TOKIO MARINE HCC

Cyber & Professional Lines Group
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Miscellaneous Medical Professional Liability and General Liability Insurance Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.
This application for Professional Liability and General Liability Insurance is intended to be used for the preliminary evaluation of a submission. When completed in its entirety, this application will enable the Underwriter to decide whether or not to authorize the binding of insurance. Please type or print clearly and answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplemental forms/applications. "You" and "Your", as used in this application, means the Applicant.

1. GENERAL INFORMATION			
Name of Applicant			
Street Address		Phone	
City, State, Zip Code		County	
Website		Contact e-mail	
No. of Locations	**If multiple names and locations, please attach a list.**		

2. FORM OF BUSINESS/OPERATIONS

a. Applicant is a(an): ☐ Corporation ☐ Partnership ☐ Professional Association ☐ Individual
☐ For Profit ☐ Not for Profit

b. Date established:

c. Where is the Applicant registered and licensed to practice (number of states)?

d. Please specify any professional societies or associations of which you are a member:

e. If the Applicant is an entity:

(1) is the entity engaged in, owned or controlled by, or associated with, any other business?	☐ Yes ☐ No
(2) is the entity owned by any physician?	☐ Yes ☐ No
(3) is the entity owned by any hospital or are any services hospital-based?	☐ Yes ☐ No
(4) have there been any changes in ownership since the date the entity was established?	☐ Yes ☐ No

If "YES" to any of the above, please provide details on a separate page.

3. COVERAGE DESIRED

a. Proposed Effective Date:	
b. Retroactive Date:	
c. Limit(s):	
d. Deductible(s):	

4. REVENUES

a. Please describe the sources and amount of the Applicant's total revenue:

Source	Amount Last Policy Year	Estimated Amount This Policy Year
(1) Charitable Contributions	$	$
(2) Government Funding	$	$
(3) Fee for Services	$	$
(4) Product Sales (attach a list of products)	$	$
(5) Other: _____	$	$
TOTAL GROSS REVENUE:	$	$

b. For PHARMACIES, please describe the sources and amounts of total revenue:

Source	Amount Last Policy Year	Estimated Amount This Policy Year
(1) Prescription Sales	$	$
(2) Non-Prescription Sales	$	$
(3) Other: _____	$	$

c. Are all drugs dispensed by the Applicant approved by the Food and Drug Administration (FDA)? ☐ Yes ☐ No
If "NO", attach explanation.

5. PROFESSIONAL ACTIVITIES AND SPECIALTY (attach narrative description, if necessary)

CHECK ALL THAT APPLY:

- ☐ Acupuncturist/Naturopathic Medicine
- ☐ Alcohol/Drug/Psychiatric Rehabilitation
- ☐ Ambulance Services
- ☐ Ambulatory Surgery Center
- ☐ Diagnostic Imaging
- ☐ Dialysis Center
- ☐ Health/Fitness Center
- ☐ Home Healthcare Agency
- ☐ Hospice
- ☐ Medical Spa (Please complete Medical Spa Supplemental)
- ☐ Medical Testing/Laboratory
- ☐ Nurse Registry
- ☐ Optometry
- ☐ Out-Patient Medical Clinic
- ☐ Out-Patient Mental Health Clinic
- ☐ Pharmacy (Please complete Pharmacy Supplemental)
- ☐ Residential Facility
- ☐ Speech Therapy
- ☐ Other (Please specify): _____

6. PATIENT BREAKDOWN

State approximate division of Applicant's patients among:

a.	Alcoholics	%	**k.**	Obstetrical	%
b.	Counseling/Family Planning	%	**l.**	Pediatric	%
c.	Communicable Disease	%	**m.**	Prisoners	%
d.	Dental	%	**n.**	Psychiatric	%
e.	Drug Addicts	%	**o.**	Research or Experimental	%
f.	General	%	**p.**	Senile or Aged	%
g.	Hemodialysis	%	**q.**	Stress Testing	%
h.	Holistic Medicine	%	**r.**	Surgical	%
i.	Medical	%	**s.**	Tubercular	%
j.	Intellectually Disabled	%	**t.**	Other: _____	%

7. SERVICES PROVIDED BREAKDOWN

State approximate division of services being provided among the following settings:

a.	Assisted Living Facilities	%	**e.**	Nursing Homes	%
b.	Clinics	%	**f.**	Physician Offices	%
c.	ER/ICU/Labor, Delivery	%	**g.**	Private Homes	%
d.	Hospitals	%	**h.**	Other: _____	%

8. EMPLOYEES AND VOLUNTEERS

a. List the number of the Applicant's employees and volunteers in each profession below. If None, state "0" by the designated profession.

