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Professional Liability Application for Social Services With No Residential Exposure

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

PROASSURANCE Treated Fairly

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

Tax ID/SSN: _____

1.1 Applicant Name: _____

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 Proposed **Effective Date**: _____ 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 a(n):
☐Employee (W-2) ☐Student ☐Ind. Contr. (1099) ☐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 Requested Limits of Liability (if available):

Professional Liability $_____ Each Medical Incident/ $_____ Aggregate
General Liability $_____ Each Occurrence/ $_____ General Aggregate

1.11 Annual Gross Receipts or Budget: Estimated Next 12 Months: $_____
Last 12 Months: $_____

1.12 Annual Payroll or Remuneration: Estimated Next 12 Months: $_____
Last 12 Months: $_____

1.13 Type of Facility: Licensed? ☐Yes ☐No If no, explain:_____

Check One or Describe:

☐Adoption Agency*
☐Child Day Care*
☐Day Care (Senior Citizens)*
☐Foster Care*
☐Hotlines (Phone Crisis Service)
☐Meals on Wheels
☐Nanny Services
☐Employee Assistance Program
☐Referral Agency* (Consultants Supplement)
☐Sheltered Workshop*
☐Other:_____

*Applicable supplemental questionnaire must be completed.

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

1.15 List memberships in professional organizations:_____

1.16 Is the applicant/facility and all professional employees licensed in accordance with applicable state and federal laws? ☐Yes ☐No
If no, explain: _____

Part II. Exposures

2.1 Does facility provide **"Day"** services? ☐Yes ☐No
If yes, what is the number of "day patients" (include "independent living" persons):
Maximum # ____ Average #____

2.2 Do you conduct a **Sheltered Workshop**? ☐Yes ☐No
If yes, the application for Sheltered Workshops for Retarded and Developmentally Disabled Persons must be completed.

2.3 Are all patients fully ambulatory (including use of cane or walker)? ☐Yes ☐No
If not, explain:_____

2.4 What was your total number of outpatient/client visits last year?_____ Estimated next year?_____

2.5 Do you conduct group therapy sessions? ☐Yes ☐No
If yes, do any sessions exceed four (4) hours in duration? ☐Yes ☐No
If yes, how many annually? _____

2.6 Describe any physical contact that may occur between you and any patients/clients or between two or more patients/clients at your direction:_____

2.7 Describe any services specifically concerned with sexual response/dysfunction of individual patients/clients:

2.8 Is there a Registered Nurse on duty? ☐Yes ☐No
If yes, how many shifts per day? _____

2.9 Is any medication prescribed? ☐Yes ☐No
If yes, list names and frequency: _____

Are medications stored in a secure manner? ☐Yes ☐No
If no, explain in detail: _____

2.10 Do you enter into any contractual agreements? ☐Yes ☐No
If yes, enclose copies of all such contracts including those contracts for use with patients/clients.

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

2.12 Are any activities or events for patients/clients conducted or sponsored away from applicants? If yes, describe: ☐Yes ☐No

2.13 Any swimming pools, exercise facilities, or athletic activities? ☐Yes ☐No
If yes, please describe (for pool give information re: pool use rules, lifeguard, fencing, and depth): _____

2.14 Describe any "fundraising" or other special events activities conducted: _____

2.15 Do you have any other premises or operations not stated in this application? ☐Yes ☐No
If yes, enclose complete description/locations of operations and insurance information.

Part III. Risk Management

3.1 Do you require staff to report all incidents (accidents)? ☐Yes ☐No
Are records of such reports kept on file by you? ☐Yes ☐No
If not, explain: _____

3.2 Are precautions taken to prevent patients/clients leaving premises or "wandering" without applicant's knowledge, such as exit alarms, etc.? ☐Yes ☐No
Please describe: _____

3.3 Is there a written emergency evacuation plan? ☐Yes ☐No

3.4 State the frequency of fire drills: _____

3.5 Does the applicant/facility have personnel trained in emergency medical care in the facility during all hours of operation? ☐Yes ☐No
Please describe: _____

3.6 Explain arrangements for medical emergencies (e.g., physician on call, transfer arrangement with hospital, etc.): _____

3.7 Number of **Professional Staff**: (**E = Employed; C = Contract**)

E	C		E	C	
☐	☐	Dieticians/Nutritionists	☐	☐	Physiotherapists/Physical Therapists
☐	☐	Occupational Therapists	☐	☐	Psychologists/Psychotherapists
☐	☐	Pharmacists	☐	☐	Psychiatrists*
☐	☐	Physicians*/Dentists*	☐	☐	Speech Therapists
☐	☐	Nurse Practitioners	☐	☐	RNs/LVNs/LPNs
☐	☐	Physician Assistants	☐	☐	Respiratory Therapists
☐	☐	Social Workers	☐	☐	Case Managers
☐	☐	Marriage/Family Counselors	☐	☐	School Counselors
☐	☐	Teachers	☐	☐	Other: _____

Complete the following for each Physician, including Medical Director, Dentist, Chiropractor, Podiatrist, Psychiatrist, Nurse Practitioners, and Physician Assistants:

* Complete Physician Supplement when applicable.

