disciplinary actions by other facilities <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span></li> <li>e. Criminal background check: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Federal <input type="checkbox"/> None</li> <li>f. Require information on any professional liability or work related claims that have previously been made against any individual <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span></li> <li>g. Require information on any allegations of sexual abuse or molestation previously made against any individual <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span></li> <li>h. Drug/alcohol testing <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span></li> </ul>
31.	Are employees required to complete appropriate annual training/competencies? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span>
32.	Does the Applicant require all foreign trained physicians to be certified by the Education Council for Foreign Medical School Graduates? <span style="float:right"><input type="checkbox"/>Yes <input type="checkbox"/>No</span>
<b>Obstetrics:</b>	
33.	a. Indicate the minimum health care professional liability insurance limits required for providers: _____ Are such limits required on a separate or shared basis? <input type="checkbox"/> Separate per provider <input type="checkbox"/> Shared among all providers
	b. In the last 12 months, what percentage of the Applicant's deliveries were: Elective C-sections: _____%      Emergency C-sections: _____%      VBACs: _____%
	c. Who has privileges to perform vaginal deliveries? <input type="checkbox"/> Family Practitioner <input type="checkbox"/> Certified Nurse Midwife <input type="checkbox"/> Obstetrician <input type="checkbox"/> Lay Midwife <input type="checkbox"/> Other: _____
	d. Who has privileges to perform C-sections? <input type="checkbox"/> Family Practitioner <input type="checkbox"/> Obstetrician <input type="checkbox"/> General Surgeon <input type="checkbox"/> Other: _____

e.	Do certified nurse midwives practice at the Applicant's facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If "Yes," are they supervised by an obstetrician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If employed, do they deliver babies in a home setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	Do lay midwives practice at the Applicant's facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If "Yes," are they supervised by an obstetrician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If employed, do they deliver babies in a home setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	What is the service level of the nursery: <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III	
h.	Are obstetricians, family practitioners, physicians, lay midwives and certified nurse midwives required to maintain continuing education in electronic fetal monitoring (EFM) with validated competency in EFM interpretation as part of the credentialing, privileging and re-credentialing processes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i.	Are all labor and delivery nurses and physicians required to successfully complete an approved course in EFM?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j.	Is continuous EFM performed on all patients in active labor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k.	Does the Applicant have any off-site birthing centers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l.	Can emergency C-sections be performed in less than 30 minutes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m.	Is there a process in place to review and measure obstetric/neonatal-specific practice, quality of care and outcomes that adhere to the professional standards of AAP/ACOG/AWHONN?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If "No," please explain:	
n.	Is the Applicant a regional referral center for newborns requiring intensive care or for high risk pregnancies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If "No," does a written procedure exist for transferring all high-risk mothers and/or babies?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Surgery:**

34. Indicate the minimum health care professional liability insurance limits required for providers: \_\_\_\_\_  
 Are such limits required on a separate or shared basis?     Separate per provider     Shared among all providers

35. Are any of the following performed at the Applicant's facility?

a.	Experimental Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Neurosurgery (brain)	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	Weight Loss/Bariatric Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	Spinal Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	Cardiothoracic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	Organ Transplantation	<input type="checkbox"/> Yes <input type="checkbox"/> No
g.	Gender Reassignment Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No

36. Does the Applicant have a quality improvement/risk management process in place for monitoring and review of policies, procedures, practices and outcomes for:
- a. Surgical Mortality  Yes  No
  - b. Surgical Complications  Yes  No
  - c. Surgical Site Infection Rate  Yes  No
  - d. Pre and Post-Operative Tissue Diagnosis  Yes  No
  - e. Readmission within 30 days of surgery  Yes  No
  - f. OR/PAR Cardiac Arrest/Mortality  Yes  No
  - g. Occurrences/near misses of wrong site/wrong patient/wrong procedure surgery  Yes  No
  - h. Occurrences of unintentionally retained foreign body (e.g. instrument/sharps/sponges)  Yes  No
  - i. Equipment (patient) related errors, malfunctions and injuries  Yes  No
  - j. Unscheduled return to the OR  Yes  No
  - k. Unscheduled admissions following ambulatory surgery  Yes  No
  - l. Mortality within 30 days of surgery  Yes  No

37. When are sponge, needle and instrument counts performed (OB, surgical and other procedures)? \_\_\_\_\_

**Bariatric / Weight Loss Surgery:**

38. Indicate the number of bariatric/weight loss surgeries performed in the last 12 months: \_\_\_\_\_
- a. Indicate the number of years the Applicant's facility has specialized in the care and treatment of bariatric/weight loss patients? \_\_\_\_\_
  - b. Is there a multidisciplinary team and unit dedicated to the care and treatment of bariatric/weight loss patients?  Yes  No
  - c. Does the Applicant perform bariatric/weight loss surgery on adolescents (under age 18 yrs)?  Yes  No  
If "Yes," how many in the last 12 months? \_\_\_\_\_
  - d. Does the Applicant's bariatric/weight loss program comply with the guidelines from the American Society of Bariatric Surgery?  Yes  No
  - e. Does the Applicant require physicians to be credentialed specifically for bariatric/weight loss surgery?  Yes  No
  - f. Is the Applicant designed as a Bariatric/Weight Loss Surgery Center of Excellence?  Yes  No

