

Professional Liability Application for Allied and Miscellaneous Services

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC



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 (including DBAs): _____

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 Entity is: Individual Corporation Partnership Professional Association/Corporation
 Other; Describe: _____

1.9 Entity is: For Profit Non-Profit
Describe Source of Funds: _____

1.10 If an individual, what is your profession? _____ as Employee Student
How many years have you been practicing? _____
In which branch of profession do you specialize? _____

1.11 Name, address and type of operation of employer, or school, if student: _____

Is your employer/employment by or through a registry or temporary employment?
Agency? Yes No Yes No

1.12 Proposed Effective Date: _____

1.13 Requested Limits of Liability (if available): \$ _____ /\$ _____
Professional Liability \$ _____ Each Occurrence
General Liability \$ _____ General Aggregate

1.14 Annual Gross Receipts: Estimated Next Twelve Months \$ _____
Last Twelve Months \$ _____

1.15 Total premises square footage occupied by applicant: _____

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1.16 List applicant entity's memberships in professional organizations: _____

1.17 Is the applicant eligible for certification or accreditation? Yes No
If yes, is applicant certified and/or accredited? Yes No
If no, explain the reason: _____

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

2.4 Breakdown of patient services:

____ % AIDS	____ % Alcoholic	____ % Bariatric
____ % Communicable	____ % Dental	____ % Disability
____ % Drug Addiction	____ % Emergency Medical	____ % Family Planning
____ % General Exams	____ % Gynecological	____ % Hemodialysis
____ % Holistic Medicine	____ % Major Surgery	____ % Minor Surgery
____ % Nutritional (Diet)	____ % Obstetric	____ % Occupational Medical
____ % Optometry/Ophthalmology	____ % Orthopedic	____ % Pediatric
____ % Psychiatric	____ % Rehabilitative Therapy	____ % Research/Experimental
____ % Stress Testing	____ % Substance Abuse	____ % Other; Describe: _____

2.5 Are any of the following performed?

Administer anesthesia (general or local)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Catheterization	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnostic tests	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
X-Rays	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reduction of Fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shock Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prescribe medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetric procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

2.6 Total number of all staff: _____

Total payroll or remuneration paid last year (E&C): \$ _____

Estimated payroll or remuneration next year (E&C): \$ _____

If you contract for services of any outside health care staff, break down total estimated annual payments to contractors by professional category: _____

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- 2.7 Do you desire coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)? Yes No
 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? Yes No
 If yes, indicate minimum limits required: _____
- b) employed 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? Yes No
 If yes, indicate minimum limits required: _____

2.8 Number of Professional Staff: E = Employed; C = Contracted
 Show total number of hours of client service provided by all categories of staff: _____

<u>E</u>	<u>C</u>	Annual Hours	<u>E</u>	<u>C</u>
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> EEG or EKG Operators
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Electrologists
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Hearing Aid Fitters
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Inhalation/Respiratory Therapists
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Laboratory Technicians
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> LPNs
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Medical Technicians
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Physio/Physical Therapists
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Podiatrists
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Prosthetic Device Fitters
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Psychologists/Psychotherapists
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> RNs
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Social Workers
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Speech Therapists
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> X-Ray or Radiologist Techs
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> X-Ray or Radiologist Therapists
<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/> Other; Describe: _____

*Attach list and indicate specialty.

2.9 Give name of Administrator/Supervisor and describe his/her training and experience: _____

2.10 Do you sell any products? Yes No
 If yes, describe and indicate estimated annual sales for each: _____

2.11 Do you rent or otherwise provide any equipment or products to others? Yes No
 If yes, describe and indicate estimated annual sales for each: _____

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

2.13 Does the applicant maintain any beds for overnight occupancy? Yes No
 If yes, indicate the number _____, type _____ and the number of patient days the last 12 months _____.

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- 2.14 Do you provide any of the following services:
- | | | |
|--|------------------------------|-----------------------------|
| A) Blood Bank/Plasma Centers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B) Cemeteries/Funeral Homes/Morticians | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C) Medical Arts Schools and Colleges | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D) Pharmacies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E) Nursing Homes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If yes, complete the appropriate supplement application.

Part III. Risk Management

- 3.1 Name, qualifications, and number or years of experience of the Medical Director:
- | Name | Title | Experience/Training | Association Membership |
|-------|-------|---------------------|------------------------|
| <hr/> | | | |
- 3.2 Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? Yes No
- 3.3 Do you conduct pre-employment screening and investigation? Yes No
- 3.4 Do you prepare job descriptions and instructional manuals for your staff?
If so, enclose a copy of each. Yes No
- 3.5 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? Yes No
- 3.6 Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? Yes No
- Explain any exceptions: _____

- 3.7 Are you equipped with an emergency 24-hour telephone call line for all of staff and patients: Yes No
- 3.8 Do you enter into any contractual agreements (other than lease of premises agreements)?
If yes, attach explanation. Yes No
- 3.9 Does the applicant advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. Yes No
- 3.10 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?
If not, are you agreeable to instituting this procedure? Yes No
 Yes No
- 3.11 Are the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. Yes No
- 3.12 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If the answer to any of 3.12 is yes, please attach a detailed explanation.**
- 3.13 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

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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	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, state none.

