Professional Liability Application for Allied and Miscellaneous Services

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 (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? ☐Yes ☐No
Agency? ☐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: ______________________________

Send submissions to: mcsubmission@proassurance.com

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

2.5 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.

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: ______________________________________

____

____

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: ______________

E	C		Annual Hours	E	C	
☐	☐	Aides or Orderlies	________	☐	☐	EEG or EKG Operators
☐	☐	Audiologists	________	☐	☐	Electrologists
☐	☐	Chiropractors	________	☐	☐	Hearing Aid Fitters
☐	☐	Dentists	________	☐	☐	Inhalation/Respiratory Therapists
☐	☐	Dental Hygienists/Technicians	________	☐	☐	Laboratory Technicians
☐	☐	Dental Assistants	________	☐	☐	LPNs
☐	☐	Dietitians/Nutritionists	________	☐	☐	Medical Technicians
☐	☐	Nurse Anesthetists	________	☐	☐	Physio/Physical Therapists
☐	☐	Nurse Midwives	________	☐	☐	Podiatrists
☐	☐	Nurse Practitioners	________	☐	☐	Prosthetic Device Fitters
☐	☐	Occupational Therapists	________	☐	☐	Psychologists/Psychotherapists
☐	☐	Optometrists	________	☐	☐	RNs
☐	☐	Opticians	________	☐	☐	Social Workers
☐	☐	Paramedics or EMTs	________	☐	☐	Speech Therapists
☐	☐	Pharmacy Technicians	________	☐	☐	X-Ray or Radiologist Techs
☐	☐	Physicians or Surgeons*	________	☐	☐	X-Ray or Radiologist Therapists
☐	☐	Physician Assistants	________	☐	☐	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 _______.

2.14 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.

Part III. Risk Management

3.1 Name, qualifications, and number or years of experience of the Medical Director:

Name	Title	Experience/Training	Association Membership

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? ☐Yes ☐No
If so, enclose a copy of each.

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)? ☐Yes ☐No
If yes, attach explanation.

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? ☐Yes ☐No
If not, are you agreeable to instituting this procedure? ☐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? ☐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 3.12 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

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	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, state none.

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 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

Optometrists, Opticians, Optical Goods Stores Supplement

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC

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. Requested Coverages:
   ______________ Optometrist Only*
   ______________ Opticians & Optical Goods Store Only*
   ______________ Both of the Above
   ______________ Other; Describe: ______________

   *Entities that have Optometrist and Optician/Optical Goods are to be insured as "Both," unless specifically requested as separate and accompanied by evidence of equal insurance for the portion of the operation for which insurance is not requested. The professional liability coverage for Opticians is always insured under the general liability policy for the Optical Goods Store.

3. (a) Annual Gross Receipts: (estimate next 12 months)
   From Optometry Services: $______________
   From Optical Goods Sales: $______________
   Other; Describe: $______________
   Total: $______________

   (b) Total Gross Receipts (previous 12 months): $______________

4. Applicant is licensed, registered, or certified as: ______________

5. Do you manufacture (or grind) lenses, eyeglasses, optical goods, or any other products? ❒ Yes ❒ No
   If yes, receipts? $______________

6. Are you a direct importer (from a foreign country) of any optical goods or any other products? ❒ Yes ❒ No
   If yes, please complete Products Supplement.

7. Do you sell products other than eyeglasses, lenses, and related materials (e.g., binoculars, microscopes, cameras, or jewelry)? ❒ Yes ❒ No
   If yes, describe and complete Products Supplement.
   ____

8. Indicate the number (by type) of staff including owners, employees, associates, and independent contractors.
   ______ Optometrists ______ Clerical/Office/Receptionists
   ______ Opticians ______ Other:______________

9. Estimated Patient Encounters:

	Next 12 Months:	Previous 12 Months:
	______ Optometrists	______ Optometrists
	______ Opticians	______ Opticians

10. Does applicant provide professional services or conduct business operations away from applicant's professional offices? ❐ Yes ❐ No
    If yes, describe and indicate percentage of overall operations associated therewith: ________________
    ____

11. Does the applicant perform any "medical acts" or use or administer any pharmaceutical agents under a "standing delegation order" of a physician? ❐ Yes ❐ No
    If yes, a) Describe all such acts and agents: ________________________________
    ____
    ____
    ____
    ____
    ____
    ____
    b) Enclose a copy of the standing delegation order.
    c) Enter approximate percentage of patient encounters wherein such acts or agents are administered. ________________________________

______________________ ____

Date Applicant/Title

Medical Products Sales or Equipment Rental Supplemental Application

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC

Tax ID/SSN: ____

A. List each product or equipment line individually and provide receipts for each. Attach a copy of your products/equipment brochures.

Describe Product/Equipment Line	Annual Receipts From Rental	Annual Receipts From Sales
1.________________________	________	________
2.________________________	________	________
3.________________________	________	________
4.________________________	________	________
5.________________________	________	________

B. Describe clients applicant sells/rents to, and % each:

_____% Individuals using products in their home
_____% Individuals in nursing homes*
_____% Nursing homes or similar residential facilities*
_____% Hospitals*
_____% Clinics/labs*
_____% Physicians*
_____% Other*; Describe ______________________________________

* If other than individuals in their home, is there a financial/ownership relationship between applicant and client or facility? ☐ Yes ☐ No If Yes, explain: ______________________________

C. Who does the servicing and repair of the products? ______________________________

Who does the servicing and repair of rental equipment? ______________________________

D. Are any products manufactured by others and sold under your entity's label? ☐ Yes ☐ No

If yes, which products? ______________________________

E. Are any additional products planned in the next twelve months? ☐ Yes ☐ No

If yes, include them under question A, and estimate the receipts in the next 12 months.

F. How are products marketed? (attach ad copy or brochures) ______________________________

____

G. Is a rental/lease agreement signed by customers prior to releasing any rental equipment?☐ ☐ Yes ☐ No
If yes, please enclose a copy of the rental agreement.

H. Is formal written inspection program for rental equipment conducted prior to each rental? ☐ Yes ☐ No

I. Are manufacturer's labels/directions/instructions provided to customers for all rentals? ☐ Yes ☐ No

J. Do the manufacturers or distributors of any of the above listed items:

1) Name your entity as an additional insured under their products liability policies? ☐ Yes ☐ No
2) Provide Certificates of Insurance for Products Liability to you? ☐ Yes ☐ No
3) Provide maintenance/service agreements for their product(s)? ☐ Yes ☐ No
4) Hold you harmless for loss arising from their products? ☐ Yes ☐ No

If the answer is yes for some products, please specify which product line and which answers: ______________

____

K. Are all manufacturers/suppliers well-known U.S. firms? ☐ Yes ☐ No If no, give details of which are not and any foreign products: ______________________________

L. If sales of medicines or drugs are made by applicant, is a licensed pharmacist employed or contracted? ☐ Yes ☐ No

If, yes indicate number: ______ Employed (W-2) ______ Contracted (1099)

Does pharmacist carry his/her own professional liability insurance?☐ ☐ Yes (Limits: __________) ☐ No

______________________ ______________________________________

Date Signature/Title

Send submissions to: mcsubmission@proassurance.com

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