Fireman's Fund®

MEDICAL FACILITIES PROFESSIONAL LIABILITY APPLICATION

INSTRUCTIONS:

1. Please type or print clearly in ink.
2. Answer ALL questions completely. If any question, or part thereof, does not apply, print **"N/A"** in the space provided. Leave no blanks. Failure to answer all questions may delay our ability to provide a quote, which may result in a gap in your coverage.
3. If you need more space, continue on a separate sheet and indicate question number.
4. Please attach:
   - Recent promotional material or brochures describing activities or services;
   - Most recent audited financial statement;
   - Risk Management and Quality Improvement Plan;
   - Current accrediting agency (JCAHO, AOA, CARF, etc.) report with recommendations and the facility's response to any contingencies;
   - Prior carrier loss runs for the previous 5 years, including current year. Loss runs should contain a breakdown of total incurred losses (paid and outstanding for indemnity and expenses) and full details of allegations on all losses paid or outstanding in excess of $50,000.

I. PRODUCER PROFILE

A. Company Name: ______________________________

B. Business Address: ______________________________
Street Address City State Zip

C. Phone: ____________________ Fax: ____________________

D. Surplus Lines Agent Name: ____________________ Phone: ____________________

E. Surplus Lines Agent's Business Address:

____
Street Address City State Zip

F. Surplus Lines Agent's License No.: ____________________

G. State in which Surplus Lines Tax is filed: ____________________

II. APPLICANT PROFILE

A. Applicant Name: (include any "DBA's:"): ______________________________

____

B. Mailing Address: ______________________________
(PO Box not acceptable) Street Address City State Zip

County: ____________________ State of Domicile: ____________________

Website Address: ____________________

C. Contact Person: ____________________ Phone: ____________________

D. Tax Status: ☐ for profit ☐ not-for-profit

E. Applicant's Legal Structure: ☐ Corporation ☐ Joint Venture ☐ Partnership ☐ Sole Proprietorship ☐ LLC

☐ Other, Explain ______________________________

F. Do you conduct business over the Internet? ☐ Yes ☐ No If yes, please attach a detailed description of your services.

G. List names, locations and descriptions of all legal entities, including subsidiaries for which the applicant is part in the space below or provide schedule.

Loc. #	Business Name & Address	Description	Date Acquired	Ownership %

H. Please describe any acquired or sold entities in the past 5 years: ______________________________

____

____

I. Number of years this facility has been operating: __________ Owned by present managers: __________

Managed by present management: __________

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

If YES, do you lease a distinct area? Yes ☐ No ☐

K. Is applicant owned or operated by any person holding a M.D. or D.O. degree? Yes ☐ No ☐

If Yes to C. or D., please describe involvement: ______________________________

L. Have you sold, discontinued or acquired any operations in the past five years, or do you plan to in the upcoming year? ☐ Yes ☐ No If yes, please explain: ______________________________

M. Do you plan to add any new procedures, products or services in the upcoming year? ☐ Yes ☐ No If YES, please explain: ______________________________

____

N. Gross Receipts

Gross Receipts for the past 12 months: $ __________

Anticipated Gross Receipts for the next 12 months: $ __________

III. COVERAGES/LIMITS/DEDUCTIBLES

A. Effective Date of Coverage Requested: __________

B. Coverage Requested:

☐ Professional Liability

☐ Claims-Made Indicate Retroactive Date: __________

- ☐ Occurrence
- ☐ General Liability
  - ☐ Claims-Made Indicate Retroactive Date: ______________
  - ☐ Occurrence
- ☐ Employee Benefit Administration Liability Indicate Retroactive Date: ______________
- ☐ Excess Limits (Complete ACORD Application if underlying Automobile or Employers Liability requested)

C. Limits of Liability Requested:

- ☐ $100,000 per Claim/$300,000 Aggregate
- ☐ $200,000 per Claim/$200,000 Aggregate
- ☐ $250,000 per Claim/$750,000 Aggregate
- ☐ $500,000 per Claim/$500,000 Aggregate
- ☐ $1,000,000 per Claim/$1,000,000 Aggregate
- ☐ $1,000,000 per Claim/$2,000,000 Aggregate
- ☐ $1,000,000 per Claim/$3,000,000 Aggregate
- ☐ Other: ________________________

D. Deductible Requested:

- ☐ $0
- ☐ $5,000
- ☐ $10,000
- ☐ $25,000
- ☐ $50,000
- ☐ Other: ____________________

(Deductible applies to each and every claim and applies to any combination of claim payments and claim expenses).