Number	Type of Profession	Number	Type of Profession
i) _____	Acupuncturist	xv) _____	Opticians
ii) _____	Counselor	xvi) _____	Optometrist
iii) _____	Chiropractor	xvii) _____	Paramedics
iv) _____	Dentist	xviii) _____	Perfusionist
v) _____	Dental Assistant	xix) _____	Pharmacist
vi) _____	EMT	xx) _____	Pharmacist Tech
vii) _____	Home Health Aide	xxi) _____	Physician Assistant
viii) _____	Inhalation Therapist	xxii) _____	Physician/Surgeon
ix) _____	Laboratory Technician	xxiii) _____	Physiotherapist
x) _____	Licensed Practical, Nurse	xxiv) _____	Psychologist
xi) _____	Massage Therapist	xxv) _____	Registered Nurse
xii) _____	Medical Director	xxvi) _____	Social Worker
xiii) _____	Nurse Anesthetist	xxvii) _____	Speech Therapist
xiv) _____	Nurse Practitioner	xxviii) _____	Other _____

b. List the number and type of independent contractors who provide professional services on behalf of the Applicant.
Use a separate sheet of paper, if necessary. If None, state "None" here: _____

c. Are all of the individuals listed **8.a.** and **8.b.** licensed in accordance with applicable state and federal regulations? **If "NO", please attach and explanations.**	☐ Yes ☐ No
d. Are all employed/contracted physicians board-certified in their specialty?	☐ Yes ☐ No
e. Do all physicians, surgeons and dentists who provide professional services on behalf of the Applicant maintain their own Medical Malpractice coverage with limits of at least $1million/$3million?	☐ Yes ☐ No
f. Are criminal background checks conducted on all employees, volunteers and independent contractors? **If "NO", attach explanation.**	☐ Yes ☐ No
g. Does the Applicant conduct pre-employment screenings and background investigations prior to hiring all employees, volunteers and independent contractors?	☐ Yes ☐ No
h. Has the Applicant or any of the individuals listed in question **8.a.** and **8.b.**: (1) ever been the subject of a disciplinary proceeding, investigation or reprimand by a governmental or administrative agency, hospital or professional association? (2) ever been convicted of a violation of any law or ordinance other than traffic offenses? (3) ever been treated for alcoholism or drug addiction? (4) ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered any such license? **If "YES" to any of the above, attach explanation.**	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
i. Does the Applicant: (1) have a written/formalized risk management/quality assurance program? (2) have a written credentialing process for all staff? (3) have written procedures for reporting all incidents? **If "NO" to any of the above, attach explanation.**	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

