Allied Healthcare Professional and General Liability Application

Today's Date: _____ Quote by: _____

Instructions:

- Answer ALL questions completely, leaving No blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.
- This application must be completed, dated and signed by a Principal or Officer of your firm. Underwriters will rely on all statements made in this application.

Supplemental Information:

- Provide any supplemental information and reference the applicable question number.
- Brochures, literature or descriptive materials provided to clients.
- Current insurance company loss reports for the past five (5) years. Specify date, description and amount outstanding/current reserve for each claim.
- Most current annual financial statements (audited or compiled).
- Expiring DEC page

SECTION 1. APPLICANT INFORMATION	
First Named insured (Applicant Entity Name): ___	DBA Name ___
Mailing Address ___	Postal Code ___
Phone Number ___	Fax Number ___
Website: ___	Contact Name & Email Address ___
Total Number of Employees ___	Number of Years under current Ownership: ___

1. Applicant is:

☐ Individual	☐ Partnership	☐ Profit
☐ Corporation	☐ Joint Venture	☐ Non-Profit
☐ Limited Liability Co.	☐ Charitable	☐ Government

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2. Description of Operations (check all that apply):

☐ Ambulance Services*	☐ Blood/ Organ Banks	☐ Clinics
☐ Community Health Dept.	☐ Correctional Health*	☐ Dental Group
☐ Dialysis	☐ Home Health*	☐ Hospice
☐ Imaging Centers	☐ Intraop Neuromonitoring*	☐ Laboratory Services*
☐ Lithotripsy Centers	☐ Medical Staffing Services	☐ Mental Health/Counseling
☐ Nurse/Therapist Staffing*	☐ Optical Facility	☐ Palliative/ Pain Mgmt.
☐ Pharmacy incl. DME*	☐ Radiation Therapy	☐ Rehabilitation Centers*
☐ Schools	☐ Sleep Centers	☐ Substance Abuse Detox*
☐ Surgery Center*	☐ Urgent Care/ Emergicenters	☐ Weight Loss Centers

☐ Other (describe): ___

*Complete the supplemental questionnaire when this class(es) is selected

3. Is the applicant currently accredited by:

☐ Accreditation Commission for Health Care (ACHC)
☐ Community Health Accreditation Program (CHAP)
☐ The Joint Commission (JCAHO)
☐ Other: _____

4. Has your business had a change of ownership in the past 3 years? ☐ Yes ☐ No
   If Yes, please explain: ___

5. Licensed Specialty: _____
6. Licensing Agency(ies): _____

7. Are all Applicants licensed in all provinces in which it is operating? ☐ Yes ☐ No
   If No, explain: ___

8. Has the Applicant's License or Certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? ☐ Yes ☐ No
   Are any such charges pending against the Applicant? ☐ Yes ☐ No

9. Has any hospital or other healthcare entity ever denied, suspended, Non-renewed, revoked, declined or in any way restricted the Applicant's Privileges? ☐ Yes ☐ No

10. Has a professional licensing board, certification board or professional ethics board ever taken disciplinary action against the Applicant? ☐ Yes ☐ No
    Are any disciplinary actions pending? ☐ Yes ☐ No

11. Has the Applicant ever been convicted of a summary or indictable offense or is any such charge pending? ☐ Yes ☐ No

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12. Has the Applicant ever been investigated by a Provincial Health Department, Licensing Board or other Governmental Body (i.e. RCMP, Dept. of Justice)? ☐ Yes ☐ No

SECTION 2. COVERAGE REQUESTED

1. Effective Date: _____

*Coverage cannot be effective prior to the date the application is submitted.

2. ☐ Healthcare Facilities Professional Liability:

☐ Claims-Made Only Retroactive Date: _____	Limit of Liability Requested: ☐ $1,000,00 %Each Professional Incident $3,000,00 %Aggregate ☐ Other: _____
Is any Applicant currently enrolled in a Patient Compensation Fund? ☐ Yes ☐ No If Yes, in what state(s) and for what limits: State(s) - _____ Limits - $_____ Each Professional Incident $_____ Aggregate	Deductible (Each Professional Incident/Aggregate): ☐ $2,500/None ☐ $5,000/None. ☐ $10,000./None ☐ $25,000/None ☐ Other: $_____

3. ☐ General Liability:

☐ Occurrence ☐ Claims-Made If Claims-Made, Retroactive Date: ___	Limit of Liability Requested: ☐ $1,000,000/ Each Occ./ $3,000,000 Aggregate ☐ Other: $___
Deductible (Each Occurrence/Aggregate): Will be the same as specified in Professional Liability section above.	

