

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: _____

Instructions:

1. Please review and complete this new business application.
2. When necessary, check all boxes that apply.
3. If you need more space for your responses, continue on a separate sheet indicating question number.

2. Application Addendum

Please attach the following:

A. Carrier Loss History:

1. **Ten years** of historical PL and GL losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.
2. Date of loss valuation must be within the past 90 days.
3. 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.
4. 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 of application (if historically written on claims-made basis).

F. Copy of current risk management and quality improvement plan.

G. Recent actuarial review supporting the funding of any self-insured retention, applicable SIR Trust documents and balance of SIR Trust account.

H. Copy of current organizational chart (corporate and risk management).

I. Copy of claim management procedures.

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

- K. Copy of current PL and GL policies.
- L. For Excess/Umbrella coverages, please provide copies of underlying policy declaration pages for all applicable coverages (auto, employers' liability, etc.).
- M. If applicable, copy of underlying auto carrier's loss run for the past five years including the following information: carrier, date of loss, report date, total incurred, status (open or closed) and a narrative of claim. Date of loss valuation must be within the past 90 days.
- N. Copy of state license.

The items requested above are **mandatory** before a quotation can be provided.

3. General Information

Applicant is: (check all applicable boxes)

- | | | | |
|--|--|-------------------------------------|---|
| A. <input type="checkbox"/> Children's hospital | B. <input type="checkbox"/> Individual | C. <input type="checkbox"/> Profit | D. <input type="checkbox"/> Accredited by JCAHO |
| <input type="checkbox"/> Geriatric hospital | <input type="checkbox"/> Partnership | <input type="checkbox"/> Non-profit | <input type="checkbox"/> Licensed by state |
| <input type="checkbox"/> General hospital | <input type="checkbox"/> Corporation | <input type="checkbox"/> Charitable | <input type="checkbox"/> Medicare approved |
| <input type="checkbox"/> Psychiatric hospital | <input type="checkbox"/> Joint Venture | | <input type="checkbox"/> Member of AHA |
| <input type="checkbox"/> Rehabilitation hospital | <input type="checkbox"/> Government | | |
| <input type="checkbox"/> Teaching hospital | | | |
| <input type="checkbox"/> Women's hospital | | | |
| <input type="checkbox"/> Other: _____ | | | |

E. Teaching Hospitals:

1. Please identify the type of training program(s) offered and the number of trainees enrolled in each program in the past 12 months:

- | | | | |
|---|----------------------|---|----------------------|
| <input type="checkbox"/> Residency | # of trainees: _____ | <input type="checkbox"/> Physical Therapy | # of trainees: _____ |
| <input type="checkbox"/> Nursing | # of trainees: _____ | <input type="checkbox"/> CRNA's | # of trainees: _____ |
| <input type="checkbox"/> Physician Assistants | # of trainees: _____ | <input type="checkbox"/> Other: _____ | # of trainees: _____ |

2. The training program(s) is/are accredited by: _____

F. Accreditation (if applicable):

1. Accreditation decision:

- | | |
|--|--|
| <input type="checkbox"/> Accredited | <input type="checkbox"/> Preliminary Denial of Accreditation |
| <input type="checkbox"/> Provisional Accreditation | <input type="checkbox"/> Denial of Accreditation |
| <input type="checkbox"/> Conditional Accreditation | <input type="checkbox"/> Preliminary Accreditation |

2. Requirements for improvement? Yes No

If *yes*, please provide a list of standards scored as non-compliant: _____

3. Did the survey identify any life safety issues? Yes No

If *yes*, please explain:

4. Were partially compliant standards identified in the supplemental findings? Yes No

If *yes*, please explain:

G. Current Insurance Program:

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

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

1. Self-Insured Retention Program (if applicable): Has an independent actuarial study been completed? Yes No
2. 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? _____

H. Prior Insurance History

1. Please list all general liability and hospital professional liability policies for the past ten years.

Policy Period	Carrier	PL Limits Per Occ/Agg Primary	GL Limits Per Occ/Agg Primary	Deductible	Claims-Made or Occurrence	Premium

2. Please list all excess/umbrella policies for the past five years.

Policy Period	Insurer	Limits	Retro Date (if applicable)	Premium

I. Insurance Coverage Desired:

Primary:	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible
Professional Liability (PL)					
General Liability (GL)					
#Limited Pollution Liability					
Excess/Umbrella:					
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 Item G, “Current Insurance Program” section above. Provide policy declaration pages for all applicable coverages.

