

# Healthcare Facility Application Non-Hospital—Renewal



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

Expiring Policy No. \_\_\_\_\_

## 1. Introductory Information

Policyholder Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Hospital Fiscal Year Begins: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Contact Email: \_\_\_\_\_

Website Address: \_\_\_\_\_

Instructions:

1. Please review and complete this renewal 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. General Information

A. Has there been a change in facility ownership or management? ☐ Yes ☐ No

If *yes*, please explain: \_\_\_\_\_

B. Provide details of any new start-up services or any services discontinued during the past fiscal year.

C. Has the facility's license been revoked, suspended or restricted during the past fiscal year? ☐ Yes ☐ No

If *yes*, please provide details: \_\_\_\_\_

D. Has any accreditation program revoked, suspended or restricted the facility's accreditation status? ☐ Yes ☐ No

If *yes*, please provide details: \_\_\_\_\_

E. Please provide a copy of the facility's latest fiscal year-end audited financial statement.

F. Please provide an updated schedule of locations and insured entities.

## 3. General Exposure Data

A. 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.

B. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

C. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

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

*\*Separate Application Required if new operation – Refer to Company*

#### 4. 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.

Do you require certification of Professional Liability Coverage?

☐ Yes ☐ No

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

B. **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

#Separate Application Required for New Personnel if not Previously Submitted

## 5. 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:	<hr/>		
Address:	<hr/>		
	<hr/>		
Tax ID No.:	<hr/>	Retroactive Date:	<hr/>
Ownership and relationship to the policyholder: <hr/>			
<hr/>			
Description of all operations and activities: <hr/>			
<hr/>			

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

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

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

Please attach additional sheets if necessary.

**Important Notice About the  
Policy of Insurance for Which  
You Have Applied**

**This Document Affects Your Legal Rights**

**Read the Following Information Carefully**

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

**Acknowledgement of Arbitration Agreement**

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

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Applicant's Signature

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Date

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Time

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Agent

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Date

---

Time

**Note:** You will need to sign this notice to be considered for coverage.