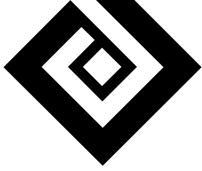


Return to:

MISC. MEDICAL PROFESSIONALS APPLICATION

(This application also requires a class specific supplemental application.)

INSTRUCTIONS:

A. Please type or print clearly. Answer ALL questions completely.
B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.
D. To this application, please attach copies of
   - Marketing or advertising brochures.
   - Descriptive materials provided to clients.
   - Copy of all accreditation reports, or other similar, if applicable.
   - Other attachments as required in response to application questions.
   - Most current annual financial statement prepared by a CPA.
E. All materials submitted or required shall be held in confidence.

GENERAL INFORMATION

1. Insured ____

   Main Location Address

   ____

   Street City State/Zip County

2. Tax Identification Number ________________ Telephone Number (____) ____________________

3. Years in Business _____ Are you currently enrolled in a Patient Compensation Fund? ☐ Yes ☐ No

4. Mailing Address (if different than above)

   ____

   Street City State/Zip County

5. List all locations and areas of operations

   ____

   Street City State/Zip County

   ____

   Street City State/Zip County

6. Provide names of all legal entities, including subsidiaries desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

7. Within the past 5 years, has applicant acquired, sold or discontinued any operations? ☐ Yes ☐ No

8. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation Other ______________________

9. Number of total employees ______________ Number of Independent Contractors ____________

10. Describe operations:
____
____
____

11. Does the applicant provide any overnight bed facilities? ☐ Yes ☐ No

12. Does the applicant perform any treatment or services on the applicant's premises? ☐ Yes ☐ No

13. Is applicant owned by or operated at a hospital, whether main location or branch? ☐ Yes ☐ No

COVERAGE REQUESTED

14. Requested Effective Date __________________________________
(If new venture, please provide owner's resume' and description of related industry experience.)

15. ____ **Professional Liability** ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date____________
(Attach copy of prior claims made policy Declarations if requesting prior acts.)

☐$ 100,000 per Incident / $ 300,000 Aggregate
☐$ 250,000 per Incident / $ 750,000 Aggregate
☐$ 500,000 per Incident / $ 500,000 Aggregate
☐$1,000,000 per Incident / $1,000,000 Aggregate
☐$1,000,000 per Incident / $2,000,000 Aggregate
☐$1,000,000 per Incident / $3,000,000 Aggregate
☐$2,000,000 per Incident / $4,000,000 Aggregate
☐$2,000,000 per Incident / $6,000,000 Aggregate
☐$3,000,000 per Incident / $5,000,000 Aggregate
(Higher limits options available upon request)

16. ____ **General Liability** ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date __________

(Attach copy of prior claims made policy Declarations if requesting prior acts.)

Each Occurrence (cannot be excess PL limit) $ ____________________
Medical Expense Limit (Per Person) $ ____________________
Fire Damage Limits of Liability (Any one Fire) $ ____________________
Products / Completed Operation Aggregate $ ____________________
General Aggregate (Other than Products) $ ____________________

17. _____ **Employee Benefits Liability** (General Liability Coverage must be selected)

Limits Requested:
☐$ 25,000 per Incident / $ 50,000 aggregate
☐$ 100,000 per Incident / $ 300,000 aggregate
☐$ 500,000 per Incident / $ 500,000 aggregate
☐$ 500,000 per Incident / $1,000,000 aggregate
☐$1,000,000 per Incident / $1,000,000 aggregate
☐$1,000,000 per Incident / $2,000,000 aggregate

18. Average professional turnover ________ % Average non-professional turnover ________%

19. Employee Benefits provided: ☐ Health ☐ Life ☐ 401K ☐ Section 125

HIRED AND NON-OWNED AUTOMOBILE LIABILITY

(General Liability Coverage must be selected. Hired Auto Liability will only be written in combination with Non-Owned Auto Liability.)

20. Limits Requested:
☐$ 100,000 per Incident / $ 100,000 aggregate
☐$ 250,000 per Incident / $ 250,000 aggregate
☐$ 500,000 per Incident / $ 500,000 aggregate
☐$1,000,000 per Incident / $1,000,000 aggregate

21. Do you have existing Auto coverage with another carrier? ☐ Yes ☐ No

22. Are driving records, MVR's checked annually? ☐ Yes ☐ No

23. Estimated annual number of non-medical patient transports:

Employee Vehicle Transports ________ Client Vehicle Transports ________

24. Are employees required to carry personal auto insurance? ☐ Yes ☐ No
If Yes, what minimum limit is required? $____________________
Are certificates of insurance kept on file? ☐ Yes ☐ No

HIRED AUTOMOBILE LIABILITY (General Liability Coverage must be selected. Hired Auto Liability will only be written in combination with Non-Owned Auto Liability.)

