beazley

MISCELLANEOUS MEDICAL PROFESSIONAL, GENERAL, PRODUCTS, AND EMPLOYEE BENEFITS LIABILITY APPLICATION

NOTICE: PART OR ALL OF THE POLICY FOR WHICH THIS APPLICATION IS MADE IS WRITTEN ON A CLAIMS MADE AND REPORTED BASIS, WHICH MEANS THAT THE POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED IN WRITING TO THE INSURER DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THIS APPLICATION CAREFULLY.

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

Requested Attachments:

1. Loss History for the last FIVE years.
2. Most Recent Financial Statements.
3. Sample copy of contract, used by the Applicant in the provision of professional services.
4. Most recent local and/or State accreditation agency reports (if applicable).
5. Any marketing brochures or literature detailing services provided.

I. APPLICANT INFORMATION:

a) Name of Applicant/Entity(s)_____

_____

b) Date of Incorporation/Start of Operations: _____

c) Physical Address (City, State, Zip Code) _____

_____

d) Telephone_____Fax_____Website_____

e) Legal Structure: ☐ Individual ☐ Partnership ☐ LLC ☐ Corporation ☐ Joint Venture ☐ Other_____

f) Tax Status: ☐ For Profit ☐ Not for Profit ☐ Governmental ☐ Other_____

g) List names, location, and descriptions of all legal entities, including subsidiaries for which Applicant is a part (continue on a separate sheet if necessary)

Loc. #	Business Name and Address	Description	Date Acquired	Ownership %	Retroactive Date

h) Have you sold, discontinued, or acquired any operations in the past 5 years, or do you plan to in the upcoming year? (Please list including name of entity and date acquired) ..... ☐ Yes ☐ No

_____

_____

i) List all licenses held by your facility including type and expiration dates.

_____

j) List any/all accreditation from governmental agencies/clients (JCAHO, AABB, AATB, FACT, ABC, CLIA, AOPO, EBAA, CAP, ASHI, etc.) and association memberships held by your facility and include a copy of your most recent report.

_____

_____

II. COVERAGE HISTORY:

a) Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

b) Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

c) Do you currently carry employee benefits liability coverage? ..... ☐ Yes ☐ No
If yes, what is the employee count, limit, deductible, and retroactive date?

_____

d) Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? ..... ☐ Yes ☐ No
If yes, please explain.

_____

III. FINANCIAL INFORMATION:

	Projected, next Fiscal/Annual Period	Past 12 Months; Most recent, full-annual	First Year Prior Financial Year:
Total Assets:			
Net Assets/Equity:			
Long Term Debt:			
Gross Revenues:			
Net Revenues/Income:			
Total Cash and Cash Equivalents:			

IV. PROFESSIONAL SERVICE/PRODUCT PROFILE:

a) Please provide a full description of services rendered.

_____

b) Operations: (for the previous 12 months please provide a breakout of the services provided, and the percentage of total gross revenues. Total must equal 100%)

	percentage		percentage
Ambulance Services		Medical Spa Services	
Ambulatory Surgical Center		Nursing Home/LTC Facility	
Behavioural Health Services		Optical Services	
Blood/Plasma Banking/sperm (see blood & tissue application)		Organ/Tissue Services/OPOs (see appendix #5)	
Clinical Trials (see appendix #2)		Pathology Services	
Community Health Clinic		Pharmacy Services (see pharmacy application)	
Fertility Services		Rehabilitation Services	
Foster/Adoption Services		Schools for Healthcare Professionals (see appendix #4)	
Genetic Testing Services		Sleep Center	
Group home/Adult Day-care		Social Services	
Healthcare Staffing (see appendix #3)		Substance Abuse Services	
Home Healthcare Services		Telemedicine Services	
Hospice Care Services		Urgent Care Center	
Imaging Services		Weight Loss Services	
Laboratory Services		All Other Services: Describe below	

All Other Services:_____

c) Please provide the number of patient contacts in the previous 12 months and current projection:

(number of visits)	Projected, next Fiscal/Annual Period	Past 12 Months; Most recent, full-annual	First Year Prior Financial Year:
Clinic			
Laboratory			
Other (specify)_____			
TOTAL VISITS			

d) Does the insured have any beds for overnight stays?..... ☐ Yes ☐ No
(If yes, number of beds and average occupancy)

_____

e) Has your facility been surveyed by an accreditation agency within the past three years? ☐ Yes ☐ No
   i. If "Yes", please list date(s) of last survey: ____/_____/_____

f) Does the insured provide any services outside of the United States? ..... ☐ Yes ☐ No
(If yes, Please explain)

_____

g) Do you compound in bulk, manufacture or wholesale medicine?..... ☐ Yes ☐ No
(If yes, Please explain)

_____

h) Does the applicant anticipate making any significant changes in the services/products provided within the next 12 months?..... ☐ Yes ☐ No
(If yes, Please explain)

_____

i) Does the insured sell any products?..... ☐ Yes ☐ No
(If yes, Please explain)

_____

j) Has a product ever been recalled? ☐ Yes ☐ No
   i. If "Yes", please explain (dates, volumes, and reasons for the recall)

_____

V. MEDICAL STAFF PROFILE:

a) Schedule of Physicians, Surgeon, Osteopath, Podiatrist, Orthodontist, Chiropractor, Psychiatrist, Psychologist or Dentist – on Staff or Contracted: (supply separate sheet if necessary)

Name	Specialty	Board Certified	Hours Worked	Volunteer, Contracted or Employed	Has own Malpractice Insurance	Medical Director
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No

i. Would you like any listed physician to be covered under the facility's policy? ☐ Yes ☐ No
(if yes, please submit a CV or application for each physician)

ii. Is physician credentialing and privileging formalized and documented? ☐ Yes ☐ No

iii. Do any of the above physicians have direct patient care responsibilities? ☐ Yes ☐ No
(if yes, what is the physician's role in providing services for the applicant's facility?)

