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

# Medical Facility Liability Insurance Renewal Application

## APPLICATION INSTRUCTIONS

**NOTICE: PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE MAY CONTAIN CLAIMS MADE COVERAGE WHICH APPLIES ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" OR ANY APPLICABLE EXTENDED REPORTED PERIOD AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.**

## ACCOUNT INFORMATION

| | | |
|---|---|---|
| 1. | Applicant Name | |
| 2. | Expiring Policy Number | |
| 3. | Mailing Address | Street: |
| | | City: State: Zip: |
| | | County: Website: |

4. Have there been any changes to the Applicant's legal structure, tax status, senior management or ownership since the last Application? ☐Yes ☐No

   If "Yes," please explain.

5. Since the last Application 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 such transactions. (For any new subsidiaries, describe operations, date of acquisition and ownership):

## FINANCIAL AND EXPOSURE DETAILS

| | | Last 12 Months | Next 12 Months (Projected) |
|---|---|---|---|
| 6. | Please provide the following: | | |
| | Total Revenues: | $ | $ |
| | Annual Patient Visits: | | |

## OPERATIONS AND ADMINISTRATION

7. Since the last Application, have there been any changes to the Applicant's:
   a. Licensing or accreditation? ☐Yes ☐No
   b. Contractual agreements? ☐Yes ☐No
   c. Risk management program? ☐Yes ☐No
   d. Transfer agreements? ☐Yes ☐No
   e. Screening / hiring procedures? ☐Yes ☐No

   If 'Yes," to any of the above, please explain:

8. **Instructions:** Please provide projected exposure details for the **next 12 months** for the Applicant and any subsidiaries or other entities seeking coverage. **Visits -** Count each patient each time they enter the Applicant's facility for health care related services. **Beds -** Use the total number of occupied beds. **Receipts –** Use gross receipts. Do not adjust this figure for items such as profits, un-collectible accounts or amounts billed but not paid.

| Ambulance | Transfers | Receipts |
|---|---|---|
| Ambulance – Air | | $ |
| Ambulance – Emergent (Ground) | | $ |
| Ambulance – Non – Emergent (Ground) | | $ |
| Ambulance – Wheelchair/Paratransit Calls | | $ |

| Clinical Trials / Research / Consulting | Receipts |
|---|---|
| Pharmaceuticals | $ |
| Medical Devices | $ |
| Medical / Surgical Procedures | $ |

| Day Care | Average Daily Census |
|---|---|
| Day Care – Adult Medical | |
| Day Care – Pediatric Medical | |
| Other (Describe): _____ | |

| Home Health / Hospice Care | Visits | Receipts |
|---|---|---|
| Hospice Home Care | | $ |
| Home Health Infusion Therapy | | $ |
| Home Health Personal Care / Non Medical | | $ |
| Home Health Skilled Care | | $ |
| Home Health Rehabilitation | | $ |

| Hospice Care Facility | Beds |
|---|---|
| Inpatient | |

| Imaging/X-Ray | Procedures | Receipts |
|---|---|---|
| Imaging – MRIs | | $ |
| Imaging – X-Ray Diagnostics | | $ |
| Imaging – CT Scans | | $ |
| Imaging – Mammograms | | $ |
| Imaging – Ultrasounds | | $ |
| Imaging – Bone Density Tests | | $ |
| Imaging – PET Scans | | $ |
| Imaging – Gamma Rays | | $ |

| Laboratory | Procedures | Receipts |
|---|---|---|
| Cardiac Catheterization Laboratory | | $ |
| Clinical Pathology Laboratory | | $ |
| Dental Laboratory | | $ |
| Medical Laboratory | | $ |
| Ocular Laboratory | | $ |
| Optical Establishment | | $ |
| Quality Control/Reference Laboratory | | $ |
| Other (Describe):_____ | | $ |

| Lithotripsy Centers | Visits | Receipts |
|---|---|---|
| Lithotripsy Centers | | $ |

| Medical Staffing /Nurse Registry | Total Hours | Receipts |
|---|---|---|
| Medical Staffing/Nurse Registry | | $ |

| Mental Health/Counseling | Visits | Receipts |
|---|---|---|
| Mental Health/Counseling - Outpatient | | $ |
| Mental Health/Partial Hospitalization | | $ |
| Mental Health/ Day Treatment Program | | $ |