**Anesthesia:**

39. a. Indicate the minimum health care professional liability insurance limits required for providers: \_\_\_\_\_  
Are such limits required on a separate or shared basis?  Separate per provider  
 Shared among all providers
- b. Staffing of the anesthesia department is by : (check all that apply)
- Contracted Anesthesiologists  Employed Anesthesiologists/Certified
  - Certified Registered Nurse Anesthetists  Registered Nurse Anesthetists
  - Anesthesia Assistants  Residents
  - Physician Assistants
- If contracted, name of contracted group: \_\_\_\_\_

- c. Are non-physician providers supervised by an anesthesiologist? Yes No  
If "No," please explain: \_\_\_\_\_
- d. Is an anesthesiologist/certified registered nurse anesthetist on the premises 24 hours a day? Yes No  
If "No," what is the maximum time for arrival at the hospital? \_\_\_\_\_
- e. Is the patient's informed consent discussion documented in the patient's medical record? Yes No

**Emergency Department:**

- 40. a. Indicate the minimum health care professional liability insurance limits required for providers: \_\_\_\_\_  
Are such limits required on a separate or shared basis?  Separate per provider  
 Shared among all providers
- b. Staffing of the emergency department is by: (check all that apply)  
 Contracted Physicians       Employed Physicians       Staff Physicians  
 Residents       Nurse Practitioners       Physician Assistants  
If contracted, name of contracted group: \_\_\_\_\_
- c. What level of care does the emergency department provide?  
 Level I       Level II       Level III
- d. Is the Applicant a dedicated trauma center? Yes No
- e. Is the emergency department staffed 24 hours a day by a physician? Yes No
- f. Does the Applicant employ EMS personnel (dispatch, EMT, paramedics, flight crew, etc.)? Yes No

- 41. Does the Applicant have a quality improvement/risk management process in place for monitoring and review of policies, procedures, practices and outcomes for:
  - a. Mortality Yes No
  - b. Unexpected deaths within 72 hours of an emergency department visit Yes No
  - c. Patients leaving without being seen/against medical advice/elopement Yes No
  - d. Discrepancies in X-Ray interpretations Yes No
  - e. Discrepancies in EKG interpretations Yes No
  - f. Unanticipated return to the emergency department within 72 hours Yes No
  - g. Compliance with clinical practice guidelines (if used) Yes No
  - h. Transfers to another facility Yes No

- 42. Does the Applicant utilize evidence based on clinical practice guidelines to manage the following:
  - a. Chest pain/myocardial infarction Yes No
  - b. Stroke Yes No
  - c. Trauma Yes No
  - d. Headache Yes No
  - e. Intoxication/substance abuse Yes No
  - f. Altered mental status Yes No
  - g. Abdominal pain Yes No