25. For what purpose, do you require hired autos?

    ____

26. Average number of hired autos rented/leased annually: __________
27. Average number of borrowed autos annually ______
28. Type of autos rented/leased/borrowed: ________________
29. Average term of rental/lease agreement: _________
30. Estimated cost of rented/leased autos for this year: _______

NON-OWNED AUTO LIABILITY (General Liability Coverage must be selected. Non-Owned Liability will can be written stand alone or in combination with Hired Auto.)

31. How often are non-owned autos used in your business? ☐ Daily ☐ Weekly ☐ Monthly
32. Are non-owned autos likely to be operated beyond 50 miles? ☐ Yes ☐ No

    If yes, how often and why? ____

STOP GAP LIABILITY

33. Stop Gap Liability (General Liability Coverage must be selected)

    Each Person $ _____________________

    Each Disease $ _____________________

    Total Limit __ $ _____________________

34. Total Annual Payroll by State: ____

35. Per Claim Deductible
    (Same deductible must be selected for both Professional and General Liability.)

    ☐ None ☐ $1,000 ☐ $5,000
    ☐ $10,000 ☐ $25,000 ☐ Other ____________________

36. List Professional Liability policies covering the firm indicated in Question #1 over the past 5 years.
If **No** insurance was in effect for a given year, state **"None"** where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

37. List General Liability policies covering the firm indicated in Question #1 over the past 5 years.
If **No** insurance was in effect for a given year, state **"None"** where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

CLAIM HISTORY

38. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier? ☐ Yes ☐ No

If **YES**, please attach information for each claim, suit or incident: that includes the following:

- Date of Accident and Date of Notice
- Claimant Name
- Amount Paid or Reserved
- Status – Open or Closed
- Insurance Carrier
- Allegations
- Description of Treatment Rendered.

39. Has any company cancelled, declined or refused to issue similar insurance? ☐ Yes ☐ No

If **Yes**, please explain:

____

BUILDING INFORMATION

Location	**1**	**2**	**3**	**4**
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq. ft.)				
e. Number of Fire Escapes / Exits				
f. Number of elevator				
g. Distance to fire station				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Heat Sensors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Smoke Detectors	☐ ☐	☐ ☐	☐ ☐	☐ ☐
g. CONSTRUCTION UPDATES	Year: __________	Year: __________	Year: __________	Year: __________
	Yes No	Yes No	Yes No	Yes No
Plumbing	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Wiring	☐ ☐	☐ ☐	☐ ☐	☐ ☐

40. Do you lease or sub-lease to others any portion of the locations listed above? ☐ Yes ☐ No
    If yes, do you require the tenant(s) carry liability insurance for occupancy? ☐ Yes ☐ No
    Do you require certificated of insurance? ☐ Yes ☐ No

41. Is a pool or gymnasium located on premises: ☐ Yes ☐ No
    If YES, please provide details regarding use and safety precautions:

____

____

____

EMERGENCY & SAFETY PROCEDURES:

42. How often are fire drills conducted? ______________________________________

43. Are smoke detectors installed in all hallways and rooms? ☐Yes ☐ No

44. How are medical emergencies handled?
    a. On Call Physicians? ☐ Yes ☐ No
    b. Affiliated Physicians on Premises? ☐ Yes ☐ No
    c. Hospital and/or emergency center? ☐ Yes ☐ No
       If YES, is hospital and/or emergency center located within a 15 minute drive under typical conditions? ☐ Yes ☐ No
    d. Other (explain)____

45. Specify arrangements for storage and dispensing of drugs:

____

46. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Effective Date	Policy Limits	State /License #	Specialty / Board Certified	Employee or Contractor	Hours per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						
Name - Physician						
Name - Physician						

HIRING / SCREENING AND EMPLOYMENT PROCEDURES

47. Are employees' / contractors' references contacted before hiring or placement: ☐ Yes ☐ No
    Check all that apply: _____ Written _____ Verbal

48. Check al the following that apply if obtained, verified, and filed as part of for each employee screening and hiring process:

Applications	_____	Multi-State Registry	_____
Drug / HIV / Hep. Testing	_____	Criminal Background Checks	_____
Education/Competency	_____	Licenses/Annual Confirmation	_____

49. Does applicant question prospects about previous claims or suits? ☐ Yes ☐ No

50. Are employees required to actively participate in continuing education? ☐ Yes ☐ No

51. Does applicant verify any pending license suspensions, revocations?
    or pending disciplinary actions? ☐ Yes ☐ No

52. Are professional employees required to carry their own insurance: ☐ Yes ☐ No
    If Yes, what minimum is required? $______________________
    Are certificates of insurance kept on file? ☐ Yes ☐ No

ACCREDITATION AND LICENSING

53. Is your facility accredited? ☐ Yes ☐ No

    If so, by whom? ____

    (Please attach verification of accreditation.)

