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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

Diagnostic Imaging Services 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. Number of estimated patient visits next twelve months:_____ last twelve months:_____

3. Describe fully the operations, activities, services, and professional procedures administered:

   _____

   _____

4. Staff: _____ Number of Full-time _____ Number Professionals** _____ Number W-2
   _____ Number of Part-time _____ Number Non-Professional _____ Number 1099

   **Complete Below for Professional Staff (W-2 and Ind. Contr. 1099)

   Number/FTE
   ____/____ Physician-employed (other than Medical Director)*
   ____/____ Physician-contract (attach copy of contract)*
   ____/____ X-Ray Technician
   ____/____ Technician Trainee
   ____/____ Other; Describe:_____
   ____/____ Other; Describe:_____

   * If any, please complete Physician's Exposure Supplement.

5. Is your facility owned by an M.D.? ☐ Yes ☐ No If yes, owner's name(s):_____
   If yes, indicate % of total services the owner's patient's tests represent:_____%

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

7. Number of estimated patient visits next twelve months:_____ last twelve months:_____

8. Does your facility participate in any clinical trials or experimental procedures, equipment, or product testing? ☐ Yes ☐ No
   If yes, attach separate sheet describing the facility's involvement and a copy of the protocol and any contracts involving same.

9. Does your facility own or operate any mobile diagnostic/imaging units? ☐ Yes ☐ No
   If yes, indicate the manufacturer/uses/sites used and the gross receipts from each unit:_____

   _____

10. Indicate which of the following devices are utilized by your facility:
    ☐ CT Scanner ☐ PET Scanner ☐ SPECT ☐ Ultrasound
    ☐ MRI ☐ MRI with ESR (Other)_____
    ☐ Fluoroscope ☐ X-Ray (Other)_____

11. Is cardiac catheterization performed at your facility? ☐ Yes ☐ No
    If yes, specify (a) what equipment is utilized: _____
    (b) who provides the cardiac monitoring: _____
    (c) staffing of the catheterization lab and their qualifications: _____
    (d) are your catheterization staff members ACLS trained? ☐ Yes ☐ No
    (e) describe the protocol for treating medication reactions: _____
    (f) list equipment/meds ready for handling of life-threatening situations: _____

12. Are therapeutic procedures performed in your facility? ☐ Yes ☐ No
    If yes, indicate:
    (a) whether each procedure is performed by a qualified M.D., or who performs the procedure?_____
    _____
    (b) who prescribes and sets dosage, and supervises the administration of the procedure? _____
    _____
    (c) who calibrates, and what is the frequency of calibration, for the equipment utilized in the procedure?
    _____

13. Does your staff **inject** any solutions, medications, contrast media into any patients? ☐ Yes ☐ No
    If yes, fully describe each substance and its usage, its storage, and the number of dosages annually of each:
    _____

14. Is a physician present to administer/supervise the injection of such substances? ☐ Yes ☐ No

15. Describe the protocol for treating adverse reactions: _____
    _____

16. Describe the occupied building fully, including: _____ Own _____ Lease _____ Rent
    _____Construction _____Age of Bldg _____Number of Stories _____Sq. Ft. Area
    _____Wiring Type/Age _____Prot. Class _____Smoke Detectors #
    _____Fire Alarm _____Central _____Local
    Sprinklered: _____Fully _____Partially _____Distance to Nearest Fire Hydrant

17. Describe in detail your facility's policy and procedures for the supervision and transfer of temporary inpatient transfers where entity is responsible for the patient while on your premises:
    _____
    _____

18. What equipment, etc. does your facility have readily available for handling life-threatening situations?
    _____

19. Are tests/film results interpreted or diagnosed by applicant? ☐ Yes ☐ No
    Are test /film results interpreted or diagnosed by third party under contract to applicant to provide said service? ☐ Yes ☐ No
    If yes, in either situation, who diagnoses/interprets?_____
    _____
    Whose letterhead is used to send interpretations/results to clients? _____
    If no, describe alternative arrangement, (e.g., statistical results only sent to client with no diagnostic interpretation or comment - client to provide own interpretation, or data sent to lab or other party of clients choosing for interpretation, etc.): _____
    _____
    _____

20. Are radiation meters worn by your professional staff? ☐ Yes ☐ No
    If yes, are regular checks for exposure made? ☐ Yes ☐ No

21. Describe the patient screening process your facility utilizes for pregnancy, pacemakers, artificial valves, etc.:

    _____

22. Does your facility require the professional staff to be trained in CPR? ☐ Yes ☐ No

23. Who performs the following in your facility?
    a. Calibration of diagnostic equipment? _____ Contractor _____ Employee
    b. Services/maintains diagnostic equipment? _____ Contractor _____ Employee

    If contractors perform either function, attach copy of contract. If employee, advise position and qualifications:

    _____

    _____

24. Have there been any equipment failures/problems resulting in injury to a patient? ☐ Yes ☐ No
    If yes, describe event(s) and steps taken to avoid recurrence: _____

    _____

25. Do you have policies and procedures in place to report all applicable problems with medical devices to the Federal Drug Administration? ☐ Yes ☐ No

26. Are logs kept of all servicing, maintenance, and calibration of precision instruments? ☐ Yes ☐ No

27. 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.

_____ _____

Date Applicant/Title