MedPro Group
a Berkshire Hathaway company

Issuing Company:
National Fire & Marine Insurance Company
Omaha, Nebraska

CLINIC PROFESSIONAL LIABILITY APPLICATION

INSTRUCTIONS

1. PLEASE PRINT LEGIBLY. IF THE APPLICATION IS APPROVED, THE POLICY WILL BE BASED ON THE INFORMATION PROVIDED.
2. PLEASE ANSWER ALL QUESTIONS. IF A QUESTION IS NOT APPLICABLE, PRINT, "N/A".
3. IF ADDITIONAL SPACE IS NEEDED, PLEASE USE THE SUPPLEMENTAL INFORMATION SECTION.

I. PRODUCER INFORMATION

A. FIRM INFORMATION

FIRM NAME _____ INDIVIDUAL NAME _____

MAILING ADDRESS _____ PHONE _____

CITY/STATE/ZIP _____ E-MAIL _____

II. APPLICANT INFORMATION

A. CONTACT INFORMATION

APPLICANT NAME _____

MAILING ADDRESS _____ COUNTY _____

STREET ADDRESS (IF DIFFERENT) _____

WEBSITE ADDRESS _____

FEDERAL TAX ID NUMBER _____

B. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM): _____
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF THE APPLICANT'S CURRENT POLICY.

C. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM): _____
ANNUAL POLICY TERMS WILL BEGIN AND END ON THE SAME MONTH AND DAY.

III. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	POLICY TYPE	DEDUCTIBLE (PRIMARY COVERAGE)
☐ **PROFESSIONAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	
☐ **GENERAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	
☐ **EXCESS - PROFESSIONAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	
☐ **EXCESS - GENERAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	

(*) IF THE APPLICANT HAS ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.), PLEASE COMPLETE SECTION II (SCHEDULE OF RELATED ENTITIES) OF THE CLINIC SUPPLEMENTAL APPLICATION, OR ATTACH A COPY OF THE APPLICANT'S ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED.

IV. GENERAL INFORMATION

A. TYPE OF LEGAL ENTITY (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

☐ PROFESSIONAL CORPORATION
☐ LIMITED LIABILITY CORPORATION (LLC)
☐ PARTNERSHIP OR PROFESSIONAL ASSOCIATION
☐ JOINT VENTURE
☐ FOR PROFIT
☐ OTHER (PLEASE EXPLAIN): _____
☐ NON PROFIT

B. ENTITY OWNERSHIP (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

☐ PHYSICIAN OWNED
☐ INDEPENDENTLY OWNED (PLEASE EXPLAIN): _____
☐ HOSPITAL OWNED
☐ OTHER (PLEASE EXPLAIN): _____

C. HOW MANY YEARS HAS THE FACILITY BEEN IN OPERATION? _____

D. HOW MANY CLINIC LOCATIONS DOES THE FACILITY HAVE? _____

PLEASE LIST ALL CLINIC LOCATIONS. IF MORE THAN 3 LOCATIONS, PLEASE ATTACH A SEPARATE PIECE OF PAPER SHOWING THE ADDITIONAL LOCATIONS.

LOCATION #1:

_____
STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____

LOCATION #2:

_____
STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____

LOCATION #3:

_____
STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____

E. DURING THE NEXT 12 MONTHS, ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS, OR DOES THE APPLICANT PLAN ON ADDING ANY ADDITIONAL LOCATIONS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

