Strickland
E & S Brokers

DAY CARE or PARTIAL HOSPITALIZATION PROGRAM
SUPPLEMENTAL APPLICATION

1. Applicant:: _____
   Address: _____
   Utilized square footage: _____ Describe "exit" alarms / security measures: _____
   Describe any off premises exposures / field trips, etc: _____
   Swimming Pool ? ☐ Yes ☐ No Playground Equipment? ☐ Yes ☐ No Give details of all pool use rules, depth, lifeguards. Describe playground equipment. _____
   _____

2. Facility's **Licensed # Client Spaces:**_____ Average Occupancy:_____ Hours of Operation:_____

3.

Age Group	**Number of Children**	**Staff / Child Ratio**		**Number of Adult Clients**
Under 2 Years	_____	_____	18 to 30 Yrs	_____
2 to 5 Years	_____	_____	31 to 45 Yrs	_____
6 to 12 years	_____	_____	46 to 65 Yrs	_____
13 to 18 years	_____	_____	Over 65 Yrs	_____

4. Give **breakdown** of percentage of **types** of clients serviced:
   Well Child _____% Mentally Retarded _____% Aged _____% Emotionally Disturbed _____%
   Alzheimer / Dementia _____% Alcohol/Drug Rehab _____% OtherDescribe _____ / _____%
5. Does **hiring** procedure include: Background/Reference Check? ☐ Yes ☐ No
   Screening for Criminal Record? ☐ Yes ☐ No
   Brief description of hiring procedures: _____
   Staff - Describe Credentials, Experience & Number of staff : _____
   _____
6. Is **transportation** provided? ☐ Yes ☐ No If yes, give description of vehicles, insurance coverage, driver screening: _____
   _____
7. What provisions are in place for **medications, injuries or illness** ? _____
   _____
8. Does applicant carry **Accident Insurance** Policy for clients ? ☐ Yes ☐ No If Yes, Limit ? _____
9. Describe procedures and precautions for child's release: _____
   _____
10. **Please attach brochure, advertising copy, and copies of enrollment form, parental release forms:**

DATE:_____ SIGNATURE:_____

PROFESSIONAL LIABILITY APPLICATION
for
HEALTH CARE SERVICES

(TO BE COMPLETED ONLY IF A MORE SPECIFIC APPLICATION IS NOT APPLICABLE)
INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.
If the answer is NONE, state NONE;
If the answer 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 **(including dba's)**: _____

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 The Applicant is (Please check and complete A) or B) below:
___ A. The **APPLICANT** is an INDIVIDUAL:
IF SO, the INDIVIDUAL is an ___ Employee ___ Student ___ Sole Practitioner
___ B. The **APPLICANT** is a:
___ Sole Proprietorship ___ Partnership ___ 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): $ _____/$ _____

1.12 Annual Gross Receipts: Estimated next twelve months - $_____
last twelve months - $_____

1.13 Annual Remuneration: Estimated next twelve months - $_____
last twelve months - $_____

1.14 Total Premises Square Footage Occupied By Applicant:_____

PART II. EXPOSURES

2.1 Service is licensed as _____

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted: _____

2.3 List all memberships in professional organizations. _____

2.4 Total number of all staff _____

2.5 Number of Professional Staff:

E	C		E	C	
___	___	Aides or Orderlies	___	___	Optometrists
___	___	Audiologists	___	___	Opticians
___	___	Chiropractors	___	___	Paramedics or EMT's
___	___	Dentists	___	___	Pharmacists
___	___	Dental Hygienists/Tech.	___	___	Pharmacy Technicians
___	___	Dental Assistants	___	___	Physicians or Surgeons*
___	___	Dietitians/Nutritionists		___	___ Physician Assistants
___	___	EEG or EKG Operators	___	___	Physiotherapists/Physical Therapists
___	___	Electrologists	___	___	Podiatrists
___	___	Hearing Aid Fitters	___	___	Prosthetic Device Fitters
___	___	Inhalation/Resp. Therap.	___	___	Psychologists/Psychotherapists
___	___	Laboratory Technicians	___	___	RN's
___	___	LPN's	___	___	Social Workers
___	___	Medical Technicians	___	___	Speech Therapists
___	___	Nurse Anesthetists	___	___	X-Ray or Radiologist Technicians
___	___	Nurse Midwives	___	___	X-Ray or Radiologist Therapists
___	___	Nurse Practitioners	___	___	Other, describe _____
___	___	Occupational Therapists			

* Attach list and indicate specialty.

E = Employed

C = Contracted

2.6 If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors and annual estimated Out Patient Vists by professional category. _____

2.7 Do you require:

A) contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?_____

B) employed or contracted physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? _____

2.8 **Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf?**

2.9 What minimum limits of Professional Liability are required? _____

2.10 What was your total number of patient/client visits last year? _____ Estimated next year? _____

2.11 Breakdown of patient services:

___% Pediatric	___% Gynecological
___% Dental	___% Emergency Medical
___% Obstetric	___% General Exams

___% Psychiatric ___% Occupational Medical
___% Rehabilitative Therapy ___% Optometry/Opthamology
___% Minor Surgery ___% Nutrition (Diet)
___% Major Surgery ___% Other(describe) _____
___% Orthopedic _____

2.12 Are any of the following performed?

Administer anesthesia (general or local)?	___ yes	___ no
Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)?	___ yes	___ no
Cardiac Catheterization	___ yes	___ no
Diagnostic tests	___ yes	___ no
Chemotherapy	___ yes	___ no
X-Rays	___ yes	___ no
Radiation Therapy	___ yes	___ no
Reduction of Fracture	___ yes	___ no
Shock Therapy	___ yes	___ no
Prescribe medication	___ yes	___ no
Obstetric procedures	___ yes	___ no

For all "yes" answers, give detailed description on separate page or back of application.

PART III. RISK MANAGEMENT

3.1 Give name of Administrator/Supervisor and describe his/her training and experience. _____

_____

_____

3.2 Do you enter into contractual agreements? ___ Yes ___ No
IF YES, enclose copies of all such contracts.

3.3 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? ___ Yes ___ No
If not, are you agreeable to instituting this procedure? ___ Yes ___ No

3.4 Enclose a copy of all brochures or advertising materials distributed by you.

3.5 Describe any "fund raising" or other special events activities conducted. _____

_____

3.6 Describe any swimming pool, playground or amusement exposure. _____

_____

_____

3.7 Do you rent, sell, or otherwise provide any equipment or products to others? ___ Yes ___ No
IF YES, complete our Products Supplememt.

3.8 Do you provide 24 hour bed and board care for any patients, or do you (wholly or in part) own, operate or administer any facility which does provide such services? ___ Yes ___ No
IF YES, complete our Residential Facilities Application.

3.9 Do you provide any of the following services:
A) Blood Bank/Plasma Centers ___ Yes ___ No

B) Cemeteries/Funeral Homes/Morticians ___ Yes ___ No
C) Medical Arts Schools and Colleges ___ Yes ___ No
D) Pharmacies ___ Yes ___ No
E) Nursing Homes ___ Yes ___ No

IF YES, complete the appropriate supplement application.

3.10 Do you have any other premises or operations exposures not stated in this application?
___ Yes ___ No IF YES, enclose complete description and underwriting/rating information.

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	Claims-Made 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	Claims-Made 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 ___ No IF YES, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____
_____
_____
_____

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._____

_____

_____

_____

_____

I understand and agree this Application and 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 <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

_____ _____

Date Applicant/Title