60.	Does the Applicant utilize telehealth (eICU, teleradiology, etc)?	☐Yes ☐No		
61.	Are clinical research studies performed?	☐Yes ☐No		
	a. If "Yes," is IRB approval obtained?	☐Yes ☐No		
	b. Who obtains consent from study participant(s)? _____			
62.	Does the Applicant participate in a patient safety organization?	☐Yes ☐No		
63.	Please indicate all written policies and procedures that the Applicant has in place:			
	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> HIPAA privacy and security  <input type="checkbox"/> Data breach/Red Flag (identity theft)  <input type="checkbox"/> Social media/text messaging/cellular phone use  <input type="checkbox"/> RAC audits  <input type="checkbox"/> Release of records  <input type="checkbox"/> Medical record retention/destruction  <input type="checkbox"/> Disclosure of unanticipated outcomes of care  <input type="checkbox"/> Service recovery/billing adjustments  <input type="checkbox"/> Patient/family/visitor complaints  <input type="checkbox"/> Incident reporting  <input type="checkbox"/> Mandated reporting of adverse events to regulatory agencies  <input type="checkbox"/> Product recalls </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Medical device failure  <input type="checkbox"/> Medication safety  <input type="checkbox"/> Informed consent/refusal of treatment  <input type="checkbox"/> Emergency preparedness  <input type="checkbox"/> Patient emergencies  <input type="checkbox"/> Visitor emergencies  <input type="checkbox"/> Safety/security  <input type="checkbox"/> Patient abduction  <input type="checkbox"/> AMA/elopements  <input type="checkbox"/> EMTALA  <input type="checkbox"/> Chain of command  <input type="checkbox"/> Peer review </td> </tr> </table>		<input type="checkbox"/> HIPAA privacy and security <input type="checkbox"/> Data breach/Red Flag (identity theft) <input type="checkbox"/> Social media/text messaging/cellular phone use <input type="checkbox"/> RAC audits <input type="checkbox"/> Release of records <input type="checkbox"/> Medical record retention/destruction <input type="checkbox"/> Disclosure of unanticipated outcomes of care <input type="checkbox"/> Service recovery/billing adjustments <input type="checkbox"/> Patient/family/visitor complaints <input type="checkbox"/> Incident reporting <input type="checkbox"/> Mandated reporting of adverse events to regulatory agencies <input type="checkbox"/> Product recalls	<input type="checkbox"/> Medical device failure <input type="checkbox"/> Medication safety <input type="checkbox"/> Informed consent/refusal of treatment <input type="checkbox"/> Emergency preparedness <input type="checkbox"/> Patient emergencies <input type="checkbox"/> Visitor emergencies <input type="checkbox"/> Safety/security <input type="checkbox"/> Patient abduction <input type="checkbox"/> AMA/elopements <input type="checkbox"/> EMTALA <input type="checkbox"/> Chain of command <input type="checkbox"/> Peer review
<input type="checkbox"/> HIPAA privacy and security <input type="checkbox"/> Data breach/Red Flag (identity theft) <input type="checkbox"/> Social media/text messaging/cellular phone use <input type="checkbox"/> RAC audits <input type="checkbox"/> Release of records <input type="checkbox"/> Medical record retention/destruction <input type="checkbox"/> Disclosure of unanticipated outcomes of care <input type="checkbox"/> Service recovery/billing adjustments <input type="checkbox"/> Patient/family/visitor complaints <input type="checkbox"/> Incident reporting <input type="checkbox"/> Mandated reporting of adverse events to regulatory agencies <input type="checkbox"/> Product recalls	<input type="checkbox"/> Medical device failure <input type="checkbox"/> Medication safety <input type="checkbox"/> Informed consent/refusal of treatment <input type="checkbox"/> Emergency preparedness <input type="checkbox"/> Patient emergencies <input type="checkbox"/> Visitor emergencies <input type="checkbox"/> Safety/security <input type="checkbox"/> Patient abduction <input type="checkbox"/> AMA/elopements <input type="checkbox"/> EMTALA <input type="checkbox"/> Chain of command <input type="checkbox"/> Peer review			
64.	Does the Applicant lease or rent any equipment from others?	☐Yes ☐No		
	If "Yes," please provide a description of the equipment:			
65.	Does the Applicant sell, rent or donate equipment to others?	☐Yes ☐No		
	If "Yes," please provide details:			
66.	Does the Applicant have any contractual agreements with independent contractors who provide services at its facility?	☐Yes ☐No		
	If "Yes,"			
	a. Indicate which services are contracted:			
	<input type="checkbox"/> Housekeeping <input type="checkbox"/> Laboratory <input type="checkbox"/> Pharmacy <input type="checkbox"/> Laundry <input type="checkbox"/> Pathology <input type="checkbox"/> Other (describe): _____			
	b. Are certificates of insurance obtained from all contracted providers?	☐Yes ☐No		
	If "Yes," indicate the minimum insurance limits required: _____			
	Please submit a copy of each contract.			
67.	Does the Applicant agree to hold others harmless (indemnify) or assume any liability in any contractual agreement?	☐Yes ☐No		

**CLAIMS HISTORY**

68. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance?  Yes  No

If "Yes," please provide dates of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed):

**NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 68 IS EXCLUDED FROM THE PROPOSED INSURANCE.

69. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be foreseen to give rise to a claim that may fall within the scope of the proposed insurance?  Yes  No

If "Yes," please provide details:

**NOTE:** WITHOUT PREJUDICE TO ANY OTHER RIGHTS OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 69 IS EXCLUDED FROM THE PROPOSED INSURANCE.

## FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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

**ARKANSAS, MINNESOTA AND OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he/she 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, which is a crime.

**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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

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

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

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

**LOUISIANA, NEW MEXICO, RHODE ISLAND APPLICANTS AND WEST VIRGINIA 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.

**MAINE, 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 may include imprisonment, fines or a denial of insurance benefits.

**MISSOURI APPLICANTS:** Any person commits a "fraudulent insurance act" if such person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.

**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.

**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.

**OREGON AND TEXAS APPLICANTS:** Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

**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.

**PUERTO RICO APPLICANTS:** Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars (\$5,000) no more than ten thousand dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**SIGNATURE AND AUTHORIZATION**

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida accounts, the preceding sentence is replaced with the following: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by us. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

We will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

We are authorized to make any inquiry in connection with this Application. Our acceptance of this Application or the making of any subsequent inquiry does not bind you or us to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to us under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, you must notify us immediately and we may modify or withdraw any quotation or agreement to bind insurance.

**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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

**NOTE: THIS APPLICATION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITITES PROPOSED FOR THIS INSURANCE.**

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____
	City: _____ State: _____ Zip: _____
Email Address	
Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: _____
	City: _____ State: _____ Zip: _____

**NOTE: FOR NEW HAMPSHIRE APPLICANTS, PRODUCER'S NAME AND SIGNATURE ARE REQUIRED.**