



Coverage provided by

LANDMARK INSURANCE COMPANY

WILMINGTON, DELAWARE

ADMINISTRATIVE OFFICES: 100 SUMMER STREET, BOSTON, MA 02110-2103
(A Capital Stock Insurance Company)

**APPLICATION FOR HEALTHCARE CLINIC PROFESSIONAL &
COMMERCIAL GENERAL LIABILITY INSURANCE**

NOTICE: THIS IS AN APPLICATION FOR A POLICY THAT MAY BE OCCURRENCE OR CLAIMS MADE. EXCEPT TO SUCH EXTENT AS MAY OTHERWISE BE PROVIDED THEREIN, THE COVERAGE OF A CLAIMS MADE POLICY IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST YOU AND REPORTED IN WRITING TO US DURING THE POLICY PERIOD. PLEASE READ THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR INSURANCE AGENT OR BROKER.

Please review this application carefully and discuss it with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

INSTRUCTIONS

- 1) Please **type or print** clearly.
- 2) Answer **ALL** questions completely, leaving no blanks (use "N/A" if Not Applicable).
- 3) If you need more space for your responses, continue on a separate sheet of company letterhead and indicate question number.
- 4) This application must be completed, dated and signed by a principal of your facility.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED

LOSS HISTORY – Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.

If you have no claims, initial here: _____

Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? Yes No If yes, give dates, allegations and disposition of each claim or suit on a sheet with company letterhead.

Has the facility ever had any Insurance Company or Lloyd's Syndicate decline, cancel, refuse to renew or accept only on special terms any Professional Liability or General Liability Insurance?

NOTE: MISSOURI APPLICANTS DO NOT RESPOND Yes No If yes, please provide explanation on a sheet with company letterhead.

Copies of most recent accreditation and inspection reports within the past three years

Copies of current audited financial statement

Copies of any contracts for professional services provided to your facility or by your facility

I. GENERAL INFORMATION **New Applicant** **Renewal Applicant**

Applicant's Facility Name: _____

Total		

2. Professional Employees/Independent Contractors. Please provide information requested for each physician providing services at your facility.

Medical Director* Name	Specialty	Insurance Carrier & Policy Number	Employee or Contractor ?	Hours/Month
Other Physicians* Names	Specialty	Insurance Carrier & Policy Number	Employee/ Contractor	Hours/Month

***A PHYSICIAN WILL ONLY BE COVERED IN HIS/HER CAPACITY AS A MEDICAL DIRECTOR FOR ACTIVITIES RELATING TO ADMINISTRATION OF THE FACILITY.**

NOTE: If any physician is to be provided coverage under this policy, a supplemental application must be completed and an additional charge will be applied

3. Other Health Care Professionals. Indicate the number in each category, full-time and part-time

	Employees Full Time – Part Time	Contractors Full Time – Part Time	Volunteers Full Time – Part Time
Dentists			
Emergency Medical Technicians			
Nurse Midwives			
Nurse Practitioners/Clinicians			
Occupational Therapists			
Physical Therapists			
Physician Assistants			
Psychologists			
RNs/LPNs/LVNs			
Social Workers			

Technicians			
Other (define)			

4. Is the facility a member of any professional organizations or associations? Yes No
 If yes, please name: _____

5. Is the facility accredited by any governmental body or other quality/patient safety organization?
 (The Joint Commission, AAAHC, etc)? (list): _____ Yes No
 No Accreditation available
 Accreditation available, facility not accredited
 If yes, please describe **and include a copy of the accreditation report.** _____

6. Do you have written requirements that all clinical staff carries Professional Liability Insurance? Yes No
 Please indicate the limits required. _____

III. RISK MANAGEMENT/LOSS CONTROL

1. Does your facility have a formalized Risk Management Program? Yes No

2. Who coordinates your Risk Management Program?
 Name: _____ Title: _____

3. Does the facility own any biomedical or other equipment used for diagnosis, monitoring or treatment purpose? Yes No

a. If yes, who is responsible for inspection and maintenance of the equipment?
 Employees Independent Contractor

b. Do qualified personnel inspect and maintain the equipment on a regular basis? Yes No

c. Are manufacturers recommendations followed for all maintenance and repair of equipment? Yes No

4. Do you have any contractual agreements with independent contractors who provide services at your facility? Yes No

If yes, please provide a copy of a sample contract.

a. Are certificates of insurance obtained from all contracted providers? Yes No

5. Does the facility provide service to others on a contractual agreement? Yes No

If yes, please describe services provided **and include a copy of the contract.** _____

6. Has the facility agreed to hold harmless or indemnify others under contract? Yes No

If yes, please describe **and include a copy of the contract.** _____

7. Does the facility rent or lease any biomedical or other equipment? Yes No

If yes, please describe: _____

8. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:

- Check of educational background, or residency program, when applicable.
- Check of previous employers In writing By telephone
- Check of personal references In writing By telephone
- Check on hospital privileges for physicians and dentists

How often do you update your list of specific privileges? _____

- Verify pending license suspensions or revocations, or pending disciplinary actions by other facilities.
- Require information on any professional liability or work-related claim that has previously been made against any individual.

9. Does your facility have written job descriptions? Yes No

IV. COMMERCIAL GENERAL LIABILITY INFORMATION

1. Please provide physical plant information as requested:

Address/Occupancy	Square Footage	Age	Type of Construction	# of Floors	Type of Fire Protection*
Patient Care Buildings					
Other Buildings					

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

2. Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

3. Do you sell or lease any medical equipment or products to patients or others in connection with your operation? Yes No

If yes, please complete the following information:

Total Annual Sales: \$ _____

Total Annual Lease/Rental Receipts: \$ _____

Category I. EXPENDABLE ITEMS – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)

Annual Sales: \$ _____

Category II. NON-EXPENDABLE ITEMS – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc. and prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.

Annual Sales: \$ _____ Annual Lease/Rental Receipts: \$ _____

Category III. DIGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.

Annual Sales: \$ _____ Annual Lease/Rental Receipts: \$ _____

Category IV. LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDA monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.

Annual Sales: \$ _____ Annual Lease/Rental Receipts: \$ _____

4. Have any of the products that you distribute ever been recalled? Yes No
5. Do you provide preventive maintenance or repairs on medical equipment leased to others? Yes No
If yes, please provide details: _____

V. POLICY INFORMATION

Please provide past policy information as requested. List all Commercial General Liability and Professional Liability policies for each of the past five years. Begin with the current policies on the top line. If claims-made, indicate retroactive date.

	Policy Period	Insurer	Policy Limits	Deductibles	Total Premium	CM or Occ
Commercial General Liability Professional Liability						
Commercial General Liability Professional Liability						
Commercial General Liability Professional liability						
Commercial General Liability Professional Liability						
Commercial General Liability Professional Liability						

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL

CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Applicant's Signature: _____
(MUST BE OFFICER OR PRINCIPAL OF BUSINESS)

Title: _____ Date: _____

Name of Agent: _____ Submitted by: _____

Date: _____ Address: _____

License #: _____