

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?			<input type="checkbox"/> Yes <input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Sell or divest another entity or facility?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Discontinue any operations or services?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Enter into any new business activities or services (including new procedures or products being offered)?			<input type="checkbox"/> Yes <input type="checkbox"/> 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

6.	Please provide the following:	Last 12 Months	Next 12 Months (Projected)
	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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. Contractual agreements?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	c. Risk management program?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. Transfer agreements?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	e. Screening / hiring procedures?			<input type="checkbox"/> Yes <input type="checkbox"/> 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	Pharmacy	# of Rx	Receipts
Ambulance - Air		\$	Pharmacy - Compounding		\$
Ambulance - Emergent (Ground)		\$	Pharmacy - Infusion		\$
Ambulance - Non - Emergent (Ground)		\$	Pharmacy - Remote Monitoring		\$
Ambulance - Wheelchair/Paratransit Calls		\$	Pharmacy - Retail		\$
Clinical Trials / Research / Consulting	Receipts		Pharmacy - Specialty		\$
Pharmaceuticals	\$				
Medical Devices	\$		Rehabilitation	Visits	
Medical / Surgical Procedures	\$		Cardiac Rehabilitation Center		
Day Care	Average Daily Census		Developmental Disability		
Day Care - Adult Medical			Physical/Occupational Rehabilitation		
Day Care - Pediatric Medical			Trauma Rehabilitation - Skilled Medical		
Other (Describe): _____			Trauma Rehabilitation - Therapy		
Home Health / Hospice Care	Visits	Receipts	Residential Facilities	Licensed Beds	Occupied Beds
Hospice Home Care		\$	Adolescent/Child Residential Care		
Home Health Infusion Therapy		\$	Apartments/Independent Living		
Home Health Personal Care / Non Medical		\$	Group Homes		
Home Health Skilled Care		\$	Halfway Houses/Shelters		
Home Health Rehabilitation		\$			
Hospice Care Facility	Beds		School - Allied Medical Professional	# of Students	# of Faculty
Inpatient			Describe: _____		
Imaging/X-Ray	Procedures	Receipts	Substance Abuse - Drug or Alcohol	Visits	Receipts
Imaging - MRIs		\$	Substance Abuse Counseling Outpatient		\$
Imaging - X-Ray Diagnostics		\$	Substance Abuse - Detoxification		\$
Imaging - CT Scans		\$	Substance Abuse - Residential		\$
Imaging - Mammograms		\$	Substance Abuse - Skilled Medical		\$
Imaging - Ultrasounds		\$	Substance Abuse - Methadone Program		\$
Imaging - Bone Density Tests		\$	Treatment Centers	Visits	Receipts
Imaging - PET Scans		\$	Cancer Treatment Center		\$
Imaging - Gamma Rays		\$	College or University Health Center		\$
Laboratory	Procedures	Receipts			
Cardiac Catheterization Laboratory		\$	Crisis Stabilization Center		\$
Clinical Pathology Laboratory		\$	Dialysis Treatment Center		\$
Dental Laboratory		\$	FTCA Clinic		\$
Medical Laboratory		\$	Health Department		\$
Ocular Laboratory		\$	Radiation Therapy		\$
Optical Establishment		\$	Sleep Center		\$
Quality Control/Reference Laboratory		\$	Other (Describe): _____		\$
Other (Describe): _____		\$	Telemedicine	Visits	Receipts
Lithotripsy Centers	Visits	Receipts	Telemedicine		\$
Lithotripsy Centers		\$	Teleradiology: Preliminary Reads		\$
Medical Staffing /Nurse Registry	Total Hours	Receipts	Teleradiology: Final Reads		\$
Medical Staffing/Nurse Registry		\$	Urgent Care/Urgicenter	Visits	Receipts
Mental Health/Counseling	Visits	Receipts	Primary Care		\$
Mental Health/Counseling - Outpatient		\$	Non-Urgent Care		\$
Mental Health/Partial Hospitalization		\$	Urgent Care		\$
Mental Health/ Day Treatment Program		\$	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
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Employee <input type="checkbox"/> 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: _____						

11. Does the Applicant have written requirements that all clinical staff carry professional liability insurance? Yes No

If "Yes," what are the minimum limits of insurance required?

\$ _____ Each Claim / \$ _____ Aggregate

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.

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.