Strickland
E & S Brokers

PROFESSIONAL LIABILITY APPLICATION
for
MEDICAL PERSONNEL SERVICE AGENCIES

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: _____

.5 Telephone Number: Office ____/_____ Fax ____/_____

1.6 Person to contact for survey: Name _____
Title _____

1.7 Year entity established: _____

1.8 Entity is ___ Individual ___ Corporation ___ Partnership
___ Professional Association/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):
Professional Liability $ _____/$ _____
General Liability $ _____ each occurrence
$ _____ general aggregate

1.12 Gross Receipts: Estimated next twelve months: $ _____
Last twelve months: $ _____

1.13 Total Premises Square Footage Occupied by Applicant: _____

PART II. EXPOSURES

2.1 Maximum number of health care staff:

___ RN's ___ CNA's/Orderlies
___ CRNA's ___ Nurse Practitioners
___ LPN's ___ Other (Specify number by category _____

*Note: Please be very specific, as coverage for certain categories is excluded on the policy unless included by endorsement.

2.2 Are all your staff members actual employees (W-2)? ___ Yes ___ No
If no, do you contract for services of any outside health care staff (1099)? ___ Yes ___ No
If yes, breakdown total estimated annual payments to contractors by professional categories: _____
_____
_____

2.3 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? ___ Yes ___ No

2.4 Enter percentage of services provided by category of staff including contracted staff:

RN's & LPN's
___ % Hospitals
___ % Nursing Homes / Assisted Living
___ % Private Doctors
___ % Private Home Care
___ % Other (Describe):_____
OTHER: _____
___ % Hospitals
___ % Nursing Homes / Assisted Living
___ % Private Doctors
___ % Private Home Care
___ % Other (Describe):_____

CNA's / ORDERLIES
____ % Hospitals
____ % Nursing Homes / Assisted Living
____ % Private Doctors
____ % Private Home Care
____ % Other (Describe): _____
OTHER: _____
____ % Hospitals
____ % Nursing Homes / Assisted Living
____ % Private Doctors
____ % Private Home Care
____ % Other (Describe):_____

2.5 List each county in which your employees and/or contract staff provide any professional services and also the % of the agency's revenue which is derived from that county: _____
_____

2.4 If home health care is provided, indicate the percentage of the following services which each represents of the home health care revenue:

___ % IV Therapy (complete IV Therapy Supplement if % above 5%)*
___ % AIDS Therapy*
___ % Chemotherapy*
___ % Infant Monitoring (SIDS, etc.)
___ % Pediatric/infant childcare, including "babysitting"

*if any, also complete supplement for IV Therapy

2.7 What is your total payroll for service personnel (including supervisors and administrators)? _____
Remuneration last year:_____ Estimated next year:_____
(Remuneration means "payroll" for all employees plus payments, if any, to independent contractors.)

2.8 Show total number of hours of client service provided by all categories of staff:
Hours last year:_____ Estimated next year:_____

2.9 Do you have any other premises or operations not stated in this application? ___ Yes ___ No
If yes, enclose complete description and underwriting/rating information.

2.10 Does any physician (other than the medical director) provide professional services to your agency?
___ Yes ___ No
If yes, describe the services provided: _____

_____

2.11 Do you require contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ___ Yes ___ No
If yes, what limits of liability do you require? _____

PART III. RISK MANAGEMENT

3.1 Name, qualifications and number of years of experience of the Medical Director, all managers and supervisors:

Association Name	Title	Experience/Training	Membership

3.2 Does your facility require the professional staff be CPR trained? ___ Yes ___ No

3.3 Do you enter into any contractual agreements? ___ Yes ___ No
If yes, enclose copies of all such contracts.

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

3.5 Do you maintain a written clinical record showing total number of visits by each category of staff for every person or organization client? ___ Yes ___ No

3.6 Is any staff provided to hospitals specifically to serve a particular specialty (i.e. OR, ICU, CCU, ER, Nurses, etc.)? ___ Yes ___ No
Enter percentage of services provided by category of staff including contracted staff:

_____ % OR
_____ % Labor / Delivery
_____ % ICU / CCU
_____ % ER
_____ % Other (Describe):_____

3.7 Describe (on a separate sheet) your requirements for employment and your pre-employment screening and investigation procedures.

3.8 Enclose a copy of your employment application.

3.9 Do you prepare job descriptions and instructional manuals for your staff? ___ Yes ___ No
If yes, enclose a copy of each.

3.10 Do you maintain records of specific areas of experience of each staff member? ___ Yes ___ No

3.11 Describe your procedures for matching staff to patients. _____

_____

_____

3.12 Who does the matching/assigning of staff to client, and what is his/her experience? _____

_____

3.13 Who does the supervising of staff, and what is his/her experience? _____

_____

3.14 Does the staff supervisor make regular audit visits on staff in the field? ___ Yes ___ No

3.15 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? _____

_____

3.16 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? ___ Yes ___ No
If no, attach explanation of any exception.

3.17 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ___ Yes ___ No

b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ___ Yes ___ No

c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ___ Yes ___ No

IF THE ANSWER TO ANY OF 3.17 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

3.18 Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations.
___ None ___ Description Attached

PART IV. <u>HISTORY</u>

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