**MISCELLANEOUS HEALTHCARE GENERAL LIABILITY AND PROFESSIONAL LIABILITY APPLICATION—CLAIMS MADE AND REPORTED BASIS**

**Please email this completed application to the IGP Specialty underwriter you are working with.**
For contact information, please visit our Healthcare Program webpage.

Desired effective date: _____

1. Complete name of facility: _____
   Address: _____
   City: _____ State: _____ County: _____ ZIP: _____
   Contact Name: _____ Title: _____
   Contact Email Address: _____ Phone: _____
   Website URL: _____
   List all other locations:

2. Applicant is:
   a. ☐ Individual ☐ Partnership ☐ Corporation ☐ Professional Association ☐ Other: _____
   b. ☐ Not-for-Profit ☐ For-Profit ☐ Both
3. Date established: _____
4. List all states in which you are licensed to practice:
5. Current accreditations or associations: ☐ NAHC ☐ TAHC ☐ JCAHO ☐ CHAP ☐ NHPCO ☐ Other: _____
6. Is the firm engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No
   **If yes,** please explain:
7. Are any services provided outside of the United States? ☐ Yes ☐ No
   **If yes,** explain; include countries, types of services provided, and percentages of revenues are derived from these services:
8. Do you provide any internet services? ☐ Yes ☐ No
   **If yes,** please describe, including confirmation of licensing in all states in which services are provided:
9. Does the applicant anticipate any facility expansions within the next year? ☐ Yes ☐ No
   **If yes,** please describe:

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10. Does the applicant own (wholly or in part), operate or administer any other business or other institution in which medical services are customarily rendered? ☐ Yes ☐ No

    **If yes,** give details:

11. Hold Harmless (Indemnification) Agreements:
    a. **In favor of the applicant:** If the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained:

    b. **In favor of others:** Has the applicant agreed to indemnity (hold harmless) others under written contract? ☐ Yes ☐ No
    **If yes, please submit a copy of the agreement.**

12. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule? ☐ Yes ☐ No
    **If yes:**
    a. Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ☐ Yes ☐ No
    b. Name and title of the Applicant's Privacy Officer: _____

13. Professional Activities and Specialty (check one):

☐ Adult Day Care
☐ Ambulatory Surgery Center
☐ Chiropractor
☐ Clinic
☐ Counselor (describe): _____
☐ Dental Hygienist
☐ Group Home
☐ Hearing Aid Fitter
☐ Home Health Care Agency
☐ Hospice
☐ Laboratory Technician
☐ Medical Staffing Agency
☐ Mental Health Center
☐ MRI Center
☐ Pharmacist
Nurse: ☐ Anesthetist ☐ LPN ☐ RN
☐ Optician or ☐ Optometrist
☐ Paramedics or ☐ EMT
☐ Perfusionist
☐ Personal Care Home
☐ Psychologist
Therapist: ☐ Inhalation ☐ Occupational ☐ Physical ☐ Speech
☐ Training School
☐ Veterinarian
X-ray: ☐ Lab ☐ Technician
☐ Other (specify): _____

14. Is there a swimming pool on premises that you own or occupy? ☐ Yes ☐ No

15. Number of patient encounters and/or patient tests carried out (patient encounters refer to number of visits, **not** number of patients):

| Type of Encounters | Number for Last 12 Months | Estimated Number for Next 12 Months |
|---|---|---|
| Patient Encounters | $ | $ |
| Patient Tests | $ | $ |

Percentage of services provided involving minors (persons under age 18): _____ %

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16. State sources and amounts of actual and projected gross revenue:

| Source | Amount this Fiscal Year | Amount Next Fiscal Year |
|---|---|---|
| a. Charitable Contributions | $ | $ |
| b. Government Funding | $ | $ |
| c. Fee for Service | $ | $ |

17. Describe the type of procedures performed at or by this facility including imaging if applicable:

18. Are all personnel performing these procedures certified? ☐ Yes ☐ No
19. Percentage of professional services performed on premises: _____ % Off premises: _____ %
20. List the number and type of applicant's employees and volunteers (if none, state "none"):

| Type of Profession | Number of Employees | Type of Profession | Number of Employees |
|---|---|---|---|
| a. Acupuncturist | | k. Pharmacist | |
| b. Inhalation Therapist | | l. Physical Therapist | |
| c. Laboratory Technician | | m. Certified Physicians Assistant | |
| d. Licensed Midwife | | p. Psychologist | |
| e. Nurse Anesthetist | | o. Registered Nurse First Assist | |
| f. Nurse, Licensed Practical | | p. Social Worker | |
| g. Nurse Practitioner | | q. Speech Therapist | |
| h. Nurse, Registered | | r. Home Healthcare Aide | |
| i. Optician | | s. Other (specify): | |
| j. Optometrist | | t. Other (specify): | |

