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Professional Liability Application for Allied and Miscellaneous Services

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 (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: _____

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)?	☐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

Medical Laboratories 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. Describe fully the operations, activities, services, and professional procedures administered:
   _____
   _____

3. Attach a list by major category of all tests performed in the last annual period. Indicate percentage breakdown of all tests by type.

4. Employees:
   _____Total Number of Full-time (including all employees)
   _____Total Number of Part-time (including all employees)
   _____Number/FTE Professional Type
   _____/_____Physicians employed (other than Medical Director)*
   _____/_____Physicians contracted (attach copy of contract)*
   _____/_____Bioanalysts
   _____/_____Cytotechnicians
   _____/_____Technologist
   _____/_____Technologist-trainee
   _____/_____Other; Describe: _____
   *If any, please complete Physician's Exposure Supplement

5. Does the laboratory own or operate any mobile laboratories? ____ Yes ____ No
   If yes, indicate manufacturer and the gross receipts from each unit: _____
   _____

6. Is your facility owned by an M.D.? ____ Yes ____ No
   If yes, owner name(s) _____
   If yes, indicate annual number and % of facility total that represents the owner's patient's tests: ____ # ____ %

7. If the answer to any part of this question is yes, attach a separate sheet and provide the following details: specific tests performed, number of tests performed per year, and percentage of gross annual receipts.
   a) Are you involved in any blood banking or crossmatching? ____ Yes ____ No
   b) Are you involved in any intravenous transfusion or in the procurement of blood and/or its components? ____ Yes ____ No
   c) Are you involved in any medical, genetic, or drug research? ____ Yes ____ No
   d) Are you involved in the manufacturing, dispensing, or testing of pharmaceuticals? ____ Yes ____ No
   e) Do you manufacture and/or sell laboratory equipment or supplies? ____ Yes ____ No
   f) Do you perform any type of environmental analyses? ____ Yes ____ No
   g) Are you involved in any services open to the public (health fairs, shopping mall exhibits)? ____ Yes ____ No
   h) Do you send tests to reference labs? ____ Yes ____ No
      If yes, please state % of receipts: _____
      Reference lab name: _____
      Location: _____

8. Does your staff perform arterial sticks? ____ Yes ____ No
   If yes, who performs? _____
   _____
   If yes, what restrictions and precautions are utilized? _____
   _____

9. Does your staff perform Pap smears? ____ Yes ____ No
   If yes, who performs the test?_____
   If yes, who reads and interprets the results? _____

10. Does the applicant provide drug screening for any entity? ____ Yes ____ No
    If yes, please attach copies of all applicable contract types and a copy of the applicant's policy on confidentiality.

11. Does the applicant perform HIV testing? ____ Yes ____ No
    If yes, please attach consent/disclosure form, copies of any contracts, and the applicant's policy on confidentiality.

12. Are biopsies performed by the applicant? ____ Yes ____ No
    If yes, specify type and number: _____

13. Does applicant prepare any immunological, pharmaceutical, or similar agents? ____ Yes ____ No
    If yes, describe: _____

14. Does your facility manufacture or distribute any "test kits" used by others, including any "home test kits"? ____ Yes ____ No
    If yes, describe in detail each type of kit, indicate gross receipts for each type of kit, and specify which kits your facility manufactures: _____
    _____

15. Are test results interpreted or diagnosed by applicant? ____ Yes ____ No
    If yes, who diagnoses/interprets? _____

16. Are diagnoses made by any non-physician members of your staff? ____ Yes ____ No
    If yes, please provide, on a separate sheet, their qualifications and who else reviews the diagnoses.

17. Are any patients ever present at the laboratory premises for the purpose of testing, obtaining specimens, or any other reason? ____ Yes ____ No
    If yes, are any of the patient transfers from a health care facility? ____ Yes ____ No
    If yes, who is responsible for these patients while they are on your premises?
    ___ Your staff ___ Accompanying staff

18. Describe the occupied building fully, including: Age _____ Construction _____ No. of stories _____
    Last remodeled _____ Sprinklered: __ Fully __ Partially __ None
    Smoke Alarms _____ Fire Alarms _____

19. Does applicant provide any services under contract? ____ Yes ____ No
    If yes, attach explanation and a copy of the contract.

20. Does applicant, or any agency or association on its behalf, advertise its professional services in any manner other than a simple listing in the telephone directory? ____ Yes ____ No
    If yes, attach a copy of all advertisements.

21. Is your facility owned by, or operated in, a hospital? ____ Yes ____ No
    If yes, which hospital? _____

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

Name	Title	Experience/Training	Association Membership

23. Are your technologist graduates of medical technology programs? ____ Yes ____ No
    If not, indicate exceptions and cite qualifications: _____

24. Is your facility eligible for certification or accreditation? ____ Yes ____ No
    If yes, is applicant certified and/or accredited? ____ Yes ____ No
    If yes, by whom? _____
    If no, explain the reason: _____

25. Describe the method and frequency of internal quality assurance screens of test results: _____

26. Are random tests performed to audit false positive results? ____ Yes ____ No
    False negatives? ____ Yes ____ No
    If no, to either question, please explain the reason: _____

27. How long does your lab retain blood, tissue, other specimens for future reference? _____

28. What professional organization's standards are followed by your lab? _____

29. How frequently are reagents checked? _____

30. Who calibrates the precision equipment in your facility? _____
    What is the frequency of those calibrations? _____

31. Who services and maintains the precision equipment in your facility? _____
    What is the frequency of servicing? _____

32. Are logs kept of the calibration and servicing of precision instruments? ____ Yes ____ No

33. Is your staff trained in CPR? ____ Yes ____ No

34. Describe the referral source(s) by which patients are directed to the entity.

_____ _____

Date Applicant/Title

Drug and Substance Abuse Testing Supplemental

PROASSURANCE MID-CONTINENT UNDERWRITERS, INC

PROASSURANCE Treated Fairly

Tax ID/SSN: _____

1. Type specimens taken/tested:
   ☐ Urine ☐ Blood
   ☐ Other; Describe:_____

2. Who does testing?
   _____ Insured's own laboratory/staff
   _____ Laboratory insured contracts with for this service (include copy of contract and confirmation that lab carries own insurance and at what limits, provide example of letterhead that results are sent out on)
   _____ Independent laboratories chosen by others (describe who selects lab facility, include copy of any contracts between the parties, confirm lab's own insurance and limits, and confirm letterhead that results are sent out on)

3. Describe exactly who reads and interprets the test results:_____

4. Describe the "protocols" in place to prevent reporting of "false positive" results:

   _____

5. Describe the "policy" regarding "confidentiality" of reports and records:

   _____

6. In the past year:
   (a) How many positive test results? _____
   (b) How many employees:
      (1) treated? _____
      (2) counseled? _____
      (3) terminated from employment? _____

7. Is portable equipment used in any on-site testing operations? Describe fully the equipment including its exact use, who manufactures, any lease involving use of same, and brochures (if available).

   _____

   _____

8. Enclose copies of contracts between Insured and Client companies.

_____ _____

Date Applicant/Title