

PROFESSIONAL LIABILITY APPLICATION
for
MEDICAL PERSONNEL SERVICE AGENCIES

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.

PART I. 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 Entity is Individual Corporation Partnership
 Professional Association/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):
Professional Liability \$ /\$
General Liability \$ each occurrence
\$ general aggregate
- 1.12 Gross Receipts: Estimated next twelve months: \$
Last twelve months: \$
- 1.13 Total Premises Square Footage Occupied by Applicant:

NOTICE

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

PART II. EXPOSURES

2.1 Maximum number of health care staff:

RN's	Aides/Orderlies
CRNA's	Nurse Practitioners
LPN's	Other (Specify number by category)

*Note: Please be very specific, as coverage for certain categories is excluded on the policy unless included by endorsement.

2.2 Are all your staff members actual employees (W-2)? Yes No
 If no, do you contract for services of any outside health care staff (1099)? Yes No
 If yes, breakdown total estimated annual payments to contractors by professional categories:

2.3 Breakdown percentage of services provided by category of staff including contracted staff:

RN's & LPN's	AIDES/ORDERLIES
% Hospitals/Nursing Homes	% Hospitals/Nursing Homes
% Private Doctors	% Private Doctors
% Home Care	% Home Care
% Other (Describe)	% Other (Describe):

OTHER:	OTHER:
% Hospitals/Nursing Homes	% Hospitals/Nursing Homes
% Private Doctors	% Private Doctors
% Home Care	% Home Care
% Other (Describe):	% Other (Describe):

2.4 List each county in which your employees and/or contract staff provide any professional services and also the % of the agency's revenue which is derived from that county:

2.5 If home health care is provided, indicate the percentage of the following services which each represents of the home health care revenue:

- % IV Therapy (complete IV Therapy Supplement if % above 5%)*
- % AIDS Therapy*
- % Chemotherapy*
- % Infant Monitoring (SIDS, etc.)
- % Pediatric/infant childcare, including "babysitting"

* if any, also complete supplement for IV Therapy

2.6 What is your total payroll for service personnel (including supervisors and administrators)?
 Remuneration last year: Estimated next year:
 (Remuneration means "payroll" for all employees plus payments, if any, to independent contractors.)

2.7 Show total number of hours of client service provided by all categories of staff:
 Hours last year: Estimated next year:

2.8 Do you have any other premises or operations not stated in this application? Yes No
 If yes, enclose complete description and underwriting/rating information.

2.9 Does any physician (other than the medical director) provide professional services to your agency?
 Yes No If yes, describe the services provided:

- 2.10 Do you require contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? Yes No
 If yes, what limits of liability do you require?

PART III. RISK MANAGEMENT

- 3.1 Name, qualifications and number of years of experience of the Medical Director, all managers and supervisors:

Name	Title	Experience/Training	Association Membership
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- 3.2 Does your facility require the professional staff be CPR trained? Yes No
 3.3 Do you enter into any contractual agreements? Yes No
 If yes, enclose copies of all such contracts.

- 3.4 Enclose a copy of all brochures or advertising material distributed by you.
 3.5 Do you maintain a written clinical record showing total number of visits by each category of staff for every person or organization client? Yes No
 3.6 Is any staff provided to hospitals specifically to serve a particular specialty (i.e. OR, ICU, CCU, ER, Nurses, etc.)? Yes No
 If yes, describe:

- 3.7 Describe (on a separate sheet) your requirements for employment and your pre-employment screening and investigation procedures.
 3.8 Enclose a copy of your employment application.
 3.9 Do you prepare job descriptions and instructional manuals for your staff? Yes No
 If yes, enclose a copy of each.
 3.10 Do you maintain records of specific areas of experience of each staff member? Yes No
 3.11 Describe your procedures for matching staff to patients.

3.12 Who does the matching/assigning of staff to client, and what is his/her experience?

3.13 Who does the supervising of staff, and what is his/her experience?

- 3.14 Does the staff supervisor make regular audit visits on staff in the field? Yes No
 3.15 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?

3.16 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? Yes No
 If no, attach explanation of any exception.

3.17 Has the applicant or any of its employees:

- a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? Yes No
- b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? Yes No
- c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No

IF THE ANSWER TO ANY OF 3.17 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

3.18 Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations.

None	Description Attached
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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	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	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

- 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.

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 DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant/Title

Supplemental information:

(please reference any questions you are referring to)