_____

b) Please provide details of all other staff utilized

Health Professional	Employed			Contracted		
	Full Time	Part Time	Hours	Full Time	Part Time	Hours
Registered Nurses						
Licensed Practical Nurses						
Licensed Vocational Nurses						
Nurse Practitioners						
Physician Assistants						
Certified Nursing Assistants						
Physical, Occupational, and Speech Therapists						
Home Health Aides						
Sitters/Companions						
Emergency Medical Technicians						
Paramedics						
Pharmacists						
Technicians						
Social Workers						
Other (please provide description)						

VI. RISK MANAGEMENT, CLAIMS HANDLING & LOSS CONTROL

a) Does the applicant have a full time risk manager on staff?..... ☐ Yes ☐ No
(If yes, please provide the following details.)

Name _____

Title _____

Telephone (____) _____-_____

Qualifications/Experience_____

b) Does the applicant have a formal, written risk management/loss prevention program?
(please provide details, separately if necessary) ..... ☐ Yes ☐ No

c) Does the applicant require new employees to participate in a training program that instructs them on all applicable company policies and procedures?..... ☐ Yes ☐ No

d) Does the applicant handle claims in-house or utilise the services of a third party administrator?
(please provide details of in-house claims personnel/TPA used)

_____

VII. CREDENTIALING:

a) Are all health professionals credentialed prior to hiring?..... ☐ Yes ☐ No

b) Are physicians required to be board certified in their speciality?..... ☐ Yes ☐ No

c) How often are physicians re-credentialed? _____

d) Prior to hiring any employee, does the applicant verify:

i. Education background and training?..... ☐ Yes ☐ No
ii. Employment references with at least two previous employers?..... ☐ Yes ☐ No
iii. Criminal record, on a Local, State and National scale? (Please indicate which apply)

_____

iv. Driving record?..... ☐ Yes ☐ No
v. Credit record?..... ☐ Yes ☐ No
vi. Drug tests?..... ☐ Yes ☐ No
vii. Sex Offender Registry?..... ☐ Yes ☐ No

e) Does the applicant keep all information on file and verify its completion prior to employment commencement?..... ☐ Yes ☐ No

VIII. INSURED HISTORY - CLAIMS, LOSSES, AND INCIDENTS:

a) Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf?..... ☐ Yes ☐ No
If Yes, how many? _____Complete a copy of our Supplemental Claim form for each

b) Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice, general liability, or products liability claim or suit?..... ☐ Yes ☐ No
If Yes, has each of these been reported to the current or any prior insurer?..... ☐ Yes ☐ No
How many? _____ Complete a copy of our Supplemental Claim form for each

c) Has the applicant or any staff:

i. ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association? ☐ Yes ☐ No
ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... ☐ Yes ☐ No
iii. ever been treated for alcoholism or drug addiction? ..... ☐ Yes ☐ No
iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? ..... ☐ Yes ☐ No
(If yes, please provide an explanation on any/all incidents)

_____

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURINSHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL ATTACHMENTS, AND THE MATERIALS SUBMITTED HEREWITH ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

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TO THE BEST OF THE UNDERSIGNED'S KNOWLEDGE, AFTER REASONABLE INQUIRY. IN MAINE, THE UNDERWRITERS MAY MODIFY BUT MAY NOT WITHDRAW ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM 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 DEPARTMENT 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 OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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Signed*:_____ Date:_____

Print Name:_____ Title: _____
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Agent's Printed Name:_____ Florida Agent's License Number:_____

Agent's Signature*:_____

*If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

☐ Electronic Signature and Acceptance – Authorized Representative

☐ Electronic Signature and Acceptance - Producer

1. Please type or print clearly.
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4. This supplemental application must be completed, dated and signed by a Principal of the Applicant.
5. Complete one form for each incident, claim, or suit.

a) Name of Applicant/Entity(s):_____

_____

b) Name of Patient/Claimant(s):_____

_____

c) Date(s) of Treatment:_____ Date of Claim/Suit:_____

d) Claimant's Allegations:_____

e) Additional Defendants:_____

f) Status of Claim: ☐ Incident (negligent act, error or omission or an **Accident** that could lead to a **Claim**)
☐ **Claim** (written notice received by any **Insured** of an intention to hold the **Insured** responsible for compensation for Damages)
☐ Suit (demand, notice, summons or other process received by the **Insured** or its representative)

g) Description of Claim: (include nature of treatment and your involvement)
a. Alleged act, error of omission on which the claims is based:_____

_____

b. Description of cases and events:_____

_____

c. Description of the type and extent of injury or damages allegedly sustained:_____

_____

h) Current Disposition of Claim:
☐ DISMISSED (action dropped without any payment to claimant of Statute of Limitations has expired)
☐ ABANDONED (no activity from claimant for over 3 years)

☐ WON by defense

☐ WON by claimant
Total Paid: $_____ Amount Paid on your behalf: $_____
Please Indicate: ☐ Court judgment, or ☐ Out of court settlement

OPEN Claimant's settlement demand: $_____
Defendant's Offer for settlement: $_____
Insurer's loss reserve: $_____

i) Explain what steps have been taken to prevent recurrences of similar claims:_____

_____

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Agent's Printed Name:_____ Florida Agent's License Number:_____

Agent's Signature*:_____

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☐ Electronic Signature and Acceptance – Authorized Representative

☐ Electronic Signature and Acceptance - Producer