



NEW BUSINESS APPLICATION

**PROFESSIONAL LIABILITY
Miscellaneous Healthcare Facilities**

NOTE - Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

INSTRUCTIONS TO THE APPLICANT:

- Please answer all questions on this application and on applicable supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The application must be signed and dated by an owner, partner, officer or director of your facility.
- Please attach the following to your completed application:
 - Brochures, pamphlets, advertisements or other descriptive literature of operations and services,
 - Copies of any surveys conducted by outside organizations within the past three years,
 - Copy of the current practice license(s),
 - Company loss runs, valued within the last 90 days, for past 5 years, or for as long as you have been in business if less than five years.
 - Current income statement and balance sheet.

I. GENERAL INFORMATION

1	Applicant/Entity Name:		
2	Mailing Address:		
	City:	County:	
	State:	ZIP:	
3	Business Address:		
	City:	County:	
	State:	ZIP:	
4	Telephone:	Web Site:	
5	Applicant Is: <input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other (describe):		
	Applicant Type: <input type="checkbox"/> For Profit <input type="checkbox"/> Not for Profit		
6	Years in Business:	Hours of Operation:	
7	Description of Operation: (complete & attach the appropriate Supplemental Application)		
	<input type="checkbox"/> Blood / Donor Bank	<input type="checkbox"/> Air or Ground Ambulance Service	
	<input type="checkbox"/> Home Health Care / Hospice Care	<input type="checkbox"/> Durable Medical Equipment Supplier	
	<input type="checkbox"/> Laboratory / Imaging	<input type="checkbox"/> Birthing Center	
	<input type="checkbox"/> Out-Patient Facility / Ambulatory Surgery Center	<input type="checkbox"/> Other (describe):	
	Provide additional details as necessary:		
8	List below all subsidiaries, date acquired, description of operation and percentage of ownership:		
	Subsidiaries	Date Acquired	Description of Operation % of Ownership
			%
			%
			%
			%
9	Within the next 12 months, does the applicant plan to: (check all that apply and provide details)		
	<input type="checkbox"/> Purchase or acquire another operation or entity?	<input type="checkbox"/> Expand the number of locations?	
	<input type="checkbox"/> Add any services?	<input type="checkbox"/> Expand operation into other States?	
	Provide details:		
10	Has the applicant sold, discontinued or acquired any operations since the retroactive date of your current policy? If YES , please provide details:		<input type="checkbox"/> Yes <input type="checkbox"/> No

II. OPERATIONS

	Projected	Current Year	Past Year	2 nd Previous Year
1 Provide applicant's total gross annual revenues:	\$	\$	\$	\$
2 If your operation is an outpatient facility, please provide the number of outpatient visits:	#	#	#	#

