If your answer requires a larger space, please use the supplementary page instead. Please indicate: "see supplementary page".

PROFESSIONAL LIABILITY APPLICATION
for
HEALTH CARE SERVICES

(TO BE COMPLETED ONLY IF A MORE SPECIFIC APPLICATION IS NOT APPLICABLE)
INSTRUCTIONS: ANSWER ALL QUESTIONS; IF THE ANSWER IS NONE, STATE NONE. IF THE QUESTION IS NOT APPLICABLE, STATE NOT APPLICABLE (N/A). IF THE SPACE PROVIDED IS INSUFFICIENT TO FULLY ANSWER THE QUESTION, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK. PLEASE DO NOT REDUCE WHEN FAXING.

PART 1. GENERAL INFORMATION

1.1 Applicant Name:

1.2 Mailing Address:

1.3 Location Address(es):

1.4 County (parish) of each location:

1.5 Telephone Number: Office Fax

1.6 Person to contact for Survey: Name:
Title:

1.7 Year entity established:

1.8 The Applicant is (Please check and complete A) or B) below:

☐ A. The APPLICANT is an INDIVIDUAL:
IF SO, the INDIVIDUAL is an ☐ Employee ☐ Student ☐ Sole Practitioner

☐ B. The APPLICANT is a-
☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Other - Describe

1.9 Entity is ☐ For Profit ☐ Non-Profit - Describe source of funds:

1.10 Proposed Effective Date:

1.11 Requested Limits of Liability (if available): $ /$

1.12 Annual Gross Receipts: Estimated next twelve months - $
last twelve months - $

1.13 Annual Remuneration: Estimated next twelve months - $
last twelve months - $

1.14 Total Premises Square Footage Occupied By Applicant:

NOTICE

TfHS POLICY (IF ISSUED) IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL TBE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

PART 11. EXPOSURES

2.1 Service is licensed as

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted:

2.3 List all memberships in professional organizations.

2.4 Total number of all staff

2.5 Number of Professional Staff:

E	C		E	C	
		Aides or Orderlies			Optometrists
		Audiologists			Opticians
		Chiropractors			Paramedics or EMT's
		Dentists			Pharmacists
		Dental Hygienists/Tech.			Pharmacy Technicians
		Dental Assistants			Physicians or Surgeons*
		Dietitians/Nutritionists			Physician Assistants
		EEG or EKG Operators			Physiotherapists/Physical Therapists
		Electrologists			Podiatrists
		Hearing Aid Fitters			Prosthetic Device Fitters
		Inhalation/Resp. Therap.			Psychologists/Psychotherapists
		Laboratory Technicians			RN's
		LPN's			Social Workers
		Medical Technicians			Speech Therapists
		Nurse Anesthetists			X-Ray or Radiologist Technicians
		Nurse Midwives			X-Ray or Radiologist Therapists
		Nurse Practitioners			Other, describe
		Occupational Therapists			

* Attach list and indicate specialty.

E = Employed

C Contracted

2.6 If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors and annual estimated Out Patient Vists by professional category.

2.7 Do you require:

A) contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

B) employed or contracted physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

2.8 What minimum limits of Professional Liability are required?

2.9 What was your total number of patient/client visits last year? ☐ Estimated next year? ☐

2.10 Breakdown of patient services:

☐ % Pediatric	☐ % Gynecological
☐ % Dental	☐ % Emergency Medical
☐ % Obstetric	☐ % General Exams
☐ % Psychiatric	☐ % Occupational Medical
☐ % Rehabilitative Therapy	☐ % Optometry/Opthamology
☐ % Minor Surgery	☐ % Nutrition (Diet)
☐ % Major Surgery	☐ % Other(describe) ☐
☐ % Orthopedic	

2.11 Are any of the following performed?

Administer anesthesia (general or local)?	☐ yes	☐ no
Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)?	☐ yes	☐ no
Cardiac Catheterization	☐ yes	☐ no
Diagnostic tests	☐ yes	☐ no
Chemotherapy	☐ yes	☐ no
X-Rays	☐ yes	☐ no
Radiation Therapy	☐ yes	☐ no
Reduction of Fracture	☐ yes	☐ no
Shock Therapy	☐ yes	☐ no
Prescribe medication	☐ yes	☐ no
Obstetric procedures	☐ yes	☐ no

For all "yes" answers, give detailed description on separate page or back of application.

PART 111. RISK MANAGEMENT

3.1 Give name of Administrator/Supervisor and describe his/her training and experience. ☐

3.2 Do you enter into contractual agreements? ☐ Yes ☐ No
IF YES, enclose copies of all such contracts.

3.3 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? ☐ Yes ☐ No
If not, are you agreeable to instituting this procedure? ☐ Yes ☐ No

3.4 Enclose a copy of all brochures or advertising materials distributed by you.

3.5 Describe any "fund raising" or other special events activities conducted. ☐

3.6 Describe any swimming pool, playground or amusement exposure. ☐

3.7 Do you rent, sell, or otherwise provide any equipment or products to others? ☐ Yes ☐ No
IF YES, complete our Products Supplement.

3.8 Do you provide 24 hour bed and board care for any patients, or do you (wholly or in part) own, operate or administer any facility which does provide such services? ☐ Yes ☐ No

IF YES, complete our Residential Facilities Application.

3.9 Do you provide any of the following services:

A) Blood Bank/Plasma Centers ☐ Yes ☐ No

B) Cemeteries/Funeral Homes/Morticians ☐ Yes ☐ No

C) Medical Arts Schools and Colleges ☐ Yes ☐ No

D) Pharmacies ☐ Yes ☐ No

IF YES, complete the appropriate supplement application.

3.10 Do you have any other premises or operations exposures not stated in this application?

☐ Yes ☐ No IF YES, enclose complete description and underwriting/rating information.

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff Date	Claims-Made Yes	Claims-Made No
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐
5.					☐	☐

If claims-made, what is the most recent retroactive date?

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff Date	Claims-Made Yes	Claims-Made No
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐
5.					☐	☐

If claims-made, what is the most recent retroactive date?

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

☐ Yes ☐ No IF YES, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary).

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?

☐ Yes ☐ No IF YES, describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant/Title

Supplementary Page

Please reference the number of the question to which these responses apply.