| Pharmacy | # of Rx | Receipts |
|---|---|---|
| Pharmacy – Compounding | | $ |
| Pharmacy – Infusion | | $ |
| Pharmacy – Remote Monitoring | | $ |
| Pharmacy – Retail | | $ |
| Pharmacy – Specialty | | $ |

| Rehabilitation | Visits |
|---|---|
| Cardiac Rehabilitation Center | |
| Developmental Disability | |
| Physical/Occupational Rehabilitation | |
| Trauma Rehabilitation – Skilled Medical | |
| Trauma Rehabilitation – Therapy | |

| Residential Facilities | Licensed Beds | Occupied Beds |
|---|---|---|
| Adolescent/Child Residential Care | | |
| Apartments/Independent Living | | |
| Group Homes | | |
| Halfway Houses/Shelters | | |

| School – Allied Medical Professional | # of Students | # of Faculty |
|---|---|---|
| Describe: _____ | | |

| Substance Abuse – Drug or Alcohol | Visits | Receipts |
|---|---|---|
| Substance Abuse Counseling Outpatient | | $ |
| Substance Abuse – Detoxification | | $ |
| Substance Abuse – Residential | | $ |
| Substance Abuse – Skilled Medical | | $ |
| Substance Abuse – Methadone Program | | $ |

| Treatment Centers | Visits | Receipts |
|---|---|---|
| Cancer Treatment Center | | $ |
| College or University Health Center | | $ |
| Crisis Stabilization Center | | $ |
| Dialysis Treatment Center | | $ |
| FTCA Clinic | | $ |
| Health Department | | $ |
| Radiation Therapy | | $ |
| Sleep Center | | $ |
| Other (Describe): _____ | | $ |

| Telemedicine | Visits | Receipts |
|---|---|---|
| Telemedicine | | $ |
| Teleradiology: Preliminary Reads | | $ |
| Teleradiology: Final Reads | | $ |

| Urgent Care/Urgicenter | Visits | Receipts |
|---|---|---|
| Primary Care | | $ |
| Non-Urgent Care | | $ |
| Urgent Care | | $ |

| Weight Loss Center | Visits | Receipts |
|---|---|---|
| Weight Loss Procedures | | $ |

9. Please provide requested information for each physician providing services at the Applicant's facility: ☐None

| Physician Names | Specialty | To Be Covered On This Policy | Check One | Hours per Month |
|---|---|---|---|---|
| | | ☐Yes ☐No | ☐Employee ☐Contractor | |
| | | ☐Yes ☐No | ☐Employee ☐Contractor | |
| | | ☐Yes ☐No | ☐Employee ☐Contractor | |
| | | ☐Yes ☐No | ☐Employee ☐Contractor | |

10. Allied Health Care Professionals (Indicate number of personnel and annual hours worked in each applicable category)

| | Employees | | Contractors | | Volunteers | |
|---|---|---|---|---|---|---|
| | Number of: | Annual Hours: | Number of: | Annual Hours: | Number of: | Annual Hours: |
| Addiction Counselor | | | | | | |
| Case Worker or Case Manager | | | | | | |
| Chiropractor | | | | | | |
| Dentist | | | | | | |
| EMT / Paramedic | | | | | | |
| Home Health Aide / Caregiver | | | | | | |
| Lab Technician | | | | | | |
| Mental Health Counselor | | | | | | |
| Nurse – RN | | | | | | |
| Nurse – LPN/LVN | | | | | | |
| Nurse Aide or Assistant | | | | | | |
| Nurse Anesthetist | | | | | | |
| Nurse Practitioner / Advanced Practice Nurse | | | | | | |
| Occupational/Speech Therapist | | | | | | |
| Optometrist | | | | | | |
| Pharmacist | | | | | | |
| Physical Therapist | | | | | | |
| Physician | | | | | | |
| Physician Assistant | | | | | | |
| Podiatrist | | | | | | |
| Psychologist | | | | | | |
| Respiratory Therapist | | | | | | |
| Social Worker | | | | | | |
| Surgical Technician | | | | | | |
| Other: _____ | | | | | | |

## 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 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. | | | |