

# Healthcare Facility Application Non-Hospital—New Business



PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

## 1. Introductory Information

Legal Entity Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Contact Email: \_\_\_\_\_  
Number of Years in Operation: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Hospital Fiscal Year Begins: \_\_\_\_\_  
Tax ID Number: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
Website Address: \_\_\_\_\_

## 2. Facility/Corporate Organization

Type of Entity:  Government  Non-Profit  Profit  Other: \_\_\_\_\_  
 Individual  Partnership  Corporation  Joint Venture

Type of Facility: \_\_\_\_\_

Do you have a Physician Medical Director?  Yes  No

Does the Medical Director provide any patient care as part of the Medical Director duties?  Yes  No

Please attach the following:

### A. Carrier Loss History:

- i. **Ten years** of historical professional liability (PL) and general liability (GL) losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.
- ii. Date of loss valuation must be within the past 90 days.
- iii. Loss run must include carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL), and narrative of claim.
- iv. Full details of allegations on all losses paid or outstanding in excess of \$100,000 even if greater than 10 years old.

B. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or, if accrediting agency reports are unavailable, please submit the state licensure report with recommendations and the institution's response to any contingencies.

C. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.

D. Identity of each employed physician including name, specialty, date of hire, retro date, primary PL carrier, is primary coverage occurrence or claims-made and PL limits (if applicable).

E. Identity related entities or subsidiaries to be considered for coverage on the policy including a brief explanation of their relationship to the applicant, scope of operations and their retro date on Schedule A (if historically written on claims-made basis).

F. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.

G. Copy of state license.

H. List of all stockholders and their percent of ownership and identify any medical designations held by any stockholder.

I. Copy of your facility accreditation.

**3. Current Insurance/Claim Information**

Type	Carrier or Self-Insured	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible	Premium
Primary Prof. Liability							
Primary General Liability							
Excess Prof. Liability							
Umbrella Gen. Liability							
Auto Liability							
Employers' Liability							
Helipad/Aviation							
Other:							

\*Please specify by layer if more than one Retro Date applies.

- A. Do you participate in a Patient Compensation Fund or similar type program in the state in which you operate?  Yes  No  
 If yes, what limit do you carry? \_\_\_\_\_
- B. Have any claims ever been made or suits brought against you or any of your employees in the last five years because of any alleged malpractice, error or mistake, or from any premise accident arising in any manner out of your operations?  Yes  No  
 If yes, attach a separate sheet listing date of occurrence, circumstances of claim and amount paid or amount reserved.
- C. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future?  Yes  No  
 If yes, please provide details: \_\_\_\_\_

**4. Insurance Coverage Desired**

Primary	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible
Professional Liability (PL)					
General Liability (GL)					
#Limited Pollution Liability					
<b>Excess/Umbrella:</b>					
Excess PL					
Umbrella GL					

\*Please specify by layer if more than one Retro Date applies.

#Separate Application Required – Refer to Company

Include the following as underlying coverages on the Excess/Umbrella (if applicable). Policy information must be indicated in the “Current Insurance” section above. Provide policy declaration pages for all applicable coverages.

- Auto Liability     Employers' Liability     Helipad/Aviation     Other: \_\_\_\_\_

For each Excess/Umbrella underlying line of insurance above, describe any claims in excess of \$10,000.

**5. General Exposure Data**

For requested visit classifications, complete number of annual visits and *not* number of procedures. For example, if someone came in and had more than one type lab work done, or maybe lab work and then x-ray, that would be just one visit and *not* the total number of procedures. For requested procedure classifications, provide the actual number of annual procedures.

Description	Number	Description	Number
Abortion Clinic	_____ Occupied Beds _____ Annual Visits	Medical Lab	_____ Annual Receipts
*Bariatric Surgery	_____ Ann. Procedures	Mental Health Counseling	_____ Occupied Beds _____ Annual Visits
Birthing Center	_____ Occupied Beds _____ Annual Visits	Municipal Health Department	_____ Annual Visits
Blood or Plasma Bank	_____ Ann. Donations	Ocular Lab	_____ Annual Receipts
Cardiac Rehabilitation	_____ Occupied Beds _____ Annual Visits	Oncology Cancer Center	_____ Occupied Beds - Radiation _____ Ann. Procedures - Chemotherapy _____ Ann. Procedures
College/University Health Center	_____ Occupied Beds _____ Annual Visits	Optical Establishment	_____ Annual Receipts
Community Health Center	_____ Occupied Beds _____ Annual Visits	Organ Bank-Direct Processing	_____ Annual Receipts
Crises Stabilization Center	_____ Occupied Beds _____ Annual Visits	Organ Bank-No Direct Processing	_____ Annual Receipts
Dental Lab	_____ Annual Receipts	Pathology Lab	_____ Annual Receipts
Developmental Disability Rehab.	_____ Occupied Beds _____ Annual Visits	Pharmacy	_____ Annual Receipts
Developmental Health Counseling	_____ Annual Visits	Physical/Occup./Speech Rehab.	_____ Occupied Beds _____ Annual Visits
Dialysis Center	_____ Annual Visits	Quality Control/Reference Lab	_____ Annual Receipts
Emergicenter	_____ Occupied Beds _____ Annual Visits	Substance Abuse-Counseling	_____ Occupied Beds _____ Annual Visits
Fitness Center/Health Club	_____ Annual Members _____ Ann. Gross Sales	Substance Abuse-Skilled Medical	_____ Occupied Beds _____ Annual Visits
Home Care-Durable Equipment	_____ Annual Receipts	*Surgery Center	_____ Occupied Beds _____ Ann. Procedures
Home Care-Intravenous Therapy	_____ Annual Visits	Trauma Rehab.-Skilled Medical	_____ Occupied Beds _____ Annual Visits
Home Care-Personal Care	_____ Annual Visits	Trauma Rehabilitation-Therapy	_____ Occupied Beds _____ Annual Visits
Home Care-Rehabilitation	_____ Annual Visits	Trauma Rehab.-Transitional Living	_____ Occupied Beds _____ Annual Visits
Home Care-Respiratory Therapy	_____ Annual Visits	Urgent Care	_____ Occupied Beds _____ Annual Visits
Home Care-Skilled Care	_____ Annual Visits	Weight Loss Center	_____ Occupied Beds _____ Annual Visits
Hospice Care	_____ Occupied Beds _____ Annual Visits	X-ray/Imaging Center	_____ Annual Receipts
Medical/Hosp./Surg. Equip. Rental	_____ Ann. Gross Sales		
Medical/Hosp./Surg. Equip. Sales	_____ Ann. Gross Sales		

