TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Health Care Organizations and Providers Liability Insurance Renewal 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.	List any new states where the Applicant is operating and providing services:	
3.	Does the Applicant have any new operations outside of the United States of America? If "Yes," please provide details:	☐Yes ☐No
4.	If the Applicant is owned, controlled or managed by another entity, has there been any changes in such ownership, control or management since last year? If "Yes," please provide details:	☐Yes ☐No
5.	Within the next 12 months, does the Applicant expect to: a. Merge, acquire or consolidate with another entity? b. Sell or divest another entity or facility? c. Discontinue any operations or services? d. Enter into any new business activities or services (including new procedures or products being offered)? If "Yes," describe the essential terms of each such transation.	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

6. Please list below any new subsidiaries, including a description of operations, relationship to the Applicant, ownership and retroactive date.

Name & Address	Decription of Operations	Relationship	Ownership %	Retroactive Date

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

7. Does the Applicant own, operate or manage any new 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.

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

Name & Address	Description of Operations	Interest	Coverage Desired
			☐PL ☐GL
			☐PL ☐GL
			☐PL ☐GL

EXPOSURE DETAILS

9. Please provide the following information:

Total number of licensed beds: _____

Inpatient Services (Number of Occupied Beds)	Projected Next 12 Months	Current Year	1st Prior Year	2nd Prior Year	3rd 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	1st Prior Year	2nd Prior Year	3rd 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): _____					

10. 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:

11. 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): _____		

Hiring/Credentialing:

12. Total number of medical staff: _____ Board Certified: _____% Board Eligible: _____%

13. Have there been any changes to screening/hiring/credentialing/training practices for medical staff, midlevel practitioners (advanced practice registered nurse, certified registered nurse anesthetist, physician assistant), and any other professionals who provide patient care services for the Applicant's operations? ☐Yes ☐No
If "Yes", please provide details:

14. 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? ☐Yes ☐No

If "Yes," please explain:

15. Do the Applicant's bylaws require physicians to carry health care professional liability insurance? ☐Yes ☐No

If "Yes," what limit is required? _____

16. In the past year, have there been any changes in your Obstetrical policies or procedures? ☐Yes ☐No

If "Yes," please explain:

17. In the past year, have there been any changes in your Surgical policies or procedures? ☐Yes ☐No

If "Yes," please explain:

18. In the past year, have there been any changes in your Bariatric/Weight Loss Surgery policies or procedures? ☐Yes ☐No

If "Yes," please explain:

19. In the past year, have there been any changes in your Emergency Department policies or procedures? ☐Yes ☐No

If "Yes," please explain:

20. In the past year, have there been any changes in your Radiology Department policies or procedures? ☐Yes ☐No

If "Yes," please explain:

General Liability Exposure:

Please provide a schedule of all locations for which coverage is requested. Schedule should include address, operation type, owned or leased, occupancy and square footage for each such location.

21. Do all of the Applicant's locations meet National Fire Protection Agency building codes? ☐Yes ☐No

22. Does the Applicant have any new construction or renovation projects planned for the next 12 months? ☐Yes ☐No

If "Yes," briefly describe:

23. Does the Applicant have any special events or fund raising events planned for the next 12 months? ☐Yes ☐No

24. Does the Applicant operate any of the following:

a. Day care center for children? ☐Yes ☐No

If "Yes,"

i. Is it open to the public? ☐Yes ☐No

ii. How many children attend daily? _____

b. Day care center for adults? ☐Yes ☐No

If "Yes," how many adults attend daily? _____

c. Fitness/wellness center? ☐Yes ☐No

If "Yes," is it open to the public? ☐Yes ☐No

25. Does the Applicant have a swimming pool on premises? ☐Yes ☐No

26. Does the Applicant have a heliport/helipad? ☐Yes ☐No

If "Yes,"

a. Where is the pad located (e.g. parking lot, top of building, etc.)? _____

b. Estimated number of landings per year? _____

c. Is the helicopter: ☐ Owned ☐ Leased

Auto Liability Exposure:

27. How many vehicles in each of the following categories does the Applicant own or operate?

Private Passenger _____ Service _____ Ambulance _____ Patient Transport _____
Emergency _____ Non-Emergency _____ Other (please describe): _____

OPERATIONS AND ADMINISTRATION

28. Please indicate accreditation(s)/certification(s) held by the Applicant:

- ☐ The Joint Commission (TJC)
- ☐ American Osteopathic Association (AOA)
- ☐ College of American Pathologists (CAP)
- ☐ Magnet Status (ANCC)
- ☐ Det Norsk e Veritas Health Care (DNV)
- ☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
- ☐ Clinical Laboratory Improvement Amendment (CLIA)
- ☐ Other: _____

29. Does the Applicant provide or participate in any student programs? ☐ Yes ☐ No

30. Does the Applicant provide or participate in any resident physician programs/rotations? ☐ Yes ☐ No

If "Yes," in what clinical specialties? _____

31. Does the Applicant require proof of health care professional liability insurance for students/residents? ☐ Yes ☐ No

32. Does the Applicant utilize integrated, electronic medical records for:

a. Inpatient services? ☐ Yes ☐ No

b. Outpatient services? ☐ Yes ☐ No

If "Yes," are integrated, electronic medical records utilized in all locations? ☐ Yes ☐ No

33. Does the Applicant have any technology upgrades planned in the next 12 months? ☐ Yes ☐ No

If "Yes," please provide details:

34. Does the Applicant utilize telehealth (eICU, teleradiology, etc)? ☐ Yes ☐ No

35. Are clinical research studies performed? ☐ Yes ☐ No

a. If "Yes," is IRB approval obtained? ☐ Yes ☐ No

b. Who obtains consent from study participant(s)? _____

36. Does the Applicant participate in a patient safety organization? ☐ Yes ☐ No

37. Please indicate all written policies and procedures that the Applicant has in place:

- ☐ HIPAA privacy and security
- ☐ Data breach/Red Flag (identity theft)
- ☐ Social media/text messaging/cellular phone use
- ☐ RAC audits
- ☐ Release of records
- ☐ Medical record retention/destruction
- ☐ Disclosure of unanticipated outcomes of care
- ☐ Service recovery/billing adjustments
- ☐ Patient/family/visitor complaints
- ☐ Incident reporting
- ☐ Mandated reporting of adverse events to regulatory agencies
- ☐ Product recalls
- ☐ Medical device failure
- ☐ Medication safety
- ☐ Informed consent/refusal of treatment
- ☐ Emergency preparedness
- ☐ Patient emergencies
- ☐ Visitor emergencies
- ☐ Safety/security
- ☐ Patient abduction
- ☐ AMA/elopements
- ☐ EMTALA
- ☐ Chain of command
- ☐ Peer review

38. Does the Applicant lease or rent any equipment from others? ☐ Yes ☐ No

If "Yes," please provide a description of the equipment:

39. Does the Applicant sell, rent or donate equipment to others? ☐Yes ☐No

If "Yes," please provide details:

40. 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:

☐Housekeeping ☐Laboratory ☐Pharmacy
☐Laundry ☐Pathology ☐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.

41. Does the Applicant agree to hold others harmless (indemnify) or assume any liability in any contractual agreement? ☐Yes ☐No

FRAUD WARNINGS

Any person who knowingly and with intent to defraud an 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.

FRAUD WARNING STATEMENTS applicable in the following states:

Alabama: 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 restitution fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas: 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.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: 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.

Delaware: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia: 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.

Florida: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kansas: Any person who, knowingly and with intent to defraud, 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 written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana: 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.

Maine: 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 denial of insurance benefits.

Maryland: 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.

Michigan: 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.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Pursuant to NRS 686A.291, any person who knowingly and willfully files a statement of claim that contains any false, incomplete or misleading information concerning a material fact is guilty of a category D felony.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: 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.

Ohio: Any person who, with 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.

Oklahoma: 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: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Pennsylvania: 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: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island: 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.

Tennessee: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Virginia: 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.

Washington: 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.

West Virginia: 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.

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 ENTITIES 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.	