9. ADDITIONAL REQUIRED INFORMATION			
a. If the Applicant provides AMBULANCE/TRANSPORT SERVICES, please answer the following:			
(1) Number of Ground Ambulances		Number of Emergency Calls (per year)	
		Number of Non-Emergency Calls (per year)	
(2) Number of Air Ambulances		Number of Transport Calls (per year)	
		Number of Body Transports (per year)	
(3) Radius of Services		Is the Applicant part of a Fire Department?	☐ Yes ☐ No
b. For AMBULATORY SURGERY CENTERS, please answer the following:			
(1) Number of Surgical Procedures in the next 12 months			
(2) Percentage of procedures using general anesthesia			
c. Do you perform obstetric surgeries, bariatric surgeries or abortions?	☐ Yes ☐ No		
d. For DIALYSIS CENTERS, please answer the following:			
(1) Number of hemodialysis treatments in the next 12 months			
(2) Number of peritoneal treatments in the next 12 months			
(3) Hours of service in the next 12 months for in-home treatments			
(4) Number of stations			
e. For ALCOHOLIC/DRUG/PSYCHIATRIC REHABILITATION CENTERS, please answer the following:			
(1) Number of total licensed beds			
(2) Do you provide off-site counseling services?	☐ Yes ☐ No		
(3) Are all counselors licensed?	☐ Yes ☐ No		
(4) Number of intern counselors			
f) For HEALTH/FITNESS CENTERS, please answer the following:			
(1) Is there a pool?	☐ Yes ☐ No		
(2) Are there tanning beds?	☐ Yes ☐ No		
g) Does the Applicant perform: **(attach detailed explanation for any "YES" answers to the following.)**			
(1) any surgeries other than incision of superficial boils or suturing superficial fascia?			☐ Yes ☐ No
(2) circumcisions?			☐ Yes ☐ No
(3) dilation and curettage?			☐ Yes ☐ No
(4) insertion of temporary pacemakers?			☐ Yes ☐ No
(5) tonsillectomies and/or adenoidectomies?			☐ Yes ☐ No
(6) caesarean sections?			☐ Yes ☐ No
(7) cosmetic plastic surgery?			☐ Yes ☐ No
(8) excision of large cysts and/or I&D of deep-seated boils or carbuncles?			☐ Yes ☐ No
(9) hysterectomies?			☐ Yes ☐ No
(10) open reduction of fractures?			☐ Yes ☐ No
(11) surgery for weight reduction of patients?			☐ Yes ☐ No
(12) abortions and/or menstrual extractions? (If **"YES"**, include trimester, method and number of abortions performed per month in description.)			☐ Yes ☐ No
(13) silicone implants?			☐ Yes ☐ No
(14) sterilization procedures/			☐ Yes ☐ No

	(15) biopsies and/or endoscopies?	☐ Yes ☐ No
	(16) therapeutic optometry (implantation of prosthetic ocular devices)?	☐ Yes ☐ No
	(17) sex change operations? (If **"YES"**, please advise the number performed per year _____)	☐ Yes ☐ No
	(18) other surgery (please describe): _____	☐ Yes ☐ No
h)	Does the Applicant perform: **(attach detailed explanation for any "YES" answers to the following.)**	
	(1) acupuncture or acupuncture anesthesia?	☐ Yes ☐ No
	(2) angiography/arteriography/venography?	☐ Yes ☐ No
	(3) cardiac catheterization?	☐ Yes ☐ No
	(4) catheterization (other than cardiac, urinary or umbilical)?	☐ Yes ☐ No
	(5) closed reduction of compound fractures?	☐ Yes ☐ No
	(6) normal deliveries?	☐ Yes ☐ No
	(7) microdermabrasion?	☐ Yes ☐ No
	(8) injection of radioisotopes and/or use of irradiated substances?	☐ Yes ☐ No
	(9) IV/infusion therapy?	☐ Yes ☐ No
	(10) AIDS therapy?	☐ Yes ☐ No
	(11) radiation therapy and/or chemotherapy?	☐ Yes ☐ No
	(12) psychiatric shock therapy?	☐ Yes ☐ No
	(13) silicone injections?	☐ Yes ☐ No
	(14) spinal anesthesia (other than saddle blocks or caudals)?	☐ Yes ☐ No
	(15) botox injections?	☐ Yes ☐ No
	(16) Chelaton therapy?	☐ Yes ☐ No
	(17) DNA testing?	☐ Yes ☐ No
	(18) genetic testing?	☐ Yes ☐ No
	(19) environmental testing?	☐ Yes ☐ No
	(20) pharmaceutical testing?	☐ Yes ☐ No
	(21) testing of any weapons?	☐ Yes ☐ No
	(22) blood banking?	☐ Yes ☐ No
	(23) clinical trials or research using animal or human test subjects?	☐ Yes ☐ No
	(24) teleradiology?	☐ Yes ☐ No
	(25) telemedicine?	☐ Yes ☐ No
i)	Does the Applicant perform hospital emergency room care:	
	(1) for its own patients?	☐ Yes ☐ No
	(2) for patients of other providers?	☐ Yes ☐ No
	(3) If answer to question **9.i)**(2) above is **"YES"**, please specify: The percentage of time devoted to this work = _____% The number of hours per month devoted to this work = _____ hours	