E. Additional Insured(s) - name, address and relationship: ____

____

____

IV. PROFESSIONAL LIABILITY EXPOSURES

A. Health Care Services Provided.

1. Applicant is best described as a:
   - ☐ Counseling/Mental Health
   - ☐ Dialysis Center (Please complete supplement)
   - ☐ Drug/Alcohol Rehabilitation (Please complete supplement)
   - ☐ Home Care/Hospice (Please complete supplement)
   - ☐ Laboratory (Please complete supplement)
   - ☐ Medical Group Home (Please complete supplement)
   - ☐ Social Services (Please complete supplement)
   - ☐ Other: _______________________________

2. Please describe more fully the nature of the Applicant's Operations:________________________________
____
____

3. Does facility have in-patient residential care? ☐ Yes ☐ No
If so, number of licensed Beds: ____________________________
Daily Average Occupied Beds: _____________________________

B. Medical/Dental Surgical Equipment

1. Are any products manufactured, distributed or sold by the facility to its patients or clients? ☐ Yes ☐ No
If YES, please give complete details, including revenue generated: ________________________________
____

a. Owned:
1) Briefly describe your preventive maintenance program: ______________________________________
____
____
2) If you use a vendor, what limits of liability do you require? $______Each Occurrence/ $______Aggregate
☐ Do Not Require ☐ N/A

b. Leased:
1) Do you repair or sell used equipment of others? ☐ Yes ☐ No
If YES, please describe: ____
2) Do you service the equipment you sell or lease? ☐ Yes ☐ No
If NO, who provides preventative or corrective maintenance: ____________________________
What limits do you require them to carry? $______Each Occurrence/ $______Aggregate
☐ Do Not Require ☐ N/A
3) Do you repackage or redesign the equipment you Sell, rent or lease? If YES, describe: ______________________________________
4) Is any of the equipment sold with your company's label? ☐ Yes ☐ No
If YES, please describe: ____
5) Do you have your own sales staff? ☐ Yes ☐ No
If YES, are they trained by the manufacturer? ☐ Yes ☐ No
Please attach a copy of your policies on Sales Training, Preventative Maintenance and Patient Education

V. STAFFING AND ADMINISTRATION

A. Medical Director Coverage Requested? ☐ Yes ☐ No
Does the Medical Director provide direct patient care? ☐ Yes ☐ No
Name of Medical Director: ______________________________
Specialty: ____

B. Allied Health Care Professionals:

	# Employees Employed	Annual Hours Worked	# Employees Contracted	Annual Hours Worked	# Employees Volunteer	Annual Hours Worked
Administrators						
Athletic Trainer (non-med, non-cert)						
Athletic Trainer (medical, LPT, RPT)						
Clerical						
Counselors						
Dietitians/ Nutritionists						
Educators						
Family Day Care Providers						
Home Health Aides						
Homemakers						
Live-in Companion						
LPN/Licensed Vocational Nurse						
Massage Therapists						
Medical Director						
Medical Office Assistant						
Medical Records Prof/Tech						
Medical Techs/SLPs						
Nurse Aides						
Nurse Practitioner/Clinical Nurse Specialist						
Nurses - Other than Staffing						
Nurses - Temporary Staffing						
Nurses Aides						
Occupational Therapists						
Occupational Therapists Assist.						
Pharmacists						
Physical Therapists						
Physical Therapists Assist.						
Physician Assistant						
Psychologist						
Rehabilitation Therapists						
Rehabilitation Therapists Assist.						
Residence Managers						
Respiratory Therapists						
Respite Care Workers						
Social Worker						
Speech & Hearing Therapists						
Sports Medicine Instructor						
Sports Medicine Therapist						
Surgeon Assistants						
Volunteers Describe:						
Other, Describe:						
Annual Payroll:						