4. ☐ Employee Benefits Liability

☐ Claims-Made Only Retroactive Date: _____ Number of employees receiving benefits: _____	Limit of Liability Requested: ☐ $1,000,000 Each Employee/ $1,000,000 Aggregate ☐ Other: $___

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5. ☐ Non-Owned Automobile Liability

Number of employees driving car for Applicant's business: _____ Employees' average number of km driven for work: _____	Limit of Liability Requested: ☐ $500,000 Per Occurrence/ $500,000 Aggregate ☐ Other: $_____

a. Are personal automobiles owned by any Applicant's employees or independent contractors used in Applicant's business? ☐ Yes ☐ No

b. Does the Applicant require all such employees and independent contractors to have auto liability insurance with limits at least equal to the province's minimum responsibility limits? ☐ Yes ☐ No

c. Does the Applicant obtain a Motor Vehicle Report (MVR) prior to an employee or independent contractor to use a personal auto for company business? ☐ Yes ☐ No

d. Does the Applicant require evidence of auto liability insurance prior to allowing an employee or independent contractor to use a personal auto on company business? ☐ Yes ☐ No

e. Does the Applicant, employees and/or independent contractors regularly transport clients? ☐ Yes ☐ No
If Yes, please explain: ___

☐

☐ _____ _____

7. ☐ Excess Liability

☐ $1,000,000 each claim/ $1,000,000 aggregate ☐ $5,000,000 each claim/$5,000,000 aggregate

☐ $10,000,000 each claim/$10,000,000 aggregate ☐ Other: $_____

8. Additional Insureds:

Please provide a list of all entities to be named as an Additional Insured(s) with complete names and insurable interest:

Name	Insurable Interest
_____	_____
_____	_____

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SECTION 3. APPLICANT'S EXPOSURES

1. Provide projected annual information for your class of business:

Class of Business	Revenue	Visits
Ambulance Services		
Clinics		
Community Health Dept.		
Correctional Health		
Hospice		
Intraoperative Neuromonitoring		
Mental Health/Counseling		
Palliative/ Pain Mgmt.		
Rehabilitation Centers		
Sleep Centers		
Substance Abuse Detox		
Surgery Center		
Urgent Care/ Emergicenters		
Weight Loss Centers		
Other (specify):		

Class of Business	Revenue
Blood/ Organ Banks	
Dental Group	
Imaging Centers	
Laboratory Services	
Lithotripsy Centers	
Optical Facility	
Pharmacy incl. DME	
Radiation Therapy	

Class of Business	Revenue	FTE's
Home Health		
Medical Staffing Services		
Schools		

Class of Business	Revenue	Beds
Group Homes		

Class of Business	Revenue	Visits	FTE's	Beds
Other (specify):				

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2. Provide historical information based on your class of business:

	3 Years Prior	2 Years Prior	1 Year Prior	Current or Expiring Year
Revenue:	$_____	$_____	$_____	$_____
Visits:	_____	_____	_____	_____
FTE's	_____	_____	_____	_____

3. Indicate all locations where the Applicant(s) provides services. (Total of all locations must equal 100%.)

☐ Applicants' Location: _____%	☐ Hospital: _____%
☐ Patients' Homes: _____%	☐ LTC/ Assisted Living Facility: _____%
☐ Clinics: _____%	☐ Prison Facilities: _____%
☐ Schools: _____%	☐ Doctor's Offices: _____%
☐ Other Locations: _____%	Describe: _____

4. Indicate the percentage of the Applicants' patients in the following age groups. (Total of all age groups must equal 100%.)

18 and younger: __%	19 to 65: __%	65 and older: __%	☐ N/A

5. If 2 or more classes are selected , provide the % of total projected annual revenues by specialized service:

__% Ambulance Services	__% Blood/ Organ Banks	__% Clinics
__% Community Health Centers	__% Correctional Health	__% Dental Group
__% Dialysis	__% Home Health	__% Hospice
__% Imaging Centers	__% Intraop. Neuromonitoring	__% Laboratory Services
__% Lithotripsy Centers	__% Medical Staffing Services	__% Mental Health/Counseling
__% Optical Facility	__% Palliative/ Pain Mgmt.	__% Pharmacy incl. DME
__% Radiation Therapy	__% Rehabilitation Centers	__% Schools
__% Sleep Centers	__% Substance Abuse Detox	__% Surgery Centers
__% Urgent Care/ Emergicenters	__% Weight Loss Centers	__% Other (specify): __