i. Are all the above individuals licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
**If no,** please explain:

ii. Does the applicant have any independent contractors? ☐ Yes ☐ No
**If yes,** list the number and type of independent contractors who provide professional services on behalf of the applicant:

iii. Is continuing education or staff development required for your employees? ☐ Yes ☐ No

iv. Name of medical director, if any: _____
Is coverage provided for the medical director under any other insurance policy? ☐ Yes ☐ No
**If yes,** please provide type of policy and name of carrier:

 

## HIRING PRACTICES

21. a. Do you conduct a criminal background check? ☐ Yes ☐ No
    b. Do you require signed applications on all prospective employees? ☐ Yes ☐ No
    c. Do you verify all professional qualifications, licenses and certifications? ☐ Yes ☐ No
    d. Do you require professional and personal references on each employee? ☐ Yes ☐ No
    e. Do you provide training and orientation for new employees? ☐ Yes ☐ No
    f. Do you verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities? ☐ Yes ☐ No
    g. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? ☐ Yes ☐ No
    h. Do you have written job descriptions? ☐ Yes ☐ No
    i. Do you require drug/alcohol screening? ☐ Yes ☐ No

## RISK MANAGEMENT/LOSS CONTROL

22. a. Is there a written, formalized Quality Assurance Program? ☐ Yes ☐ No
    b. Is there a written, formalized Risk Management Program? ☐ Yes ☐ No
    c. Do you maintain a standard system to handle a patient's complaints or suggestions? ☐ Yes ☐ No
    f. In case of an emergency, is management available 7 days a week, 24 hours a day? ☐ Yes ☐ No

## INSURANCE AND CLAIM INFORMATION

23. a. Do you currently carry Professional Liability Insurance? ☐ Yes ☐ No

**If yes,** list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

| Policy Period **FROM** MM/DD/YY | Policy Period **TO** MM/DD/YY | Insurance Company | Limit of Liability | Deductible | Policy Form: Claims Made **OR** Occurrence? | Premium |
|---|---|---|---|---|---|---|
| | | | $ | $ | | $ |
| | | | $ | $ | | $ |
| | | | $ | $ | | $ |
| | | | $ | $ | | $ |
| | | | $ | $ | | $ |

If claims made, what is the retroactive date/prior acts date on your current policy? _____

b. Do you currently carry **Commercial General Liability Insurance?** ☐ Yes ☐ No

**If yes,** list the Commercial General Liability Insurance currently carried by the firm:

| Policy Period | Carrier | Limit of Liability BI/PD | Deductible | Policy Form: Claims Made **OR** Occurrence? | Premium |
|---|---|---|---|---|---|
| | | $ | $ | | $ |

If claims made, what is the retroactive date/prior acts date on your current policy? _____

 

## CLAIMS HISTORY

24. a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.**
**IF NO PRIOR COVERAGE, COMPLETE CLAIM SUPPLEMENT.**

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No
**If yes,** provide full details.

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
☐ Yes ☐ No
**If yes,** fully describe the circumstances and follow-up action taken:

## SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 CONTAINING 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 applicable in most states:** 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

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**I/We hereby declare that the statements and particulars in this application are true and I/we agree that this application shall be the basis of the contract with the insurance company.**

Applicant signature _____ Date _____

Typed or printed name: _____ Title: _____

 

**PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:**

1. Copy of prior five (5) years currently valued company loss run
2. Copy of the declaration page of your most recent professional liability policy
3. If a start-up firm, copy of the pro forma business plan
4. Copy of any advertising brochures or advertisements
5. Copy of a sample client contract
6. Resumes/CVs for all key personnel, principals, executives, medical directors and/or administrators

Limits of Liability desired for Professional Liability:

☐ $100,000/$100,000 ☐ $250,000/$250,000 ☐ $500,000/$500,000
☐ $1,000,000/$1,000,000 ☐ $1,000,000/$2,000,000 ☐ $1,000,000/3,000,000
☐ Other: $ _____ / $ _____

Deductible desired:

☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: $ _____

MINIMUM AND MAXIMUM DEDUCTIBLES WILL BE SUBJECT TO UNDERWRITING APPROVAL.

**YOU SHOULD SECURE PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS, DENTISTS, SURGEONS AND NURSE ANESTHETISTS.**

 