



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:

<u>E</u>	<u>C</u>		<u>E</u>	<u>C</u>	
___	___	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? ___ Yes ___ No

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:

- | | |
|---|--|
| <input type="checkbox"/> % Pediatric | <input type="checkbox"/> % Gynecological |
| <input type="checkbox"/> % Dental | <input type="checkbox"/> % Emergency Medical |
| <input type="checkbox"/> % Obstetric | <input type="checkbox"/> % General Exams |
| <input type="checkbox"/> % Psychiatric | <input type="checkbox"/> % Occupational Medical |
| <input type="checkbox"/> % Rehabilitative Therapy | <input type="checkbox"/> % Optometry/Ophthalmology |
| <input type="checkbox"/> % Minor Surgery | <input type="checkbox"/> % Nutrition (Diet) |
| <input type="checkbox"/> % Major Surgery | <input type="checkbox"/> % Other(describe) _____ |
| <input type="checkbox"/> % 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 Supplement.

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	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	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 DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant/Title