☐ Yes ☐ No

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6. Will any new services be offered in the next 12 months?
   If Yes, please describe: ___

7. Will any services be discontinued in the next 12 months? ☐ Yes ☐ No
   If Yes, please describe: ___

8. Have any services been discontinued in the last 24 months? ☐ Yes ☐ No
   If Yes, please describe: ___

9. Does the applicant provide any overnight bed facilities?? ☐ Yes ☐ No
   If Yes, number of beds: ___

10. Does the Applicant provide Pediatric Care? ☐ Yes ☐ No
    If Yes, describe types of pediatric services: ___

11. Does your facility employ a Medical Director? ☐ Yes ☐ No
    If Yes, Name: ___ Duties: ___

12. Do your medical protocols meet all local, state and federal requirements? ☐ Yes ☐ No

13. Is the applicant involved in any research activities? ☐ Yes ☐ No
    If Yes, please describe: ___

14. Description of employees or contracted personnel:

	Number of Employees (FTE's)	(Hours)	Number of IC's (FTE's)	(Hours)	Carry Their Own Insurance
Administrative Support Staff					☐ Yes ☐ No
Alcohol/Drug Counselor					☐ Yes ☐ No
Bio-Medical Technician					☐ Yes ☐ No
Cardiology Tech					☐ Yes ☐ No
Certified Lab or Clinical Lab Tech					☐ Yes ☐ No
Dental Hygienist					☐ Yes ☐ No
Dialysis Technician					☐ Yes ☐ No
Dietician					☐ Yes ☐ No
Doula					☐ Yes ☐ No
EEG Technician					☐ Yes ☐ No
EKG Technician					☐ Yes ☐ No
EMS Basic					☐ Yes ☐ No
EMS Paramedic					☐ Yes ☐ No
Home Health Aide					☐ Yes ☐ No
LPN					☐ Yes ☐ No

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Medical Assistant					☐ Yes ☐ No
Medical Social Worker					☐ Yes ☐ No
Nurse Aide					☐ Yes ☐ No
Nurse Practitioner - Adult, Family Planning, Geriatric					☐ Yes ☐ No
Nurse Practitioner - OBGYN					☐ Yes ☐ No
Nurse Practitioner -All Other					☐ Yes ☐ No
Occupational Therapist					☐ Yes ☐ No
Pharmacist					☐ Yes ☐ No
Physical Therapist					☐ Yes ☐ No
Physician Assistant					☐ Yes ☐ No
Radiation Therapist					☐ Yes ☐ No
Registered Nurse					☐ Yes ☐ No
Sitter/Companion					☐ Yes ☐ No
Sports Medicine Therapist					☐ Yes ☐ No
X-Ray/Radiology Technician					☐ Yes ☐ No
TOTAL:					

a. These independent contractors will not be Insureds and will not have coverage under the policy for which the Applicants are applying. Such independent contractors should either obtain their own insurance, or request to be endorsed onto the policy.

b. FTE means Full Time Equivalents. 1 Full Time Equivalent = 2,080 annual hours.

15. Is coverage requested for employed Physicians/Surgeons? If yes, please complete the following schedule and attach:
    - Physician's loss runs for five years
    - Evidence of provincial licensure, including any reports of regulatory violations

Physician Name	Description/ Specialty	Retroactive Date	Hire Date and Termination Date	Hrs Worked Per Week
			/	
			/	
			/	
			/	
			/	
			/	
			/	

16. Any other pertinent information about your business: _____

_____

_____

_____

SECTION 4. PREVIOUS INSURANCE

1. Professional Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability Each claim/Aggregate	Retention/Deductible Each claim/aggregate	Premium	CM/Occ.
___	___	$ / $	$___ / $___	$___	☐ CM Retro Date: ☐ Occ.
___	___	$___ / $___	$___ / $___	$___	☐ CM Retro Date: ___ ☐ Occ.
___	___	$___ / $___	$___ / $___	$___	☐ CM Retro Date: ___ ☐ Occ.