\*Separate Application Required – Refer to Company

Are any procedures performed on persons rendered unconscious through anesthesia?  Yes  No

If *yes*, give detailed description of how anesthesia is provided, including minimum patient age and number of overnight beds on premises or affiliated. \_\_\_\_\_

**6. Personnel**

A. Physicians providing health care services at this entity:

Name	Specialty	Board Certified	Limits	C=Contracted E=Employed O=Owner	Current Insurance Carrier

Please attach additional sheets if necessary.

B. Do you require certification of Professional Liability Coverage?

Yes  No

If yes, how much? \_\_\_\_\_

Non-Physician Personnel	No. Employed	No. Contracted
Anesthesiology Assistant		
Audiologists		
*Chiropractors		
*Dentists		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
*Nurse Anesthetists - Are they supervised by an anesthesiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Nurse Midwives		
*Nurse Practitioners/Clinical Nurse Specialists		
Occupational/Physical Therapists		
Opticians		
*Optometrists		
*Oral Surgeons		
Paramedics or EMT's		
*Perfusionists		
Pharmacists		
Pharmacy Technicians		
*Physician Assistants		
Physiotherapists		
*Podiatrists		
*Psychologists/Psychotherapists		
RNs		
Social Workers		
Speech Therapists		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe):		

\*Separate Application Required – Refer to Company

**7. Premises and Operations**

- A. Are there any construction plans for the next twelve months?  Yes  No  
 If *yes*, please provide cost of project: \_\_\_\_\_
- B. Total square footage of Parking Lots or Decks: \_\_\_\_\_
- C. Total number of swimming pools: \_\_\_\_\_
- D. Total number of lakes: \_\_\_\_\_
- E. Total number of fountains: \_\_\_\_\_
- F. Does the facility have a day care center? Child:  Yes  No Adult:  Yes  No  
 Is it open to the public? Child:  Yes  No Adult:  Yes  No  
 Number enrolled in the past 12 months: Child: \_\_\_\_\_ Adult: \_\_\_\_\_
- G. Does the facility have a Fitness Center/Health Club?  Yes  No  
 Number of members enrolled in the past 12 months: \_\_\_\_\_  
 Annual Gross Sales: \_\_\_\_\_
- H. Is Limited Pollution Liability coverage desired? If *yes*, separate application required.  Yes  No
- I. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required.  Yes  No

**Fraud Warning** – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

**Consent to Conditions of Consideration of the Application for Insurance**

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

**Important:** Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Insurance Agent/Broker (if applicable):	
Agent: _____	Phone: _____
Agency: _____	Fax: _____
Address: _____	Email: _____
_____	License No.: _____
Signature: _____	_____

**Insured Entities and D/B/A's  
Schedule A**

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Entity Name:	_____		
Address:	_____ _____		
Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____ _____		
Description of all operations and activities:	_____ _____		

Please attach additional sheets if necessary.

## Fraud Warning Notices



Please read the fraud warning notice for your state.

**General Fraud Warning** – 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.

**Alabama** - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**Arkansas Fraud Warning** – Any person who knowingly presents a false or fraudulent claim for payment for 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.

**Colorado Fraud Warning** – 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 Agencies.

**District of Columbia Fraud 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.

**Florida Fraud Warning** – 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 of the third degree.

**Kansas Fraud Warning** – Any person who knowingly and with intent to defraud any insurance company or other person by presenting any written statement as part of an application for insurance, the rating of an insurance policy, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto has committed a fraudulent insurance act.

**Kentucky Fraud Warning** – 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.

**Maine Fraud Warning** - 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 denial of insurance benefits.

**Maryland Fraud Warning** – Any person who knowingly or willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Jersey Fraud Warning** – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Ohio Fraud Warning** – Any person who, with the 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.

**Oklahoma Fraud 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.

**Oregon Fraud Warning** – Any person who, with an intent to knowingly defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement or a material fact, may be guilty of insurance fraud.

**Pennsylvania Fraud Warning** – 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.

**Tennessee Fraud Warning** – 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.

**Vermont Fraud Warning** - Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Virginia Fraud Warning** – 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.

**Washington Fraud Warning** - 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.

**West Virginia Fraud Warning** - 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.