Name	Professional Status	E, C, or I	Maintains Own Malpractice Ins.	Limit of Liability	Cert. of Ins. Obtained
		E = Employee C = Contract I = Independent			

3.8 Do you have any physicians on staff admitting patients or treating patients who have restricted licenses? If yes, explain on separate sheet. ☐Yes ☐No

3.9 Name, qualification, and number of years of experience of the Medical Director, all managers, and supervisors:

Name Title Experience/Training Association Membership

_____

_____

_____

3.10 Does the applicant have written screening and hiring policies and procedures for all prospective employees, independent contractors/consultants, and volunteers? ☐Yes ☐No
If yes, please provide copies of the procedures, including samples of employment applications.

3.11 Are there written guidelines regarding sexual misconduct? ☐Yes ☐No
If yes, please provide copies of all policies and procedures including training materials.

Part IV. History

4.1 List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer Number	Policy Liability	Limits of Premium	Eff. Date	Claims-Made Form No	Claims-Made Form Yes

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, state none.

Insurer Number	Policy Liability	Limits of Premium	Eff. Date	Claims-Made Form No Yes
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? ☐No ☐Yes
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? ☐No ☐Yes
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 ProAssurance Mid-Continent Underwriters, 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 applicant has not withheld 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

Pregnancy Centers Supplement

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

PROASSURANCE Treated Fairly

Note: Supplement must be dated and signed by owner, partner, officer, or administrator.

Please type or print in ink.

Tax ID/SSN: _____

1. Applicant Name (including DBAs): _____

2. Please list all services offered by the applicant: _____

   _____

3. Breakdown of patient services (%) by outpatient visits:

_____% AIDS	_____% Gynecology
_____% Alcoholic	_____% Nutritional (diet)
_____% Bariatric	_____% Obstetrical
_____% Drug Addiction	_____% Pediatric
_____% Family Planning	_____% Psychiatric
_____% General Exams	_____% Substance Abuse
_____% Other; Describe: _____	

4. Indicate the number of professional employees, volunteers, and independent contractors:
   (If none, state none.)

Physicians, Surgeons & Dentists	No. of Employees and Volunteers	No. of Independent Contractors
a) Physicians: No surgery (other than incisions of boils, suturing of skin, or other obstetrical procedures)		
b) Physicians: Minor surgery or obstetrical procedures not constituting major surgery		
c) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists Doing Plastic Surgery		
d) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons		
e) Physician's & Surgeon's Assistants, Nurse Practitioners (describe duties on separate sheet)		
f) Unlicensed Interns		

If any of these categories are providing services, complete the Physician's Exposure Supplement.

5. Allied Health Professionals:

	No. of Employees and Volunteers	No. of Independent Contractors		No. of Employees and Volunteers	No. of Independent Contractors
a) EEG/EKG Technician			g) Pharmacist		
b) Medical Lab Tech.			h) Psychotherapist		
c) Nurse Anesthetist			i) Physician's Asst.		
d) Nurse Midwife			j) Radiation Tech.		
e) Nurse Practitioner			k) RN, LVN, LPN		
f) Social Worker			l) Surgical Tech.		

Are all of the above individuals licensed in accordance with applicable state and federal regulations?
If no, attach explanation. ❒ Yes ❒ No

6. Please provide the number of outpatient visits by category.

Type No. of Visits/Tests Clinics - Total	Next Twelve Months	Last Twelve Months
a. Physician		
b. Physician Asst./Nurse Practitioner		
c. Other Allied Health Professionals		
d. Laboratory		
e. Surgery (procedures)		
f. Imaging/X-Ray		
g. Other: _____		