- Auto Liability
 Employers’ Liability
 Helipad/Aviation
 Other: _____

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

4. Professional Exposures

A. Other Services Provided by Insured

- | | |
|---|--|
| <input type="checkbox"/> Assisted Living Facilities (Application Required) | <input type="checkbox"/> ACO/MCO/PHO (coverage cannot be provided) |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Nuclear Medicine |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Nuclear Therapy |
| <input type="checkbox"/> Morgue | <input type="checkbox"/> Open Heart Surgery |
| <input type="checkbox"/> Schools or Professional Training Programs
(Nursing, EMT, CRNA, etc.) Provide details. | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Medical Mgmt. Services (mgmt. of non-owned entities)
(separate application required) | <input type="checkbox"/> Radiology |
| | <input type="checkbox"/> Respiratory Therapy |
| | <input type="checkbox"/> Social Services |

1. Ambulances:

- a. Is excess/umbrella coverage desired for ambulance(s)? Yes No
- b. Are ambulances used as: First Responders Patient transport Both
- c. Number of ambulances in fleet: _____
- d. Service radius: _____ miles
- e. Number of emergency runs in the past 12 months: _____

2. Blood Banks:

- a. Please identify the screening test(s) utilized by the hospital: _____
-
- b. Accredited by:
- | | |
|--|---|
| <input type="checkbox"/> American Assn. of Blood Banks | <input type="checkbox"/> College of American Pathologists |
| <input type="checkbox"/> American Blood Centers | <input type="checkbox"/> JCAHO |
| <input type="checkbox"/> American Red Cross | <input type="checkbox"/> Other: _____ |
- c. Is any blood or blood product bought or obtained from outside the U.S.? Yes No
If yes, please explain:

- d. Does the blood bank outsource its blood testing? Yes No
If *yes*, please provide details: _____
- e. Number of volunteered and paid donations in the past 12 months: _____
- f. Number of pheresis procedures in the past 12 months: _____
- g. Number of outpatient transfusions in the past 12 months: _____
- h. Number of therapeutic plasma exchanges in the past 12 months: _____
3. Day Care (Child and/or Adult):
- a. Is the day care center on the hospital premises? Child: Yes No Adult: Yes No
- b. Is the day care center open to the public? Child: Yes No Adult: Yes No
- c. Number enrolled in the past 12 months: Child: _____ Adult: _____
4. Fitness Center/Health Club:
- a. Is the facility on the hospital premises? Yes No
- b. Is the facility open to the public? Yes No
- c. Number of members enrolled in the past 12 months: _____
- d. Annual Gross Sales: _____
- e. Types of programs provided: _____
5. Skilled Nursing/Extended Care:
- a. Long term care beds are located: Within the hospital In a stand-alone facility
- b. If a stand-alone facility:
- i. Is the stand-alone facility on the hospital premises? Yes No
- ii. Does the stand-alone facility fall under the hospital's risk management? Yes No
- iii. Does the stand-alone facility follow policies established by the hospital? Yes No
6. Heliport:
- a. Does the hospital have a heliport? Yes No
If *yes*, please provide the number of landings in the past 12 months: _____
- b. Does the hospital obtain a certificate of insurance from the helicopter service? Yes No
- c. Is the hospital named as an additional insured on the helicopter service's policy? Yes No
7. Transplant:
- a. Number of tissue donations: _____ Past 12 months _____ Projected next 12 months
- b. Number of organ donations: _____ Past 12 months _____ Projected next 12 months
- c. Accredited by:
- Assn. of Organ Procurement Organization Eye Bank Assn. of America
- American Assn. of Tissue Banks Other: _____
- d. Does the hospital have a formal policy regarding the informed consent process? Yes No
- e. Has the hospital been involved in any tissue FDA recalls? Yes No
If *yes*, please explain: _____
- f. Has the hospital initiated any voluntary tissue recalls in the past 5 years? Yes No
If *yes*, please explain: _____
- g. Are any tissues procured/recovered from outside the U.S.? Yes No
If *yes*, please explain: _____
- h. Are any non-human tissues used in any way at the hospital? Yes No
If *yes*, please explain: _____
- i. Do you accept "John Doe" donors? Yes No
- j. Do you participate in a living donor program? Yes No