	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 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 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 Signature/Title

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Fitness Center/Instruction/Health Club Supplement



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. Staff - Indicate numbers for each of the following categories of staff:

	No. Employed (W-2)	No. Contracted (1099)
Self-Defense/Fitness Instructor:	_____	_____
Massage/Physical Therapy:	_____	_____
Nutritionalist/Counselor:	_____	_____
Others; Describe:	_____	_____

3. Total number of members/clients: _____

Maximum number on premises at one time? _____

4. Break down the number of members/clients by age group as follows:

_____ Under 5 years of age	_____ 18 - 30 years old
_____ 5 - 12 years old	_____ 30 - 60 years old
_____ 12 - 18 years old	_____ Over 60 years old

5. Indicate martial arts/self-defense styles instructed and check the appropriate contact types and safety equipment required.

Style Instructed	Contact				Safety Equipment				
	Full	Touch	Head	Groin	Mouth	Head	Hand	Foot	Groin

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6. Equipment/Facilities:
 (a) Indicate the number of exposures and describe all exercise units now shown:

Exposure	Number	Exposure	Number
Free Weight Equipment (pounds)	_____	Swimming Pool	_____
Machine Weight Equipment (# units)	_____	Whirlpool/Hot Tub	_____
Cardio-Vascular Equipment (# units)	_____	Sauna/Steam Bath	_____
Stretching Equipment (# units)	_____	Tennis/Racquetball Ct	_____
Kicking Bags	_____		_____
Tanning Units*	_____		_____
* Does UVB exceed 5%?			_____ Yes _____ No
(b) Are instructions and warnings posted concerning the proper use of all equipment and facilities?			_____ Yes _____ No
(c) Who inspects/maintains equipment? _____ Is this by documented schedule?			_____ Yes _____ No
(d) Are all wet areas protected with non-slip surfaces? Describe: _____			_____ Yes _____ No
(e) Do all heated elements have tamperproof thermostats in place?			_____ Yes _____ No
(f) Do all heat elements have guard rails?			_____ Yes _____ No
(g) Are wiring and electrical equipment FDA-approved and UL-listed?			_____ Yes _____ No
(h) Is any equipment loaned or rented to clients?			_____ Yes _____ No
(i) Written agreement signed?			_____ Yes _____ No

7. Describe in detail any instruction which involves the use of any weapons (other than non-functional props): _____

8. Do you travel to tournaments? _____ Yes _____ No. If yes, indicate the number of tournaments and the number of applicants, members/clients participating: _____

9. Do you sponsor or host any tournaments? (**Note:** No coverage is afforded for this activity unless specifically endorsed on your policy) _____ Yes _____ No. If yes, describe in detail including, but not limited to, where held, number of attendees, number of participants, receipts received, the "style" involved, and safety equipment required: _____

10. Do you conduct demonstrations away from your own premises? _____ Yes _____ No
 If yes, indicate the number conducted: _____, where conducted: _____,
 and the number of your members/clients participating: _____

11. Do you conduct special self-defense classes for social groups, public groups, or similar organizations?
 Yes _____ No _____ If yes, indicate
 # Classes: _____ # Students: _____ Gross Receipts: _____

Describe the groups involved, where held, and type and style of instruction provided: _____

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12. Do you sell or distribute any products or equipment? _____ Yes _____ No
 If yes, indicate:

(a) Product/Equipment	Yes	No	Receipts
Uniforms	_____	_____	_____
Food, Vitamins, Herbs	_____	_____	_____
Weapons (describe)	_____	_____	_____
Equipment (describe)	_____	_____	_____
Other: _____	_____	_____	_____
Other: _____	_____	_____	_____

(b) Do you sell any products under your own label? ___ Yes ___ No If yes, give detailed description of products, receipts from sales, who manufacturers, and their products liability coverage:

(c) Do you provide food service via:
 Restaurant service? _____ Yes _____ No Vending machines? _____ Yes _____ No

13. Do you carry an "accident" policy to cover your members/clients for injuries sustained while participating in your instruction? _____ Yes _____ No
 If yes, indicate:

Insurer	Policy #	Limit of Liability	Policy Term
_____	_____	_____	_____

Note: This coverage will be **required** in most circumstances.

14. Describe any formal training/education requirements for employees: _____

15. Is the staff required to have CPR training? _____ Yes _____ No
 First Aid? _____ Yes _____ No
 Are instructors present during all sparring? _____ Yes _____ No

16. Are Liability Release Forms** signed by members/clients? _____ Yes _____ No

17. Are Liability Release Forms** signed by the parents (both) or registered legal guardian of any minor (under 18 years of age) before being permitted to participate in any activity? _____ Yes _____ No

****Attach copies of all Liability Release forms**

18. Indicate which apply to property: _____ Sprinklered _____ Fire Alarm _____ Smoke Detectors
 _____ # Exits Clearly Marked _____ # Fire Extinguishers

19. Do you have a written incident/occurrence reporting policy and procedure? _____ Yes _____ No

 Date

 Applicant/Title

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