7. Does the applicant perform:
   a. X-Ray Services? ❒ Yes ❒ No
      If yes, number of annual X-ray exposures for determination of whether pregnant or not: _____
      The number for tracking development of the fetus through pregnancy or diagnosis: _____
      What qualifications are required of the staff? _____
   b. Does the applicant prescribe drugs for weight reduction of patients? ❒ Yes ❒ No
   c. Are any of the following preformed?
      1) Obstetrics ❒ Yes ❒ No
         a) Pre-natal ❒ Yes ❒ No
         b) Deliveries ❒ Yes ❒ No
         c) Elective or Therapeutic Abortions ❒ Yes ❒ No
         d) If clinic provides pre-natal care only, do clinic physicians or nurse midwives attend patient at designated hospital at time of delivery? ❒ Yes ❒ No
         e) If answer to d) is no, are clinic pre-natal records provided to delivering physician and to the designated hospital prior to delivery? ❒ Yes ❒ No
      2) Chemical/Substance Abuse Services
         a) Counseling? ❒ Yes ❒ No
         b) Methadone or similar substances, dispensed or prescribed? ❒ Yes ❒ No
      3) Do you provide home health care services? ❒ Yes ❒ No

8. Is your facility owned by an M.D.? ❒ Yes ❒ No
   If yes, owner name(s): _____

9. Does the applicant perform any:
   a. Cosmetic Plastic Surgery? ❒ Yes ❒ No
      Describe: _____
      _____
   b. Hysterectomies? ❒ Yes ❒ No
   c. Surgery for Weight Reduction of Patients? ❒ Yes ❒ No
   d. Abortions and/or Menstrual Extractions? ❒ Yes ❒ No
   e. Sterilization Procedures? ❒ Yes ❒ No
      Describe: _____
   f. Biopsies and/or Endoscopies? ❒ Yes ❒ No
      List Types Performed: _____
      _____
      _____
   g. Other Surgery? ❒ Yes ❒ No
      Describe: _____
      _____

10. Does the applicant perform gynecology?
   a. Surgical ❒ Yes ❒ No
   b. Family Planning ❒ Yes ❒ No
      If yes, indicate number of patients: _____
      Describe range of services: _____
      _____

11. Does your clinic require the professional staff be trained in CPR? ❒ Yes ❒ No

12. Describe the referral source(s) by which patients are directed to the entity:_____
      _____

13. Do you have any restricted licensed physicians on staff? ❒ Yes ❒ No
      If yes, explain: _____
      _____
      _____

_____ _____
Date Applicant/Title

Sexual Misconduct Coverage Supplemental Application

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

ProAssurance Treated Fairly

Tax ID/SSN: _____

1. Applicant: _____

2. Has the applicant had any incidents or claims reported for sexual misconduct or any other allegation of abuse? ☐ Yes ☐ No
   If yes, provide full details:
   _____
   _____
   _____

3. Has the applicant or any employee, volunteer, or other person working for the applicant ever been arrested or convicted of a crime? If yes, provide full details: ☐ Yes ☐ No
   _____
   _____
   _____

4. Describe all background checks performed: _____
   _____
   _____
   _____

5. Are there written guidelines regarding sexual misconduct? If yes, provide copies of all policies and procedures including training materials. ☐ Yes ☐ No

6. What steps have been taken to prevent or avoid a sexual misconduct incident?_____
   _____
   _____
   _____

Date:_____ Signature:_____

Non-Owned Auto Supplemental Application

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

PROASSURANCE Treated Fairly

If non-owned auto coverage is desired, please complete the following:

Note: Non-owned coverage is written only as an endorsement to the General Liability policy, does not include Hired Car, and shares the limits, deductibles and other conditions of the general liability policy. This coverage is not intended to cover livery operations by the insured, whether a fee is charged or not, and therefore excludes bodily injury to passengers of any insured non-owned autos.

Tax ID/SSN: _____

1. How many employees drive their personal auto in connection with your business: _____
   How many of these are part-time employees? 15-25 hrs wk _____ Under 15 hrs wk _____

   If persons other than employees use their personal auto in connection with your business, please describe and give number: _____

   _____

   None _____

2. What are the ages of the drivers? ☐18-25 ☐25-35 ☐35-45 ☐45-5 ☐55-65 ☐Over 65

3. Does applicant check all driver's MVRs? Yes ☐ No ☐

4. Does applicant require minimum limits of at least 100/300 BI - 50 PD? Yes ☐ No ☐
   Please attach evidence of each driver's auto insurance showing the limits carried.

5. Does applicant require employees or others to provide transportation for patients/clients in their personal auto? Yes ☐ No ☐

6. Does applicant have owned, leased, or hired autos used in business? Yes ☐ No ☐
   Insurance coverage: Carrier: _____
   Limit: _____ Effective Date: _____

7. Have any auto claims been made or occurrences reported during the past five years? Yes ☐ No ☐
   If yes, describe, indicate open/closed status, and amounts paid or reserved:

   _____

   _____

   _____

_____ _____

Date Applicant/Title

Send submissions to: mcsubmission@proassurance.com

Two RIverway, Suite 750, Houston, TX 77056 • ProAssuranceMidContinent.com