F. CERTIFICATIONS/ACCREDITATIONS HELD BY THE FACILITY:

☐ AAUCM ☐ JCAHO ☐ AAAHC ☐ NAFAC ☐ UCAOA ☐ AAAASF ☐ OTHER: _____

PLEASE PROVIDE A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

G. ARE ALL LOCATIONS ACCREDITED BY AT LEAST ONE OF THE ORGANIZATIONS LISTED IN QUESTION F., ABOVE? ☐ YES ☐ NO

IF NO, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. DOES THE FACILITY HAVE WRITTEN POLICIES IN PLACE ADDRESSING TELEPHONE ADVICE AND TELEPHONE REQUESTS FOR MEDICATION? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
2. DOES THE FACILITY HAVE WRITTEN POLICIES IN PLACE DESCRIBING THE PRECAUTIONS FOR DEALING WITH PATIENTS WITH INFECTIOUS DISEASES INCLUDING AN ISOLATION POLICY? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
3. IS THE IDENTITY OF PATIENTS RECEIVING TESTS OR MEDICATIONS VERIFIED BY REVIEW OF TWO FORMS OF PATIENT IDENTIFICATION PRIOR TO THE ADMINISTRATION OF THE TEST OR MEDICATION? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
4. DOES THE ORGANIZATION CREATE AND MAINTAIN A MEDICAL RECORD FOR EVERY PATIENT WITH CONTACT INFORMATION AND DATE(S) OF SERVICE? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
5. DOES THE CLINIC HAVE WRITTEN POLICIES AND PROCEDURES TO PROTECT PATIENT PRIVACY? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____

H. MEDICAL DIRECTOR:

_____
NAME OF MEDICAL DIRECTOR

____ - ____ - _____ _____
PHONE NUMBER EMAIL

I. ANNUAL PAYROLL:

TOTAL ANNUAL PAYROLL: $ _____

IV. GENERAL INFORMATION (CONTINUED)

J. TOTAL PROJECTED ANNUAL REVENUE: $ _____ **PRIOR YEAR REVENUE:** $ _____

% MEDICARE: _____ % COMMERCIAL PAYORS: _____ %

% MEDICAID: _____ % % OTHER: _____ %

V. CLINIC OPERATIONS

A. IS THE CLINIC DESIGNATED (DEEMED) AS A FEDERALLY QUALIFIED HEALTH CENTER (FQHC)? ☐ YES ☐ NO

1. WHEN DID THE ORGANIZATION FIRST OBTAIN DEEMED STATUS? ____ / ____ / _____ (MM / DD / YYYY)
2. HAVE THERE BEEN ANY CHANGES IN THE CLINIC'S DEEMED STATUS SINCE FIRST BECOMING DEEMED? ☐ YES ☐ NO

   IF YES, PLEASE EXPLAIN: _____
3. IS THE APPLICANT AWARE OF ANY ACTIVITIES THAT FALL OUTSIDE THE SCOPE OF THE APPLICANT'S FTCA DEEMING STATUS? ☐ YES ☐ NO

   IF YES, PLEASE EXPLAIN: _____

B. IS THE FACILITY QUALIFIED FOR ANY OTHER TYPE OF CHARITABLE IMMUNITY UNDER ANY OTHER LAWS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

C. ANNUAL VISITS TO THIS FACILITY:

CURRENT NUMBER		PROJECTED NUMBER	
DEEMED	NON-DEEMED	DEEMED	NON-DEEMED

D. DOES THE CLINIC HAVE A PROCESS IN PLACE REGARDING HOW TO INFORM PATIENTS OF THE OUTCOME OF THEIR DIAGNOSTIC TEST(S) WHEN PATIENTS ARE EITHER UNABLE TO RECEIVE TEST RESULTS DURING THEIR VISIT(S) OR WHEN THE PATIENTS RESULTS ARE REVISED DUE TO FURTHER EVALUATION? ☐ YES ☐ NO

E. ARE PATIENTS WHO PRESENT WITH CONDITIONS REQUIRING FOLLOW-UP CARE PROVIDED REFERRALS TO APPROPRIATE PRIMARY CARE OR SPECIALTY PHYSICIANS? ☐ YES ☐ NO

F. IN THE NEXT 12 MONTHS, DOES THE CLINIC PLAN TO CHANGE ANY OF THE SERVICES IT OFFERS? (I.E. ADDING OR DISCONTINUING ANY SERVICES) ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

G. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

H. ARE PATIENTS REQUIRED TO MEET SPECIFIC CRITERIA IN ORDER TO QUALIFY FOR SERVICES? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

I. HOW ARE NON-VOLUNTEER PROVIDERS COMPENSATED? _____

J. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES THAT WILL BE PERFORMED AT THE FACILITY:

- ☐ ABORTIONS
- ☐ ALCOHOL/DRUG TESTING
- ☐ ALLERGY SHOTS
- ☐ ALTERNATIVE/INTEGRATIVE/COMPLIMENTARY MEDICINE
- ☐ ANESTHESIA
  - ☐ TOPICAL
  - ☐ NERVE BLOCKS (PLEASE LIST TYPES): _____
  - ☐ GENERAL
- ☐ BEHAVIORAL HEALTH
- ☐ CHIROPRACTIC
- ☐ COSMETIC PROCEDURES (PLEASE LIST TYPES): _____
- ☐ DENTAL
- ☐ DIAGNOSTIC RADIOLOGY, IF APPLICABLE, ARE ALL FILMS OVERREAD BY A RADIOLOGIST? ☐ YES ☐ NO
- ☐ DIALYSIS
- ☐ ECG, IF APPLICABLE, ARE ALL TEST RESULTS OVERREAD BY A CARDIOLOGIST? ☐ YES ☐ NO
- ☐ FRACTURES
- ☐ HOME HEALTH CARE
- ☐ IMMUNIZATIONS
- ☐ LABORATORY (PATHOLOGY)
- ☐ OBSTETRICS, IF APPLICABLE, PLEASE DESCRIBE TYPES OF SERVICES PROVIDED: _____
- ☐ OCCUPATIONAL MEDICINE, IF APPLICABLE, PLEASE LIST THE COMPANIES WITH WHICH THE CLINIC CONTRACTS TO PROVIDE SERVICES AND EXPLAIN THE SERVICES PROVIDED: _____
- ☐ OCCUPATIONAL/PHYSICAL THERAPY, IF APPLICABLE, NUMBER OF VISITS: _____
- ☐ OSTEOPATHIC MANIPULATION THERAPY
- ☐ PHARMACY
- ☐ PHYSICALS
- ☐ RESEARCH/EXPERIMENTAL, IF APPLICABLE, PLEASE EXPLAIN: _____
- ☐ SOCIAL SERVICES
- ☐ SUBSTANCE ABUSE TREATMENT
  - ☐ METHADONE
- ☐ TREATMENT FOR CHRONIC PAIN; NUMBER OF VISITS, IF APPLICABLE: _____
- ☐ URGENT CARE
- ☐ OTHER: _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

VI. MEDICAL STAFF

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN THAT PRACTICES AT THE APPLICANT'S FACILITY. (IF MORE ROOM IS NEEDED, PLEASE ATTACH A SEPARATE ROSTER OF MEDICAL STAFF).

IMPORTANT NOTE: IF COVERAGE IS REQUESTED FOR PHYSICIANS, PLEASE SO STATE ON SECTION III (SCHEDULE OF MEDICAL PROFESSIONALS) OF THE CLINIC SUPPLEMENTAL APPLICATION. ALSO COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR EACH PHYSICIAN.

PHYSICIAN'S NAME	MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)	PRIMARY LICENSE NUMBER	INDICATE PRIMARY SPECIALTY	NUMBER OF HOURS PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT THE FACILITY	VOLUNTEER?
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO
					☐ YES ☐ NO

B. ARE THE PHYSICIANS PRACTICING AT THE APPLICANT'S FACILITY BOARD CERTIFIED? ☐ YES ☐ NO

IF NO, HOW MANY ARE NOT BOARD CERTIFIED? _____

C. DOES THE FACILITY HAVE ANY PHYSICIANS ON STAFF THAT DO NOT MAINTAIN STAFF PRIVILEGES AT A HOSPITAL? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