- k. Does the hospital place all organs through United Network for Organ Sharing? Yes No
 If *no*, do you have a protocol for ensuring compatibility? Yes No

- l. Please indicate all of the transplant operations at the hospital:
- | | | |
|--|--|---|
| <input type="checkbox"/> Eye Procurement | <input type="checkbox"/> Tissue Processing | <input type="checkbox"/> Organ Procurement Operations |
| <input type="checkbox"/> Lab Testing | <input type="checkbox"/> Tissue Procurement | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Tissue Storage | <input type="checkbox"/> Tissue Distribution | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Tissue Labeling | <input type="checkbox"/> OR for Procurement | <input type="checkbox"/> Other: _____ |

8. Please list research programs conducted:

9. Are there any new services or operations scheduled to begin during the next fiscal year? Yes No
 If *yes*, please explain:

B. Inpatient Beds:

	Annual Licensed	Occupied	Inpatient Days
General/Acute Care			
Psychiatric – Do you accept involuntary admissions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Intensive Care			
Coronary Care			
Drug & Alcohol			
Rehabilitation			
Pediatrics			
*Hospice			
*Nursing Home (coverage may not be available)			
*Extended Care			
*Assisted Living			
Maternity			
Bassinets (Standard)			
Bassinets (Staff Enhanced Electronic Fetal Monitoring Training)			
Total Hospital Beds (including Bassinets):			

*Separate Application Required – Refer to Company

Number of Annual Admissions: _____

C. **Hospital Based or Free Standing Outpatient Utilization and Services** – 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/Hosp./Surg. Equipment Rental	_____ Annual Gross Sales
*Bariatric Surgery	_____ Annual Procedures	Medical/Hosp./Surg. Equipment Sales	_____ Annual Gross Sales
Birthing Center	_____ Occupied Beds _____ Annual Visits	Medical Lab	_____ Annual Receipts
Blood or Plasma Bank	_____ Annual Donations	Mental Health Counseling	_____ Occupied Beds _____ Annual Visits
Cardiac Rehab	_____ Occupied Beds _____ Annual Visits	Municipal Health Department	_____ Annual Visits
College/University Health Center	_____ Occupied Beds _____ Annual Visits	Ocular Lab	_____ Annual Receipts
Community Health Center	_____ Occupied Beds _____ Annual Visits	Oncology Cancer Center	_____ Occupied Beds
Crises Stabilization Center	_____ Occupied Beds _____ Annual Visits	- Radiation	_____ Annual Procedures
Dental Lab	_____ Annual Receipts	- Chemotherapy	_____ Annual Procedures
Developmental Disability Rehab.	_____ Occupied Beds _____ Annual Visits	Optical Establishment	_____ Annual Receipts
Developmental Health Counseling	_____ Annual Visits	Organ Bank-Direct Processing	_____ Annual Receipts
Dialysis Center	_____ Annual Visits	Organ Bank-No Direct Processing	_____ Annual Receipts
Emergency Room (hospital)	_____ Annual Visits	Pathology Lab	_____ Annual Receipts
Emergicenter (free standing)	_____ Occupied Beds _____ Annual Visits	Pharmacy (excluding inpatient)	_____ Annual Receipts
Home Care - Durable Equipment	_____ Annual Receipts	Physical/Occupational/Speech Rehab.	_____ Occupied Beds _____ Annual Visits
Home Care - Intravenous Therapy	_____ Annual Visits	Quality Control/Reference Lab	_____ Annual Receipts
Home Care - Personal Care	_____ Annual Visits	Substance Abuse-Counseling	_____ Occupied Beds _____ Annual Visits
Home Care - Rehabilitation	_____ Annual Visits	Substance Abuse-Skilled Medical	_____ Occupied Beds _____ Annual Visits
Home Care - Respiratory Therapy	_____ Annual Visits	*Surgery Center (free standing)	_____ Occupied Beds _____ Annual Procedures
Home Care - Skilled Care	_____ Annual Visits	Trauma Rehabilitation - Skilled Medical	_____ Occupied Beds _____ Annual Visits
Hospice Care	_____ Occupied Beds _____ Annual Visits	Trauma Rehabilitation - Therapy	_____ Occupied Beds _____ Annual Visits
Hospital Clinics, Dispensaries or Infirmaries	_____ Annual Visits	Trauma Rehab. - Transitional Living	_____ Occupied Beds _____ Annual Visits
#Hospital Other Outpatient Services	_____ Annual Visits	Urgent Care (free standing)	_____ Occupied Beds _____ Annual Visits
Hospital Outpatient/One-day Surgery	_____ Annual Procedures	Weight Loss Center	_____ Occupied Beds _____ Annual Visits
Hospital Psychiatric Outpatient	_____ Annual Visits	X-ray/Imaging Center	_____ Annual Receipts