j)	Does the Applicant prescribe or dispense weight reduction drugs? If **"YES"**, list drugs used and indicate the percentage of the Applicant's practice (1) devoted to weight reduction, (2) frequency and duration of prescriptions for weight reduction drugs and (3) quantity dispensed by the Applicant.	☐ Yes ☐ No
k)	Does the Applicant administer any methadone treatments?	☐ Yes ☐ No
l)	Is anesthesia (other than topical or by means of local infiltration) administered by either the Applicant or others working on behalf of the Applicant? **If "YES", attach detailed explanation.**	☐ Yes ☐ No
m)	Does the Applicant maintain any beds for overnight occupancy? **If "YES", provide number of licensed beds by location:**	☐ Yes ☐ No
n)	State number of x-ray machines owned or operated by the Applicant and indicate whether they are used for diagnosis or treatment or both: State by whom treatment is given and number of procedures:	
o)	Does the Applicant own (wholly or in part), operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? **If "YES", provide details, including name, location, size and number of beds:**	☐ Yes ☐ No
p)	Does the Applicant sell or lease any equipment for use by any other persons or entities? **If "YES", provide details, including name, location, size and number of beds:**	☐ Yes ☐ No
r)	Number of estimated patient encounters and patient tests in the next 12 months (**Note: "patient encounters" refers to number of visits; not number of patients**):: Patient encounters: _____ Patient tests: _____	

10. INSURANCE

a. Please describe the Applicant's Professional Liability coverage for the last five (5) years:

Insurance Carrier	Limit	Deductible	Premium	Policy Period

If the expiring Professional Liability policy is claims-made, what is the retroactive date? _____

b. Has any insurer cancelled or refused to renew any similar insurance during the past five (5) years? **If "YES", please explain.**	☐ Yes ☐ No
c. Is the Applicant currently insured under a Commercial General Liability Policy? **If "YES", please provide details:**	☐ Yes ☐ No

Insurance Carrier	Limit	Deductible	Claims-Made or Occurrence	Premium	Policy Period

d. Has any application for Professional Liability or General Liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, or has such insurance ever been cancelled, non-renewed or accepted only on special terms? **If "YES", please provide details on a separate page.**	☐ Yes ☐ N

11. LOSS HISTORY

If the answer to any question in 11.a. through 11.b. below is "YES", please complete a Claim Supplemental Form for each claim, allegation or incident, and submit a currently valued loss runs for the past five (5) years.

a. In the past five (5) years, has any claim been made, or legal action been brought, against you, any of your current or former officers, directors, owners, partners or employees, or any other person or entity proposed for this insurance?	☐ Yes ☐ No
b. Are you or any other person or entity proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in any professional liability or general liability claim(s) being made against any person or entity proposed for this insurance?	☐ Yes ☐ No

NOTICE TO APPLICANT

The insurance for which you are applying will not respond to incidents about which any person proposed for coverage had knowledge prior to the effective date of the policy, nor will coverage apply to any claim or circumstance identified or that should have been identified in question 11. of this application.

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 CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by claim expenses and, in such event, the Insurer shall not be liable for claim expenses or any judgment or settlement that exceed the limit of liability.

I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact, and that I agree that this application shall be the basis of the contract with the Underwriters.

CERTIFICATION AND SIGNATURE

The Applicant has read the foregoing and understands that completion of this application does not bind the Underwriter or the Broker to provide coverage. It is agreed, however, that this application is complete and correct to the best of the Applicant's knowledge and belief, and that all particulars which may have a bearing upon acceptability as a Professional Liability and General Liability Insurance risk have been revealed.

It is understood that this application shall form the basis of the contract should the Underwriter approve coverage and should the Applicant be satisfied with the Underwriter's quotation. It is further agreed that, if in the time between submission of this application and the requested date for coverage to be effective, the Applicant becomes aware of any information which would change the answers furnished in response to any question of this application, such information shall be revealed immediately in writing to the Underwriter.

This application shall be deemed attached to and form a part of the Policy should coverage be bound.

Must be signed by an officer of the company.

Print or Type Applicant's Name	Title of Applicant
Signature of Applicant	Date Signed by Applicant

Please submit completed applications to submissions@cidinsurance.com
Attn: Lexi Johnson
Any questions, please call (800) 922-7283
or fax to (619) 593-2008