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

- Insurance Requirements – Please explain any "NO" answers in the comments section below
  1. Indicate if employed or contracted healthcare professional carry Professional Liability Insurance:
     a. Physicians and Surgeons? ☐ Yes ☐ No
     b. Oral Surgeons, Dentists, Nurse Anesthetists, Nurse Practitioners, Physician Assistants and Nurse Midwives? ☐ Yes ☐ No
     c. Allied Health Care Professionals? ☐ Yes ☐ No
  2. Indicate the minimum professional liability insurance limits required for employed or contracted:
     a. Physicians and Surgeons? $______ Each Occurrence/ $______ Aggregate
     c. Oral Surgeons, Dentists, Nurse Anesthetists, Nurse Practitioners, Physician Assistants and Nurse Midwives? $______ Each Occurrence/ $______ Aggregate
     c. Allied Health Care Professionals? $______ Each Occurrence/ $______ Aggregate
  3. How often do you verify professional liability insurance limits? ____________________

  Comments: ____________________

- Hiring, Screening, and Training Procedures for Employees, Contractors and Volunteers
  1. Does screening and hiring procedures include the following?
     a. Educational background ☐ Yes ☐ No
     b. Previous employers/ employment history ☐ Yes ☐ No
     c. Personal references ☐ Yes ☐ No
     d. Hospital Privileges for Physicians, Oral Surgeons and Dentists ☐ Yes ☐ No
        How often do you update your list of specific privileges? ____________________
     e. Pending license suspensions or revocations, or any pending disciplinary actions by other facilities ☐ Yes ☐ No
     f. Criminal background check: ☐ County ☐ State ☐ Federal ☐ None
     g. Medical Professional claims history ☐ Yes ☐ No
     h. Drug and alcohol abuse screening ☐ Yes ☐ No
  2. If an individual has had a previous claim, license suspension or revocation, how does that impact your procedures or that person? Are any additional criteria applied? ____________________
  3. Are each of the above procedures followed and documented? ☐ Yes ☐ No
     If NO, please explain: ____________________
  4. Have you or any of your employees ever been:
     a. the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or government agency, hospital or professional association? ☐ Yes ☐ No
     b. convicted for an act committed in violation of any law or ordinance other than traffic offenses?

☐ Yes ☐ No

If YES to either of the above, please attach a detailed explanation.

5. What training is provided for new staff (e.g. Aides, Volunteer, Technicians)? ____________________________

____

6. Is continuing education available for all employees? ☐ Yes ☐ No
7. Are written job descriptions established for all employees and volunteers? ☐ Yes ☐ No
8. Before staff can provide care, is a competency based checklist used to assess and document their skills? ☐ Yes ☐ No

