

RENEWAL APPLICATION
FOR
MISCELLANEOUS HEALTH CARE
PROFESSIONAL LIABILITY OR PROFESSIONAL & GENERAL LIABILITY
CLAIMS MADE AND REPORTED BASIS.
PLEASE TYPE OR PRINT IN INK

1. Full name of Renewal Applicant: _____

Expiring Policy No: _____ Expiration Date: _____
Address: _____
City: _____ State: Zip: _____ County: _____
Contact name: _____ Title: _____ Email address: _____
Phone: _____ Web site Address: _____ Fax: _____
List all other locations (use an additional sheet of paper if necessary): _____

2. Is the firm engaged in, owned by or associated with or controlled by any other business? _____ Yes No
If yes, give details (use an additional sheet of paper if necessary): _____
3. Are any services provided outside of the United States? _____ Yes No
If yes, please explain, including what countries, what type of services are provided and what percentage of your revenues are derived from these services: _____
4. Does the applicant anticipate any facility expansions within the next year? _____ Yes No
If yes, please describe: _____

5. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? _____ Yes No
If yes, give details: _____
6. Hold Harmless (Indemnification) Agreements: -
(a) In favor of the applicant: - if the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained: _____

(b) In favor of others: - has the applicant agreed to indemnify (hold harmless) others under written contract? _____ Yes No
If yes, please submit a copy of the agreement.

7. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule? _____ Yes No

If yes,

(i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? _____ Yes No

(ii) Provide the name and title of the Applicant's Privacy Officer. _____

8. Is there a swimming pool on premises? _____ Yes No

9. **Professional Activities and Specialty (check one)**

- | | |
|--|---|
| <input type="checkbox"/> Adult Day Care | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Nurse: Anesthetist <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Optician <input type="checkbox"/> Optometrist <input type="checkbox"/> |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Paramedics EMT <input type="checkbox"/> |
| <input type="checkbox"/> Counselor (Describe) | <input type="checkbox"/> Perfusionist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Personal Care Home |
| <input type="checkbox"/> Group Home | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Hearing Aid Fitter | <input type="checkbox"/> Therapist: Inhalation <input type="checkbox"/> Occupational <input type="checkbox"/> |
| <input type="checkbox"/> Home Health Care Agency | Physical <input type="checkbox"/> Speech <input type="checkbox"/> |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Training School |
| <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Medical Staffing Agency | <input type="checkbox"/> X-ray: Lab <input type="checkbox"/> Technician <input type="checkbox"/> |
| <input type="checkbox"/> Mental Health Center | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> MRI Centers | |

10. State sources and amounts of actual and projected gross revenue:

Source	Amount this Fiscal Year	Amount Next Fiscal Year
a. Charitable Contributions		
b. Government Funding		
c. Fee for Service		

11. Please state the percentage of services provided involving minors (persons under age 18) _____%

12. Describe the type of procedures performed at or by this facility: _____

13. Are all personnel performing these procedures certified and properly trained to perform these procedures? _____ Yes No

14. Percentage of professional services performed: _____ % on premises _____ % off premises

15. List the number and type of applicant's employees and volunteers (if none, state "none"):

Number	Type of Profession	Number	Type of Profession
(a)	Acupuncturist	(k)	Pharmacist
(b)	Inhalation Therapist	(l)	Physical Therapist
(c)	Laboratory Technician	(m)	Certified Physicians Assistant
(d)	Licensed Midwife	(n)	Psychologist
(e)	Nurse Anesthetist	(o)	Registered Nurse First Assist
(f)	Nurse, License Practical	(p)	Social Worker
(g)	Nurse Practitioner	(q)	Speech Therapist
(h)	Nurse, Registered	(r)	Home Health Care Aide
(i)	Optician	(s)	Other (specify):
(j)	Optometrist	(t)	Other (specify):

- a. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes No
If no, attach an explanation.
- b. Does the applicant have any independent contractors? Yes No
If yes, list the number and type of independent contractors who provide professional services on behalf of the applicant: _____
- c. Is continuing education or staff development required for your employees? Yes No
- d. Name of medical director, if any: _____
(i) Is coverage provided for the medical director under any other insurance policy? Yes No
(ii) If yes, please provide type of policy and name of carrier: _____

HIRING PRACTICES

- 16. Have there been any changes in your hiring practices since you completed the application for the prior policy, for which this is a renewal application? Yes No
If so, please advise: _____

RISK MANAGEMENT/LOSS CONTROL

- 17. Have there been any changes in your risk management/loss control practices since you completed the application for the prior policy, for which this is a renewal application? Yes No
If so, please advise: _____

MATERIAL CHANGES

- 18. Have there been any material changes in your operations since you completed the application for the prior policy, for which this is a renewal application? Yes No
If so, please advise: _____

CLAIMS HISTORY

19. Since completion of the application for the policy identified in Question 1 above:

- a. Have there been any judgments, settlements, or dismissals of any previously reported claims to any prior insurer? Yes No

If so, please advise: _____

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s), offense(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No

If yes, provide full details. _____

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation? Yes No

If yes, fully describe the circumstances and follow up action taken: _____

NOTE TO THE APPLICANT – PLEASE READ CAREFULLY

This renewal application and any materials submitted herewith are supplemental to all prior application(s) and renewal application(s) and any materials submitted therewith for all policies for which this policy would be a renewal. All such application(s) and renewal application(s) and any materials submitted therewith, together with this renewal application and any materials submitted therewith, shall be deemed attached thereto as if physically attached hereto, and shall constitute the complete renewal application. The renewal application shall be the basis of the contract should a renewal policy be issued and will be attached to and become part of the renewal policy. The information provided by the applicant within this renewal application shall be deemed material to the issuance of the policy and Underwriters will have relied upon this application and attachments in issuing any policy.

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

*Notice applicable in most states:

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant's Signature / Title

Date