D. IN THE TABLE BELOW, STATE BY TYPE THE NUMBER OF HEALTH PROFESSIONALS (OTHER THAN PHYSICIANS) WHO WORK AT THE FACILITY:

IMPORTANT NOTE: IF COVERAGE IS REQUESTED FOR HEALTH PROFESSIONALS OTHER THAN PHYSICIANS, PLEASE REQUEST SUCH COVERAGE ON SECTION IV (SCHEDULE OF MEDICAL PROFESSIONALS) OF THE CLINIC SUPPLEMENTAL APPLICATION. IF SEPARATE LIMITS ARE NEEDED FOR ANY INDIVIDUAL, ALSO SUBMIT AN APPLICATION FOR EACH SUCH INDIVIDUAL.

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED
NURSE PRACTITIONERS			
PHYSICIAN ASSISTANTS			
LPNs/RNs			
LABORATORY TECHNICIANS			
SOCIAL WORKERS			
OTHER (PLEASE SPECIFY):			

E. DOES THE APPLICANT SUPERVISE ANYONE OTHER THAN ITS OWN EMPLOYEES? ☐ YES ☐ NO

IF YES, DESCRIBE THE RESPONSIBILITY OF BOTH THE SUPERVISORY AND SUPERVISED INDIVIDUALS, AND THE RELATIONSHIPS BETWEEN THE INDIVIDUALS: _____

ALSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL, THE NUMBER OF INDIVIDUALS THE FACILITY SUPERVISES:

_____

VII. RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT PROGRAM? ☐ YES ☐ NO

B. IS THERE A FULL-TIME RISK MANAGER? ☐ YES ☐ NO

IF NO, WHAT ARE THEIR OTHER RESPONSIBILITIES AND HOW MUCH TIME IS DEVOTED TO RISK MANAGEMENT?

_____

C. IS THERE A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ YES ☐ NO

1. IF YES, DOES THIS PROCEDURE REQUIRE REVIEW AND APPROPRIATE CORRECTIVE ACTION BE TAKEN? ☐ YES ☐ NO
2. IS THERE A FOLLOW-UP TO ASSURE COMPLIANCE? ☐ YES ☐ NO

VII. RISK MANAGEMENT (CONTINUED)

D. IS THERE AN ONGOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE? ☐ YES ☐ NO

1. IF YES, IS THE PERSON RESPONSIBLE FOR RISK MANAGEMENT A MEMBER OF THIS COMMITTEE? ☐ YES ☐ NO
2. TO WHOM IS THE QUALITY ASSURANCE COMMITTEE ACCOUNTABLE?

NAME _____ TITLE _____

3. WHAT QUALITY INDICATORS ARE MONITORED? PLEASE LIST: _____
4. DOES THE APPLICANT MONITOR INFECTION RATES AT THE FACILITIES? ☐ YES ☐ NO

E. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS THAT IS PART OF THE QUALITY MANAGEMENT PROGRAM? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

F. IS THERE AN ONGOING CONTINUING EDUCATION PROGRAM FOR:

NURSING STAFF? ☐ YES ☐ NO

OTHER ALLIED HEALTH PROFESSIONALS? ☐ YES ☐ NO

G. NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:

NAME _____ TITLE _____

VIII. CREDENTIALING

A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF, DOES THE APPLICANT:

1. VERIFY EDUCATIONAL BACKGROUND? ☐ YES ☐ NO
2. CHECK ALL REFERENCES INCLUDING PAST EMPLOYERS? ☐ YES ☐ NO
3. CHECK FOR PENDING LICENSE SUSPENSIONS, REVOCATIONS OR DISCIPLINARY ACTIONS BY OTHER FACILITIES? ☐ YES ☐ NO
4. CHECK CRIMINAL HISTORY? ☐ YES ☐ NO
5. REQUIRE PRIOR MEDICAL PROFESSIONAL CLAIM HISTORY? ☐ YES ☐ NO