54. Is applicant licensed to do business in the states listed above where required? ☐ Yes ☐ No
    Has applicant's license ever been suspended, revoked or restricted? ☐ Yes ☐ No
    (If yes, please provide details).____

    ____

55. Is applicant certified for Medicare / Medicaid reimbursement? ☐ Yes ☐ No

RISK MANAGEMENT

56. What management body oversees the quality of patient care?
    (e.g. medical director, advisory board, etc.) ____

57. Do you have a formal written quality assurance and risk management program? ☐ Yes ☐ No
    Person Responsible: __________________________ Title: __________________________

CONTRACTUAL AGREEMENTS

58. Does applicant enter into contractual agreements (i.e. hospitals, nursing homes)? ☐ Yes ☐ No

59. Do contractual agreements contain hold harmless or indemnification clauses favorable to the applicant? ☐ Yes ☐ No

60. Is applicant required to name any other entity as an additional insured? ☐ Yes ☐ No
If so, please list name and address of each entity and the business relationship
____
____
____

61. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? If so, please attach explanation (including name of physicians, details of financial relationship, type of referrals).

"Financial relationship" means all ownership or investment interests, compensation arrangements, and medical directorships with applicant.

GENERAL LIABILITY

62. Does applicant sponsor any sporting, fundraising or social events? ☐ Yes ☐ No
Please explain ____

63. Does applicant sell any medical supplies and/or equipment? ☐ Yes ☐ No
If Yes, Annual Receipts $__________________________

64. Does applicant rent or lease any medical supplies and/or equipment? ☐ Yes ☐ No
If Yes, Annual Receipts $__________________________

INVENTORY (products handled) is based on your Gross Revenue in percentages. Gross Revenue percentages must equal 100%.

Apnea Monitors	______%	Oxygen Concentrators	______%	Wheelchairs	______%
Ventilators-Life Support	______%	Oxygen Valves/Reg.	______%	Tens Units	______%
Install Grab/Safety Bar	______%	Scooter/Tn-Carts	______%	Disposable	______%
Sell Grab/Safety Bar	______%	Motorized Wheelchairs	______%	Beds, crutches,	
Van Conversions	______%	Stair Lifts	______%	walkers, commodes	______%
Oxygen Cylinders		☐ residential	______%	CPM	______%
(Pressure)	______%	☐ commercial	______%	Braces ☐ pre-made	______%
Liquid Oxygen	______%	Wheelchair Lifts	______%	*CPAP/* BiPAP	______%
Parenteral Therapy	______%	Enteral Therapy	______%	Nebulizers	______%
Pharmacy	______%	Other Items List Below	______%	Low Air Loss Mattress	______%
		__________________	______%	Latex Gloves **	______%

TOTAL of all three columns (Must = 100%): ________%

65. Do you use any independent contractors for your HME business (1099's)? ☐ Yes ☐ No

If yes, how many? ____

66. Do you contract or subcontract labor for installation, service or repair of any products? ☐ Yes ☐ No

If yes, what items ____

67. Do you provide any type of warranty? ☐ Yes ☐ No

If yes, please explain ____

68. Do you or your employees install any equipment (i.e. involving the use of tools of any kind) in customers homes? ☐ Yes ☐ No

If yes, what equipment ____

Pharmacy – If there is any percentage shown above next to Pharmacy, please answer the following questions.

69. Is pharmacy a closed door pharmacy or open door pharmacy? ☐ Closed Door ☐ Open Door

If closed door, what kind of meds are you doing? ____

____

70. Are you mixing? ☐ Yes ☐ No

If mixing, what is your procedure? ____

71. Is there a pharmacist on staff? ☐ Yes ☐ No

72. Does the pharmacist carry their own Professional Liability policy? ☐ Yes ☐ No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Underwritten by United National Insurance Company, Diamond State Insurance or any members of United National Group.