VI. CONTRACTUAL AGREEMENTS

A. Does Legal Counsel review all contractual agreements? ☐ Yes ☐ No

B. Have you agreed to hold harmless or indemnify others under contract? ☐ Yes ☐ No

C. Please describe any services provided to other entities: ____

____

D. Please describe any contracted services provided to you: ____

____

VII. RISK MANAGEMENT

A. Is there a written, formalized Risk Management/Quality Management Program? ☐ Yes ☐ No

B. Does the governing body periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No

C. Who coordinates your Risk Management Program?

Name:____

Title:____

Telephone Number: _________________________________

Email Address: ____________________________________

D. Is the Risk Manager accountable and solely responsible for Risk Management? ☐ Yes ☐ No

If NO, describe other responsibilities: ____

E. Is the Risk Manager responsible for reviewing incident reports? ☐ Yes ☐ No

F. Is the staff required to report all incidents, which might result in a claim to the administrator? ☐ Yes ☐ No

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

H. Are medical records released to third parties without the consent of the patient or client? ☐ Yes ☐ No

VIII. BUILDING INFORMATION

A. Date Built: ____

B. Number Stories:____

C. Total Floor Area: ____

D. Number Exits:____

E. Number of Elevators: ____

F. Building sprinklered?____

G. Is fire alarm sounded: ☐ Locally ☐ Central Station ☐ Neither

H. Is there a service contract on fire alarm? ____________________________________

I. Distance to nearest fire station: ____

J. Fire Department is: ☐ Paid ☐ Volunteer

K. Is a pool located on premises: ☐ Yes ☐ No

IX. INSURANCE AND LOSS HISTORY

Please provide insurance information for the past five years.

A. Professional Liability Coverage

Name of Carrier	Policy Period	Limits of Liability	Deductible Amount	Claims-Made or Occurrence

B. General Liability Coverage

Name of Carrier	Policy Period	Limits of Liability	Deductible Amount	Claims-Made or Occurrence

C. Please attach a copy of your most recent policy Declarations Page. If you haven't purchased insurance coverage before, please explain____

____

D. Has any insurance company ever cancelled, non-renewed, or declined to accept your Professional or General Liability Insurance? ☐ Yes ☐ No

If YES, please explain ____

____

(***NOTICE TO MISSOURI RESIDENTS: This question does not apply.)***

E. Is your current carrier offering renewal terms? ☐ Yes ☐ No

F. Have you or any of your staff been the subject of disciplinary or investigatory proceedings or reprimanded by a governmental or an administrative agency, hospital or professional association? ☐ Yes ☐ No
If YES, please explain ______________________________

____

G. Have you been the subject of any license suspension or revocation or been placed under probation? ☐ Yes ☐ No
If YES, please explain ______________________________

____

X. CLAIM HISTORY

A. Has any Professional or General Liability Claim or suit been brought in the past five (5) years against you or any predecessor in interest concerning the facility ☐ Yes ☐ No

B. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future?
☐ Yes ☐ No If YES, have you notified your current carrier? ☐ Yes ☐ No

C. Please complete the following for each claim, suit or incident. If you need more space, please continue on a separate sheet.

Claimant:	Age:
Date of Accident:	Date of Notice:
Insurance Carrier:	Amount Paid or Reserved:
Allegations:	
Description of Treatment Rendered:	

Claimant:	Age:
Date of Accident:	Date of Notice:
Insurance Carrier:	Amount Paid or Reserved:
Allegations:	
Description of Treatment Rendered:	

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Underwritten by the Interstate Indemnity Company, the Interstate Fire & Casualty Company, or the Fireman's Fund

Insurance Company of Ohio, member companies of the Interstate Insurance Group, part of the Fireman's Fund Insurance Group.

XI. NOTICE TO APPLICANT

Notice: 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.

Notice to Arkansas, Louisiana and New Mexico Applicants: Any person who knowingly presents a false or fraudulent claims for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an Insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from Insurance proceeds shall be reported to the Colorado Division of Insurance within the Departments of Regulatory Agencies.

Notice to District of Columbia 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.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with the intents to defraud any Insurance Company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime.

Notice to Maine Applicants: It is a crime to provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to New Jersey Applicants: Any person who included 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 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.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against and insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: WARNING: Any person who knowingly, and with intent to injure, defend or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Notice to Pennsylvania Applicants: Any person who knowingly and with the intent to defraud any Insurance Company or other person files and application for Insurance or statement of claim containing any fact 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 Tennessee & Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to

an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

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.

SIGNATURE OF APPLICANT : ______________________________ **DATE:** ______________

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

Executive Offices:
33 W. Monroe Street
Chicago, Illinois 60603

SUPPLEMENTAL APPLICATION
HOME HEALTH AND STAFFING AGENCIES

(Please note that this Supplemental Application must be completed for each facility/location. The Medical Professional Liability Coverage Application must be completed and submitted with all Supplemental Applications).