B. ARE THE CREDENTIALS OF EACH PHYSICIAN REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES? ☐ YES ☐ NO

C. IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK? ☐ YES ☐ NO

D. DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN, PODIATRIST AND DENTIST WORKING AT THE APPLICANT'S FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

1. IF YES, WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED? $ _____ / $ _____
2. ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

E. WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED FOR NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT THE APPLICANT'S FACILITY TO CARRY? $ _____ / $ _____

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

F. HAS THE LICENSE OF ANY PHYSICIAN, PODIATRIST OR DENTIST PROVIDING SERVICES AT THE CENTER BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

G. HAVE ANY CURRENT OR FORMER EMPLOYEES OR CONTRACTORS: (PLEASE ATTACH AN EXPLANATION OF ANY "YES" ANSWERS)

1) EVER BEEN THE SUBJECT OF DISCIPLINARY OR INVESTIGATIVE PROCEEDINGS, OR A REPRIMAND BY A GOVERNMENTAL LICENSE BOARD OR ADMINISTRATIVE AGENCY, HOSPITAL OR PROFESSIONAL ASSOCIATION? ☐ YES ☐ NO

2) EVER BEEN INDICTED FOR, CHARGED WITH, OR CONVICTED OF, ANY ACT COMMITTED IN VIOLATION OF ANY LAW OR ORDINANCE, OTHER THAN TRAFFIC OFFENSES, OR HAD HOSPITAL PRIVILEGES, DEA LICENSE, OR MEDICARE/MEDICAID PRIVILEGES REFUSED, DENIED, REVOKED, SUSPENDED, RESTRICTED, SUBJECT TO A REPRIMAND, PLACED ON PROBATION OR VOLUNTARILY SURRENDERED? ☐ YES ☐ NO

IX. GENERAL LIABILITY

IS GENERAL LIABILITY COVERAGE BEING REQUESTED? ☐ YES ☐ NO
IF YES, COMPLETE THIS SECTION. IF NO, SKIP TO SECTION X.

A. PLEASE INDICATE WHICH OF THE FOLLOWING APPLY (IF ANY):

☐ DAYCARE CENTER

☐ HABITATIONAL RISKS (APARTMENT, DWELLING, HOTEL, ETC.)

☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS

☐ SWIMMING POOLS

☐ FITNESS CENTERS

☐ WATERCRAFT

☐ SECURITY SERVICE

IF ANY OF THE ABOVE APPLY, PLEASE EXPLAIN: _____

_____

_____

X. EXCESS LIABILITY

IS EXCESS LIABILITY COVERAGE REQUESTED? ☐ YES ☐ NO
IF YES, COMPLETE THIS SECTION. IF NO, SKIP TO SECTION XI.

A. HAS THE APPLICANT'S EXCESS PROFESSIONAL OR COMMERCIAL GENERAL LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS? ☐ YES ☐ NO
IF YES, WHAT WAS THE PRIOR LIMIT AND WHEN WAS IT INCREASED?
$ _____ / $ _____ _____ _____
MM YYYY

XI. COVERAGE HISTORY AND INFORMATION

****NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATE OF MISSOURI.**
A. HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER INSURANCE COVERAGE TO THE APPLICANT? ☐ YES ☐ NO
IF YES, PLEASE PROVIDE DETAILS: _____

_____

B. PLEASE CHECK WHICH TYPE OF NOTICE THE APPLICANT'S PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE IT WILL FORMALLY RECOGNIZE A CLAIM UNDER ITS POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

☐ WRITTEN NOTICE FROM THE APPLICANT THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

C. HAS THE APPLICANT CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS? ☐ YES ☐ NO
IF YES, HAS THE APPLICANT FORWARDED THEM TO THE APPLICANT'S CURRENT INSURER? ☐ YES ☐ NO
IF YES, PROVIDE THE DATE OF THE REVIEW AND THE NAME AND TITLE OF THE PERSON CONDUCTING THE REVIEW:

_____ _____ _____ _____
MM YYYY NAME TITLE

D. PLEASE PROVIDE THE APPLICANT'S INSURANCE HISTORY FOR THE LAST FIVE YEARS.

POLICY PERIOD	MOST RECENT YEAR	1 YEAR PRIOR	2 YEARS PRIOR	3 YEARS PRIOR	4 YEARS PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
GENERAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
EXCESS LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					

XII. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)

FOR EACH CLAIM, POTENTIAL CLAIM OR SUIT MENTIONED BELOW, PLEASE COMPLETE SECTION I (LOSS HISTORY) OF THE CLINIC SUPPLEMENTAL APPLICATION.

A. HAS THE APPLICANT (INDEPENDENTLY OR THROUGH A NAMED INSURED) BEEN INVOLVED NOW OR IN THE PAST, DIRECTLY OR INDIRECTLY, IN A CLAIM, POTENTIAL CLAIM, OR SUIT ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION OR ANY FORMER OR PRESENT EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE CORPORATION, PARTNERSHIP OR ORGANIZATION? ☐ YES ☐ NO

IF YES, HOW MANY? _____

IF YES, HAVE THESE BEEN REPORTED TO THE APPLICANT'S INSURER? ☐ YES ☐ NO

B. DOES THE APPLICANT OR ANY OF ITS EMPLOYEES/CONTRACTORS HAVE KNOWLEDGE OF ANY INCIDENT, OR UNEXPECTED ADVERSE OUTCOME RESULTING IN INJURY OR DEATH, CLAIM, POTENTIAL CLAIM, OR SUIT IN WHICH THE APPLICANT MAY BECOME INVOLVED, INCLUDING WITHOUT LIMITATION, KNOWLEDGE OF ANY INJURY ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES WHICH MAY GIVE RISE TO A CLAIM INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION, OR ANY FORMER OR PRESENT EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE CORPORATION, PARTNERSHIP OR ORGANIZATION WHICH MAY GIVE RISE TO A CLAIM? ☐ YES ☐ NO

IF YES, HOW MANY? _____

IF YES, HAVE THESE BEEN REPORTED TO THE APPLICANT'S INSURER? ☐ YES ☐ NO

XIII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION. IF NOT AVAILABLE, PLEASE EXPLAIN.

A. A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.
B. FTCA DEEMING APPLICATION (IF APPLICABLE)
C. LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.
D. LOSS INFORMATION. RECENTLY VALUED LOSS RUNS FROM THE APPLICANT'S INSURANCE CARRIERS COVERING THE LAST TEN (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS.
E. ANNUAL REPORT (IF ONE IS PUBLISHED).
F. ALL CURRENT **ADVERTISING MATERIALS.**
G. ORGANIZATIONAL CHART INCLUDING THE **NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.**
H. COPY OF THE APPLICANT'S CURRENT INSURANCE POLICY.

XIV. IMPORTANT NOTICE

THIS INSURANCE MAY CONTAIN CLAIMS-MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE AND REPORTED DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE. PLEASE READ AND REVIEW THE POLICY CAREFULLY.

XV. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ THE FOLLOWING:
ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DECEIVE, OR, DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.

XVI. STATE SPECIFIC NOTICES

If Delaware: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 and Delaware Bulletin No. 46 including the following: Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

If Illinois: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under Illinois Bulletin 2011-06 And The Religious Freedom Protection and Civil Union Act which states: "The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married" or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

If Rhode Island: **THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.**

XVII. PLEASE READ AND SIGN

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on his, her or the facility/entity's behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that neither I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

SIGNATURE OF OFFICER OR AUTHORIZED REPRESENTATIVE	TITLE	DATE

XVIII. SUPPLEMENTAL INFORMATION