

United National Group

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)**

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	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Heat Sensors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Smoke Detectors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
g. CONSTRUCTION UPDATES	Year: _____	Year: _____	Year: _____	Year: _____
Plumbing	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Wiring	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

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 all 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		<input type="checkbox"/> residential	_____%	CPM	_____%
(Pressure)	_____%	<input type="checkbox"/> commercial	_____%	Braces <input type="checkbox"/> 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)

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.

Return to:

**DIALYSIS CENTERS
SUPPLEMENTAL APPLICATION**

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

(Please note that this Supplemental Application must be completed for each facility/location providing outpatient dialysis treatment. The Misc. Medical Professionals Application must be completed and submitted with all Dialysis Centers Supplemental Application.)

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: _____

PATIENT / TREATMENT INFORMATION

5. Fully describe the exact purpose of the operations, activities, services and professional procedures administered:

6. 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

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

8. Are medical records released to third parties without the written consent of the patient? Yes No

YES, please explain: _____

9. Is a supervising physician on premises at the time of all hemodialysis treatments at the facility? Yes No

If NO, please explain: _____

10. As respects the dialysis machine(s):

a. Does the facility service its own machines: Yes No

b. Is the facility an additional insured under the manufacturer's or distributor's products liability coverage? Yes No

If the answer to b. is YES, please identify

- named insured under such policy: _____
- insurance company _____
- limits of liability _____
- coverage is claims made occurrence

11. Is treatment initiated only under a physicians work order? Yes No

12. The number of treatments for each of the past three years was:

200 ____; 200 ____; 200 ____.

STAFF

13. Total Employees _____ # Total Independent Contractors _____ #

14. Health Care Professionals

	# Employees/ Contractors Shift 1	# Employees/ Contractors Shift 2	# Employees/ Contractors Shift 3
Administrators			
Clerical			
Medical Records			
Nurses / Nurse Aides			
Nurse Practitioner / Clinical Nurse Specialist			
Pharmacists			
Physician / Physician Assistant			
Social Workers			

(Complete job descriptions must accompany this application for those professionals indicated in Question 14 above.)

15. 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						
Name - Physician						
Name - Pharmacist						

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