SIGNATURE OF APPLICANT ______________________________________ **DATE** _______________

(Must be signed by principal, partner or officer of group or individual applying for insurance.)

Producer: ____

Telephone Number: (_______) ________________________

Producer's Address:

____

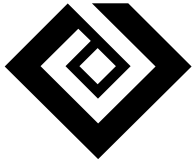
Street City State/Zip

Surplus Lines Agent:

____ License # _________________________________

(Applicable in AL, CO, FL, LA, MA, MS, NH, NJ, NM, NY, OK, RI, SD, TN, WV, and HI)

<u>Notice to New York Applicants:</u> 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 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 such violation.



Return to:

DRUG & ALCOHOL REHABILITATION SUPPLEMENTAL APPLICATION

(This application is supplemental to the Misc. Medical Professionals application.)

(Please note that this Supplemental Application must be completed for each facility/location providing substance abuse rehabilitation. The Misc. Medical Professionals Application must be completed and submitted with all Drug & Alcohol Supplemental Applications).

NAME OF FACILITY:______________________________

ADDRESS: ______________________________

Street City State/Zip County

LICENSING

1. Licensed by state of:______________________________
2. License #: ______________________________
3. Expiration Date:______________________________
4. Has License ever been revoked, suspended, placed on probation or restricted in any way? ☐Yes ☐ No
   If YES, please explain: ______________________________

FACILITY OPERATIONS

5. Fully describe the exact purpose of the operations, activities, services and professional procedures administered:
6. Does facility have in-patient residential care? ☐ Yes ☐ No
7. Licensed Bed Capacity ______________
8. Present number of patients:

   Ambulatory ______________
   Skilled Acute Care ______________
   Intermediate Care ______________

9. Age of patients:

   Number of over 65 ______________
   Between 50 & 65 ______________
   Between 25 & 49 ______________
   Between 18 & 24 ______________
   Under 18 ______________

10. Does program include transitional / halfway houses? ☐ Yes ☐ No

11. Do halfway houses have resident managers? ☐ Yes ☐ No

12. Is the facility affiliated with any correctional or penal facilities? ☐ Yes ☐ No

13. Does the facility provide outpatient services: ☐ Yes ☐ No

    If YES, the percentage of patients seen solely on an out-patient basis; _________ %
    The number of patients treated during the last three years: 20 _____; 20 _____; 20 _____.

14. Is Methadone treatment administered: ☐ Yes ☐ No

    If YES, please attach complete details on procedures and give the number of methadone treatments for each of the past three years: 20 ________; 20 _______; 20 _______.

15. Does facility include detox? ☐ Yes ☐ No

16. Is the facility a member of the National Assoc. of Alcoholism Treatment Programs? ☐ Yes ☐ No

PATIENT / TREATMENT INFORMATION

17. Are medication or drugs given:

    a. Only under a physician's written orders? ☐ Yes ☐ No

    b. Only by authorized medical professionals? ☐ Yes ☐ No

    If the answer to a. or b. above is NO, please explain

    ____

18. Are drugs administered according to Federal Drug Enforcement Agency rules? ☐ Yes ☐No

19. Is a complete physician's examination required prior to admission or treatment? ☐ Yes ☐No

20. Is a complete medical history of each patient or client retained on premises? ☐Yes ☐ No

21. Are medical records released to third parties without the written consent of the patient? ☐ Yes ☐ No
    YES, please explain:____

22. Are patient's or client's subject to voluntary commitment?
    If so, please explain procedure: ____

    Court order? ☐ Yes ☐ No

    Physician’s written instructions? ☐ Yes ☐ No

    Other (give details) ____

STAFF

23. Total Employees ______________ #   Total Independent Contractors _______________#

24. Health Care Professionals

	# Employees/ Contractors Shift 1	# Employees/ Contractors Shift 2	# Employees/ Contractors Shift 3
Administrators			
Clerical			
Counselors			
Dieticians			
Medical Records			
Nurses / Nurse Aides			
Nurse Practitioner / Clinical Nurse Specialist			
Occupational Therapists			
Pastoral Counselors			
Pharmacists			
Physician / Physician Assistant			
Psychologists			
Resident Managers			
Social Workers			
Speech & Hearing Therapists			
Volunteers			

(Complete job descriptions must accompany this application for those professionals indicated in Question 23 above.)

25. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Effective Date	Policy Limits	State of Licensure	License Number	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						

I **DECLARE** that the information contained in this supplement is true and that no material facts have been suppressed or misstated.

I **UNDERSTAND** that an incorrect or incomplete response could void my coverage.

Signature of Applicant

Date