3	Is the applicant accredited by or a member of any professional organization or association? If YES , please name: _____ If accredited, please provide a copy of the accreditation report.					<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Is applicant certified for Medicare reimbursement?					<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Does the applicant maintain a current State license? If YES , please provide copy.					<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Has applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any State or Federal licensing board or regulatory agency? This includes, but is not limited to, Medicare, Medicaid, or other reimbursement programs. If YES , please provide details:					<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Are all operations provided out of the main location? If NO , please attach a listing of all locations including a description of services conducted at each location.					<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Are any services provided for or at Nursing Homes, Assisted Living Facilities, or Long Term Care Facilities? If YES , please describe:					<input type="checkbox"/> Yes <input type="checkbox"/> No
9	a	Does applicant have any contractual agreements with independent contractors to provide services at the applicant's facility?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	b	Does contractual agreement contain a hold harmless or indemnification clause favorable to applicant?				<input type="checkbox"/> Yes <input type="checkbox"/> No
	c	Does applicant obtain certificates of insurance in the amount of \$1M/\$3M (minimum) from all Healthcare Professionals (e.g. Resident, Intern, Physician, Surgeon, Dentist, Psychiatrist, Licensed or Certified Registered Nurse Anesthetist, Nurse, Midwife, Podiatrist and Chiropractor) rendering professional services at the facility?				<input type="checkbox"/> Yes <input type="checkbox"/> No
10	a	Does applicant provide services to others on a contractual agreement? If YES , please describe services provided:				<input type="checkbox"/> Yes <input type="checkbox"/> No
	b	Does the applicant agree to hold harmless or indemnify others under contract? If YES , please provide details:				<input type="checkbox"/> Yes <input type="checkbox"/> No
11	Does applicant sell or lease any medical supplies and/or equipment to others? If YES , please complete and attach the Durable Medical Equipment Supplemental Application.					<input type="checkbox"/> Yes <input type="checkbox"/> No
12	Does applicant provide any overnight bed facilities? If YES , advise number of beds:					<input type="checkbox"/> Yes <input type="checkbox"/> No
13	Do you have written protocols and transfer agreements to transfer patients in the event of a life-threatening emergency? Please provide a copy of those documents and advise:					<input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of the facility:					
	Number of miles to the facility: _____ Miles					
Driving time to facility: _____ Minutes						
14	Please provide the following information for each medical director providing services at the applicant's facility:					
	Medical Director's Name	Specialty	Insurance Carrier & Policy Number	Limits	Employee/ Contractor	Hours per Month
Please note: Coverage for Medical Director is limited to administrative duties as described in the policy form.						
15	Identify the number of other employed health care professionals providing services at the applicant's facility:					
	Type of Professional	# Full Time Employees	# Part Time Employees	# Full Time Contractors	# Part Time Contractors	Contractors Annual Hours
	EMT					
	Nurse					
	Nurse Aid					
	Nurse Practitioner					
	Occupational Therapist					
	Paramedic					
	Pharmacist					
	Phlebotomist					
	Physical Therapist					
	Physician Assistant					
	Radiation Technician					
	Respiratory Therapist					
Social Worker						
Speech Therapist						
III. RISK MANAGEMENT/LOSS CONTROL						
1	Does applicant utilize a formal written Risk Management Program? If YES , attach a written summary of the Table of Contents or a copy of the written policy/procedure document.					<input type="checkbox"/> Yes <input type="checkbox"/> No

2	Who has the overall responsibility for Risk Management & Loss Control?				
	Name:				
	Title:				
	Telephone:				
3	Who is to be contacted for loss control survey, if different than above?				
	Name:				
	Title:				
	Telephone:				
4	a	Does applicant own any equipment used for diagnosis, monitoring or treatment purposes?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	b	Is there a written procedure followed for the inspection and maintenance of any equipment that is owned or leased?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	c	Who is responsible for inspecting and maintaining the equipment: <input type="checkbox"/> Employees <input type="checkbox"/> Independent Contractors			
	d	If Independent Contractors are utilized, are certificates of insurance obtained?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	e	Is inspection and maintenance performed according to the manufacturer's recommendations?			<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Indicate which hiring/screening procedures are used for employees and contractors: (check all that apply)				
	<input type="checkbox"/> References checked: <input type="checkbox"/> In writing <input type="checkbox"/> By telephone				
	<input type="checkbox"/> Criminal records checked				
	<input type="checkbox"/> Require information on any professional liability or work-related claim or suit				
	<input type="checkbox"/> Verify any pending license suspensions, revocations or pending disciplinary actions by other facilities				
6	Are "Informed Consent" forms used? If YES , please provide a copy.				<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Is there a written policy or procedure document describing:				
	a	Employee training?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	b	Incident reporting?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	c	Medical equipment training?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	d	Infection control?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	e	Patient acceptance?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	f	Patient evaluations?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	g	Safety for workers in offsite locations?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	h	Lifting requirements?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	i	Drug administration procedures?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	j	Food preparation?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	k	Patient discharge procedures?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
	l	Advance directives such as a "Living Will"?			<input type="checkbox"/> NA <input type="checkbox"/> Yes <input type="checkbox"/> No
8	Does applicant have written job descriptions in place for:				
	a	All professionals?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	b	All clinical support staff?			<input type="checkbox"/> Yes <input type="checkbox"/> No
IV. BUILDING INFORMATION					
1	Building Construction:		Year Built:		
2	Number of Stories:		Number of Exits per Floor:		
3	Are there smoke detectors and fire extinguishers?				<input type="checkbox"/> Yes <input type="checkbox"/> No
4	Is the building completely sprinklered?				<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Are there fire alarms? If YES , advise number and type				<input type="checkbox"/> Yes <input type="checkbox"/> No
6	Fire Department is: <input type="checkbox"/> Paid <input type="checkbox"/> Volunteer				
7	Are the electrical, heating, and plumbing systems up to code and regularly inspected?				<input type="checkbox"/> Yes <input type="checkbox"/> No
V. PRIOR POLICY and LOSS INFORMATION					
1	Please provide the following information pertaining to applicant's past 5 years of professional liability coverage:				
	Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy <input type="checkbox"/> CM <input type="checkbox"/> Occ
					<input type="checkbox"/> CM <input type="checkbox"/> Occ
					<input type="checkbox"/> CM <input type="checkbox"/> Occ
					<input type="checkbox"/> CM <input type="checkbox"/> Occ
					<input type="checkbox"/> CM <input type="checkbox"/> Occ
2	Has the applicant ever had any insurance company decline, cancel, rescind, or non-renew any Professional and/or General Liability Insurance Policy? If YES , please provide details:				<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Is the applicant aware of any of the following:				
	a	Known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made?			<input type="checkbox"/> Yes <input type="checkbox"/> No
	b	Knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that have not been reported to a prior insurance			<input type="checkbox"/> Yes <input type="checkbox"/> No

