

**APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER)  
PROFESSIONAL AND GENERAL LIABILITY INSURANCE**

**(CLAIMS MADE AND REPORTED BASIS)**

Please email this application back to the underwriter with whom you are working.  
For contact information please visit [www.usrisk.com/healthcare.html](http://www.usrisk.com/healthcare.html)

**I. GENERAL INFORMATION:**

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary)**: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_ Title: \_\_\_\_\_ Email address: \_\_\_\_\_

Phone: \_\_\_\_\_ Web site Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Location: Stand alone \_\_\_\_\_ Hospital \_\_\_\_\_ School \_\_\_\_\_ Correctional Facility \_\_\_\_\_ Other \_\_\_\_\_

2. List all Locations, by name and address where Applicant is registered and licensed to operate:

Location 1: \_\_\_\_\_

Location 2: \_\_\_\_\_

Location 3: \_\_\_\_\_

Location 4: \_\_\_\_\_

3. Applicant is: a.  Individual  Partnership  Corporation  Professional Association  Other: \_\_\_\_\_  
b.  Not-for-profit  For-profit  Both

4. Date established: \_\_\_\_\_ / \_\_\_\_\_

5. List all states where you are licensed to practice: \_\_\_\_\_

6. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered?  Yes  No  
If Yes, provide details: \_\_\_\_\_

7. Current accreditations or associations:  NAHC  TAHC  JCAHO  CHAP  NHPCO  Other: \_\_\_\_\_

8. 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): \_\_\_\_\_

9. Please list the individual shareholders or partners of the facility:  
\_\_\_\_\_

10. Does the applicant or any partner, owner or director own (wholly or in part), operate or administer, any hospital, nursing home or other institution where medical services are customarily rendered?  Yes  No  
If yes, give details: \_\_\_\_\_

11. Name(s) of all partners or members of the clinic who provide professional services: \_\_\_\_\_
12. Does the Applicant participate in any state patient compensation fund?  Yes  No
13. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")?  Yes  No  
If Yes, what percentage of services are provided under the FTCA? \_\_\_\_\_
14. 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: \_\_\_\_\_
15. Do you provide any internet services?  Yes  No  
If yes, please attach an explanation, including confirmation of licensing in all states in which services are provided.  
\_\_\_\_\_
16. Does the applicant anticipate any facility expansions within the next year?  Yes  No  
If yes, please describe: \_\_\_\_\_
17. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)?  Yes  No  
If yes, please attach a copy of ALL of the advertisements.
18. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advise is offered to the public?  Yes  No
19. 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 indemnity (hold harmless) others under written contract?  Yes  No  
If yes, please submit a copy of the agreement.
20. 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. \_\_\_\_\_

**II. OPERATIONS:**

1. Days/hours of operation: \_\_\_\_\_
2. (a) Provide the name and specialty of the Applicant's Medical Director: \_\_\_\_\_  
(b) Does the Applicant's Medical Director have direct patient contact?  Yes  No  
(c) Is the Applicant's Medical Director  full-time or  part-time?
3. Applicant's professional specialty: \_\_\_\_\_
4. Provide the percentage of patients/clients:
- |                       |        |                          |        |                 |        |
|-----------------------|--------|--------------------------|--------|-----------------|--------|
| Bariatrics            | _____% | Holistic medicine        | _____% | Sleep Disorders | _____% |
| Communicable Disease  | _____% | Obstetrical              | _____% | Stress Testing  | _____% |
| Correctional Medicine | _____% | Oncology                 | _____% | Students        | _____% |
| Dental                | _____% | Pain Management          | _____% | Substance Abuse | _____% |
| Disability Evaluation | _____% | Pediatric                | _____% | Surgical        | _____% |
| Family Planning       | _____% | Physical Rehabilitation  | _____% | Urgent Care     | _____% |
| Free Clinic           | _____% | Psychiatric              | _____% |                 |        |
| Hemodialysis          | _____% | Research or Experimental | _____% |                 |        |
- Must Total 100%**
5. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: \_\_\_\_\_
6. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.? .....  Yes  No