*Separate Application Required – Refer to Company

#Referred for lab, x-ray, other diagnostic test, etc.

D. Non-Physician Personnel

No. Employed

No. Contracted

	No. Employed	No. Contracted
Aids or Orderlies		
Anesthesiology Assistants		
*Chiropractors		
*Dentists		
Inhalation / Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
Nuclear Medicine Technicians		
*Nurse Anesthetists - Are they supervised by anesthesiologists? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Nurse Midwives		
*Nurse Practitioners / Clinical Nurse Specialists		
Occupational / Physical Therapists		
*Optometrists		
Paramedics or EMT's		
*Perfusionists		
Pharmacists		
*Physician Assistants		
Physiotherapists		
*Podiatrists		
*Psychologists / Psychotherapists		
RNs		
Social Workers		
*Surgical Assistants (Certified or Licensed)		
Other (describe)		

*Separate Application Required – Refer to Company

_____ Total number of all employees including professional, clerical, executive, and maintenance.

_____ Number of Leased Employees. Provide a list of positions where utilized.

E. Physicians/Medical Staff – Employed and Contracted (include Residents and Interns):

1. Are credentials of staff physicians checked and approved prior to the granting of privileges? Yes No
2. Are staff physician privileges and overall performances evaluated periodically? Yes No
3. Are there procedures in place to restrict or suspend any staff physician's privileges? Yes No
4. Has there been any requirement to notify the National Practitioners Data Bank of any suspension, peer review action or liability payment involving any member of the medical or dental staff? Yes No
If *yes*, please explain:
5. Are all privileges granted to staff physicians detailed in writing? Yes No
6. Do the hospital by-laws and/or the medical staff by-laws specify that staff physicians maintain malpractice insurance for themselves and their employees who may work in the institution? Yes No
If *yes*, what limits are required:
7. If coverage is desired for physicians, Physician Applications must be completed, returned and approved.
8. Number of Physicians with admitting privileges: _____

5. Medical Service Departments

A. Emergency Department:

1. Is the emergency department staffed and operational 24 hours a day? Yes No
If *no*, please explain:
2. Is emergency department staffed by:
 Employed physicians Contract group Rotating Staff
3. a. If under contract, name of group: _____
b. If contract group, are certificates of insurance required? Yes No
If *yes*, what minimum limits are required: _____ Per Claim _____ Aggregate
4. a. Are all physicians Board Certified or eligible in Emergency Medicine? Yes No
b. Are the emergency physicians required to respond to Cardiac/Respiratory arrests or other medical emergencies occurring in the institution? Yes No
5. Is the emergency room equipped with the following:
a. Is Emergency Resuscitation cart equipped with defibrillator? Yes No
b. Electrocardiograph machine? Yes No
c. Staffed radiology room(s)? Yes No
d. Dedicated triage area and staff? Yes No
e. Dedicated trauma room(s)? Yes No
f. Dedicated laboratory personnel? Yes No
6. Do any of the emergency department staff routinely work more than a 12-hour shift? Yes No
If *yes*, please explain:
7. Are all emergency room patients seen by a physician before discharge? Yes No