	carrier?	
c	Knowledge of any request for medical records by a patient or his/her attorney which might result in a claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d	Knowledge or information relating to service(s) on a Board which might result in a claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e	Knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES to any of the above, please provide details:		

VI. COVERAGE REQUESTED

NOTE: The Company may not offer or quote requested coverage.

Effective Date:

Retroactive Date:

Important: *Declarations Page of your current policy must be attached if a retroactive date is requested.*

Primary Liability: Professional Liability Claims Made
 General Liability Claims Made Occurrence

Important: *Limits for Professional Liability and General Liability must be the same when both provided, even though they apply separately.*

Limits of Liability:	<input type="checkbox"/> \$250,000 / \$750,000	Deductible:	<input type="checkbox"/> \$5,000 (minimum)
	<input type="checkbox"/> \$500,000 / \$1,500,000		<input type="checkbox"/> \$7,500
	<input type="checkbox"/> \$1,000,000 / \$1,000,000		<input type="checkbox"/> \$10,000
	<input type="checkbox"/> \$1,000,000 / \$3,000,000		<input type="checkbox"/> Other: \$
Excess Limit of Liability:	<input type="checkbox"/> \$1,000,000 / \$1,000,000		
	<input type="checkbox"/> \$2,000,000 / \$2,000,000		
	<input type="checkbox"/> \$3,000,000 / \$3,000,000		
	<input type="checkbox"/> \$4,000,000 / \$4,000,000		
	<input type="checkbox"/> \$5,000,000 / \$5,000,000		

VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1	You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and	
2	This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):	
	<input type="checkbox"/> Ambulance Service Supplemental Application	<input type="checkbox"/> Durable Medical Equipment Supplemental Application
	<input type="checkbox"/> Out-Patient / Ambulatory Surgery Center Supplemental Application	<input type="checkbox"/> Home Health Care and Hospice Care Supplemental Application
	<input type="checkbox"/> Blood / Donor Banks Supplemental Application	<input type="checkbox"/> Laboratory & Imaging Supplemental Application
	<input type="checkbox"/> Birthing Center Supplemental Application	<input type="checkbox"/> Other (specify):
	<input type="checkbox"/> Claim Information Supplemental Application	
3	Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:	
	a	Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
	b	Representations you are making on behalf of all persons and entities proposed to be insured;
	c	A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4	This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.	
5	You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.	

FRAUD WARNING

Notice to Applicants of all states except New Jersey, New York, Pennsylvania, and Washington D.C.:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material 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 the person to criminal and civil penalties and denial of insurance benefits.

Notice to 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.

Notice to New York Applicants:

Any person who knowingly and with the 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 provision.

Notice to Pennsylvania Applicants:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Notice to Washington D.C. Applicants:

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.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where General Star National Insurance Company is "non-admitted or "surplus lines"), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