7. Applicant's Gross Revenues:

	<u>Last Twelve Months</u>	<u>Next Twelve Months</u>
Fee for Service	\$ _____	\$ _____
Medicare/Medicaid Funds	\$ _____	\$ _____
Research	\$ _____	\$ _____
Other (describe)	\$ _____	\$ _____
<b>TOTAL GROSS REVENUES</b>	\$ _____	\$ _____

8. Number of outpatient/client visits:

	<u>Last Twelve Months</u>	<u>Next Twelve Months</u>
Clinics	_____	_____
Laboratory	_____	_____
X-ray/Imaging	_____	_____
Pharmacy	_____	_____
<b>TOTAL VISITS:</b>	_____	_____

9. Does the Applicant maintain any beds for overnight occupancy:

- (a) On the Applicant's premises?  Yes  No  
 If Yes,  
 (i) No. of beds: \_\_\_\_\_  
 (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.
- (b) Off the Applicant's premises?  Yes  No  
 If Yes,  
 (i) No. of beds: \_\_\_\_\_  
 (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

**III. STAFF:**

1. Indicate the number of professional employees, independent contractors and volunteers. If None, state None

	<b>Employees</b>		<b>Independent Contractors</b>		<b>Volunteers</b>	
	<b>Full-Time</b>	<b>Part-Time</b>	<b>Full-Time</b>	<b>Part-Time</b>	<b>Full-Time</b>	<b>Part-Time</b>
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures						
Physicians: Minor surgery or obstetrical procedures not constituting major surgery						
Anesthesiologists						
Obstetrics-Gynecologists						
Oncologists						
Ophthalmologists						
Urologists						
Dentists						
Chiropractors						
Nurse Anesthetists						
Nurse Practitioners						
Optometrists						
Pharmacists						
Physician Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Other(describe):						

2. Are all of the above persons licensed in accordance with applicable state and federal regulation?  Yes  No  
If No, attach explanation.
3. Do all professional staff maintain a Professional Liability Insurance Policy?  Yes  No  
If Yes, what are the minimum limits of liability that the Applicant requires?  
\$ \_\_\_\_\_ each claim / \$ \_\_\_\_\_ aggregate

**IV. PROFESSIONAL SERVICES:**

1. Does the Applicant's employees or independent contractors:
- (a) Perform any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia?  Yes  No  
If Yes, list all minor/invasive procedures \_\_\_\_\_
  - (b) Perform any anti-aging procedures, including Botox or other injectables?  Yes  No
  - (c) Perform abortions and/or menstrual extractions?  Yes  No
  - (d) Perform any experimental procedures or research testing?  Yes  No  
If Yes, are they FDA approved?  Yes  No  
If No, attach a description.
  - (e) Perform any chelation therapy services?  Yes  No  
If Yes, explain: \_\_\_\_\_
  - (f) Administer anesthesia other than topical or local infiltration?  Yes  No  
If Yes, attach detailed explanation.
  - (g) Use drugs for weight reduction for patients?  Yes  No
  - (h) Administer any methadone treatment?  Yes  No  
If Yes,
    - (i) Provide the number of treatments during the:  
Last 12 months \_\_\_\_\_ Next 12 months \_\_\_\_\_
    - (ii) Attach a description of treatment and controls used.
  - (i) Provide teleradiology services?  Yes  No  
If Yes, provide description of services and for whom services are provided \_\_\_\_\_
  - (j) Offer professional advice to the public via the internet, newspapers or broadcasts?  Yes  No  
If Yes, provide details \_\_\_\_\_
  - (k) Advertise professional services in any manner other than a simple listing in a telephone directory? .....  Yes  No  
If Yes, attach a copy of all advertisements.
2. Does the Applicant use a collection agency?  Yes  No  
If Yes,
  - (a) Name of agency: \_\_\_\_\_
  - (b) Does the agency have authority to file a collection suit on behalf of the Applicant?  Yes  No