B. Anesthesiology:

1. Is anesthesiology department staffed by:
 Employed physicians Contract group Employed CRNA's Staff physicians
2. a. If under contract, name of group: _____
b. If contract group, are certificates of insurance required? Yes No
If *yes*, what minimum limits are required: _____ Per Claim _____ Aggregate
3. Are all anesthesiologists required to be Board Certified or eligible in Anesthesiology? Yes No
4. Is the anesthesia care performed by CRNA's supervised and reviewed by the anesthesiologists? Yes No
If *no*, please explain: _____
5. Do any of the anesthesia services staff routinely work more than a 12-hour shift? Yes No
If *yes*, please explain:
6. Is there an anesthesiologist or CRNA on the premises 24 hours a day? Yes No
7. Are CRNA's to be provided coverage on the hospital's policy? Yes No

C. Radiology:

1. Is radiology department staffed by:
 Employed physicians Contract group Staff physicians
2. a. If under contract, name of group: _____
b. If contract group, are certificates of insurance required? Yes No
If *yes*, what minimum limits are required: _____ Per Claim _____ Aggregate
3. Are all radiologists required to be Board Certified or eligible in Radiology and/or Nuclear Medicine? Yes No

4. Is there a radiologist on the premises 24 hours a day? Yes No
5. Are teleradiology services provided or utilized by the hospital? Yes No
If *yes*, does the radiologist hold all necessary valid licenses? Yes No

D. Obstetrics:

1. a. Is the facility a regional referral center for newborns requiring intensive care or high risk pregnancies? Yes No
b. If *no*, does a written procedure exist for transferring all high risk mothers and/or babies who the hospital is not qualified to treat? Yes No
2. How many births at your facility: (previous 12 months)? _____
3. a. How many cesarean sections: (previous 12 months)? _____
b. Are all C-sections performed by obstetricians? Yes No
If *no*, what other specialties perform C-sections: _____
c. How many vaginal births after C-section: (previous 12 months)? _____
4. Is continuous electronic fetal monitoring performed on all patients in active labor? Yes No
If *no*, please explain:
5. Do nurse midwives practice at your hospital? Yes No
6. Do you perform Water Births? Yes No

E. Surgery:

1. Indicate the total number of surgical procedures performed in the last year: _____
a. Number of inpatient surgeries: _____
b. Number of outpatient/one-day surgeries: _____
2. Does the facility have a surgical site identification procedure in place? Yes No
3. Are sponge, needle and instrument counts performed in the course of a surgical procedure? Yes No
If *yes*, at what intervals of the operation: _____
4. Are any of the following performed at your facility?
- | | | | |
|--------------------------|--|--------------------------------|--|
| Open Heart Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurosurgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Experimental Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gender Reassignment Operations | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Weight Reduction Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Laser Assisted Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |

6. Hospital Administration and Management

- A. Are operations managed by employees of the hospital? Yes No
- B. Are operations managed and operated by a contract Management Company? Yes No
1. Name of Management Company: _____
2. What operational positions are occupied by contracted Management Company employees?
3. Is the Management Company required to maintain the following policies of insurance:
- | | |
|--|--|
| a. Commercial General Liability | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Directors & Officers including Errors and Omissions | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Fiduciary & Crime | <input type="checkbox"/> Yes <input type="checkbox"/> No |

C. Hospital Corporate Organization

If coverage is to be considered for any "additional insureds" please provide a schedule of entities. Additional insureds are entities extended vicarious liability coverage subject to policy provisions, as a result of the actions of the policyholder or the actions of the policyholder's scheduled entities and subsidiaries. See Schedule A attached.

D. Risk Management

1. Who coordinates your risk management program?

Name: _____ Title: _____

Telephone number: _____

2. Is there a written risk management program that has been approved by the governing body? Yes No

3. Does the governing body review the effectiveness of the program and approve necessary changes? Yes No

4. Is the risk manager accountable and solely responsible for risk management? Yes No

If *no*, explain other responsibilities:

5. Does the risk management program include the following:

a. Occurrence reporting Yes No

b. Claim management Yes No

c. Formal link to quality management Yes No

d. Contract review and evaluation Yes No

e. Review and participation in medical staff committees Yes No

f. Safety program and safety committee Yes No

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. Other retail operations provided to the public:

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.