NAME OF FACILITY:____

ADDRESS: ____

I. LICENSING:

A. Is the applicant licensed to do business in the states where required? ☐Yes ☐ No

B. If YES, please provide copy of the current license with this application and complete the following.

1. Name on License: ______________________________
2. Licensed by state of:______________________________
3. License #: ______________________________
4. Expiration Date:______________________________

C. Has License ever been revoked, suspended, placed on probation or restricted in any way? ☐Yes ☐ No

If YES, please explain: ______________________________

II. GENERAL INFORMATION:

A. Are you a member of the National Association for Home Care (NAHC) or any other association? ☐ Yes ☐ No

If yes, please specify: ______________________________

B. Are you accredited by CHAP, JCAHO or any other accrediting organization? ☐ Yes ☐ No

If yes, please specify: ______________________________

III. FACILITY OPERATIONS/ STAFFING:

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

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

If YES, please describe: ______________________________

____

C. Do you want independent contractors added to the policy as insureds? ☐ Yes ☐ No

D. Where are employees placed, by percentage?

Private Homes____ Hospitals____ Nursing Homes____ Medical Clinics____

Doctor's Offices____ Other____ (Describe) ____________________

E. Do you engage in any business other than Home Health Care / Temporary Staffing? If so, describe:

____

____

F. Are employees completing Daily Work reports (Nursing notes, Hospital notes, etc.)? ☐ Yes ☐ No

G. Are all employees bonded? ☐ Yes ☐ No

H. Do you place any Nurse Practitioners? ☐ Yes ☐ No

I. Do any of your employees staff the:

Emergency Room ☐ Yes ☐ No

Labor & Delivery Rooms ☐ Yes ☐ No

Intensive Care Units ☐ Yes ☐ No

If yes, please specify the number of employees in each category: ____________________

J. Complete job descriptions must accompany this application for professionals employed/ contracted by your facility.

K. Attach a copy of your employment application.

IV. PHYSICIAN INFORMATION

A. Please identify by name and function served, all physicians including (psychiatrists, osteopaths, dentists or chiropractors) employed or affiliated with the facility:

Name	Type of Doctor	Specific Duties in Facility Operations

B. Is your facility insured under the Professional Liability issued to each person specified above? ☐ Yes ☐ No

Certificates of insurance for doctors will be required, so please state:

Name of Doctor	Insurance Carrier	Insurance Limit	Expiration date of Coverage

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

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

INTERSTATE
INSURANCE
GROUP

55 East Monroe Street Ste 3300
Chicago, Illinois 60603
Fax: (312) 577-9486

Staff Roster

Please be certain to complete ***both*** columns. This will allow us to calculate Full Time Equivalent Employees, which, in turn, allows us to be much more price-competitive.

	Number of Employees & Independent Contractors	Total Annual Hours by Class	Total Annual Payroll by Class
Administration/Directors/Coordinators	___________	___________	____________
Clerical	___________	___________	____________
Counselors	___________	___________	____________
Dieticians/Nutritionists	___________	___________	____________
Educators/Teachers	___________	___________	____________
Family Day Care Providers	___________	___________	____________
Homemakers	___________	___________	____________
Massage Therapists	___________	___________	____________
Medical Office Assistants	___________	___________	____________
Medical Records Technicians	___________	___________	____________
Nurses	___________	___________	____________
Nurses Aides	___________	___________	____________
Nurse Practitioners	___________	___________	____________
Occupational Therapists	___________	___________	____________
Pharmacists	___________	___________	____________
Physical Therapists	___________	___________	____________
Physicians Assistants	___________	___________	____________
Psychologists	___________	___________	____________
Residence Managers	___________	___________	____________
Respiratory Therapists	___________	___________	____________
Respite Care Providers	___________	___________	____________
Social Workers	___________	___________	____________
Speech and Hearing Therapists	___________	___________	____________
Surgeon Assistants	___________	___________	____________
Volunteers (Non-Medical)	___________	___________	____________
Other (Please provide details)	___________	___________	____________