**V. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)**

1. Complete the following for each of the Applicant's facilities:
- | Location Number | Name of Facility | Address | Description of Facility | Does the Applicant Maintain a Garage? (Yes/No) | Is There an Adjacent Exposure? (Yes/No) |
|-----------------|------------------|---------|-------------------------|--|---|
| 1.              | .....            | .....   | .....                   | .....  | .....                                   |
| 2.              | .....            | .....   | .....                   | .....  | .....                                   |
| 3.              | .....            | .....   | .....                   | .....  | .....                                   |
| 4.              | .....            | .....   | .....                   | .....  | .....                                   |

2. Complete the following for each of the Applicant's locations:
- |   | Location 1 | Location 2 | Location 3 | Location 4 |
|---|------------|------------|------------|------------|
| Square Footage*                               | _____      | _____      | _____      | _____      |
| Year Built                                    | _____      | _____      | _____      | _____      |
| Year Remodeled                                | _____      | _____      | _____      | _____      |
| Number of Stories                             | _____      | _____      | _____      | _____      |
| Type of Construction (frame, brick, concrete) | _____      | _____      | _____      | _____      |
| Percentage of Building Occupied by Applicant  | _____      | _____      | _____      | _____      |
| Other occupants? (Yes/No)                     | _____      | _____      | _____      | _____      |

\*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:
- (a) Complete Sprinkler System?  Yes  No
  - (b) At least two clearly marked exits on each floor?  Yes  No
  - (c) Self-closing fire doors on each floor?  Yes  No
  - (d) Automatic fire alarm system connected to a local fire department?  Yes  No
  - (e) Smoke detectors?  Yes  No
  - (f) Emergency electrical system?  Yes  No
  - (g) Heat sensors?  Yes  No
  - (h) Fire escape(s)?  Yes  No
  - (i) Posted emergency evacuation procedures?  Yes  No
  - (j) Properly maintained fire extinguishers?  Yes  No
- If any of the above are answered No, provide details by attachment.
4. Does the Applicant have a written safety program in place?  Yes  No  
If Yes, attach a copy of the written safety program.
5. Does the Applicant have written procedures for incident reporting?  Yes  No
6. Do any of the Applicant's locations have any:
- (a) Exposure to flammables, explosive, chemicals?  Yes  No
  - (b) Catastrophe exposure?  Yes  No
  - (c) Exposure to radioactive materials?  Yes  No
7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials?  Yes  No
8. Does the Applicant sell or lease any medical equipment or products to patients/clients or others in connection with Applicant's operation?  Yes  No  
If Yes, Total Annual Sales \$ \_\_\_\_\_  
Total Annual/Lease Rental Receipts \$ \_\_\_\_\_
9. Does the Applicant:
- (a) Loan or rent machinery or equipment to others?  Yes  No
  - (b) Own any elevators or escalators?  Yes  No
  - (c) Own or rent any parking facility?  Yes  No
  - (d) Provide any recreational facility?  Yes  No
  - (e) Have a swimming pool on the premises?  Yes  No
  - (f) Sponsor any sporting or social events?  Yes  No

**VI. INSURANCE INFORMATION:**

1. Do you currently carry the following:

- a. Professional Liability Insurance?  Yes  No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the retroactive date/prior acts date on your current policy? \_\_\_\_\_

- b. Commercial General Liability Insurance?  Yes  No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy? \_\_\_\_\_

**VII. HISTORY:**

1. Has the Applicant or any of its employees ever:
  - (a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Yes  No
  - (b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  Yes  No  
If Yes, provide details. \_\_\_\_\_
  - (c) Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  Yes  No  
If Yes, provide details. \_\_\_\_\_
  - (d) Had any professional license or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license?  Yes  No  
If Yes, provide details. \_\_\_\_\_
2. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years?  Yes  No  
If Yes, attach a copy of such insurer's notice.

**VIII. CLAIMS HISTORY:**

1. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance?  Yes  No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS  
IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT**

2. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you?  Yes  No  
If yes, provide full details. \_\_\_\_\_
3. 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: \_\_\_\_\_

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.

