

Professional Liability Application for Allied and Miscellaneous Services

PROASSURANCE
MID-CONTINENT
UNDERWRITERS, INC



Send submissions to midcsubmis@proassurance.com.

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

- 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: _____

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: _____

- 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 _____.

- 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

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

Diagnostic Imaging Services Supplement



Note: Supplement must be dated and signed by owner, partner, officer, or administrator.

Please type or print in ink.

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