2. Date of Applicants' first Claims Made Professional Liability Policy (mm/dd/yy):

3. Has the Applicant been continuously insured under a claims made professional liability policy since this date? ☐ Yes ☐ No

4. If this application is for new Claims-Made coverage including prior acts, will all current Primary and Excess Claims-Made policies accept claims for (a) a written Notice, demand or service of suit against any Applicant, and (b) specific circumstances

reasonably likely to give rise to a written Notice, demand or service of suit against any Applicant? ☐ Yes ☐ No

SECTION 5. RISK MANAGEMENT

1. Does the Applicant utilize a formal written Quality Improvement and Risk Management Program? ☐ Yes ☐ No
   If Yes, please attach a copy of your procedures.
2. Is the overall responsibility for risk management assigned to one individual in your firm? ☐ Yes ☐ No
   If Yes, Name/Title: ___
   If No, please describe how risk management is monitored: ___
3. Does the Applicant have an informed consent process in place? ☐ Yes ☐ No
4. Does the Applicant have a formal incident reporting procedure? ☐ Yes ☐ No
5. Does the Applicant have a formalized training and education program with staff attendance required at mandatory in servicing? ☐ Yes ☐ No
6. Are patient records protected in accordance with provincial privacy related legislation (PIPEDA, PHIPA, ect.)? ☐ Yes ☐ No
   If No, explain:
7. Does the Applicant require certificates of insurance from all independent contractors: ☐ Yes ☐ No
8. Does the Applicant have a written crisis management plan for dealing with staff, victims, family, authorities, and the media if there is an incident of abuse? ☐ Yes ☐ No

SECTION 6. EMPLOYMENT PRACTICES

1. Does the Applicant perform criminal background checks on prospective employees, independent contractors and volunteers? ☐ Yes ☐ No
   If Yes, at what level is the criminal searched conducted? (check those applicable)
   ___County ___Provincial___Federal ___Indictable ___Summary
2. Are job descriptions provided for all professional and Nonprofessional employees? ☐ Yes ☐ No
3. Does the Applicant verify employment related references? ☐ Yes ☐ No
4. Do licensed employees actively participate in continuing educational programs ☐ Yes ☐ No
5. Does the Applicant verify certification and/or professional licensure status of all employees and independent contractors at hire date and on an ongoing basis? ☐ Yes ☐ No

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6. Has the Applicant formalized a drug and alcohol screening program requiring all employees/contractors to satisfy drug and alcohol testing prior to hire/placement? ☐ Yes ☐ No

7. Does the Applicant screen employees for any previous allegations against them involving sexual abuse or molestation? ☐ Yes ☐ No

8. Does the Applicant confirm in writing any of the following relative to prospective employees:

   Whether their medical professional liability insurance has been denied or cancelled? ☐ Yes ☐ No

   Whether they have been involved in any professional liability claims or litigation? ☐ Yes ☐ No

   Whether any action has ever been taken on their clinical privileges? ☐ Yes ☐ No

SECTION 7. CLAIMS & INCIDENT REPORTING INFORMATION

1. Has the Applicant ever had an incident that resulted in an allegation of abuse including sexual abuse or molestation? ☐ Yes ☐ No

2. Has the Applicant ever had professional liability insurance canceled or Non-renewed? ☐ Yes ☐ No

3. Is the Applicant aware of any events which may result in any claim or suit being made? ☐ Yes ☐ No

4. Does the Applicant have a process to identify circumstances regarding loss events reasonably likely to give rise to a written Notice, demand or service of suit, for purposes of timely reporting to the Applicants' current Claims-Made insurers before expiration? ☐ Yes ☐ No

5. Have all such claims or specific circumstances reasonably likely to give rise to a claim been made under all the Applicants' current Claims-Made policies and accepted by all current insurers for coverage there under?
   If No, please explain: ___ ☐ Yes ☐ No

6. Has any patient requested release of their records to an attorney? ☐ Yes ☐ No

SECTION 8. COVID-19 REVIEW

1. As of March 2020, is your organization in compliance with the COVID-19 standards developed by the following agencies. Please click on the hyperlink to review agency position and check the response box that applies to your company.

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	YES	NO	NOT APPLICABLE
CDC for Facilities			
OSHA			
CMS Hospital Infection Control Self-assessment tool:			
CMS Home Health			
Correctional Health *			
State-mandated Responses			

2. Have any company locations been closed due to a potential outbreak of COVID-19 amongst employees or visitors? ___Yes ___No If yes, please explain.
_____.

3. Has the company received a lawsuit for its transmittal of or response to COVID-19? ___Yes ___No If yes, please describe. _____.

4. Has your organization projected the number of COVID-19 patients it is likely to treat during the next six months? ___Yes ___No If yes, how many? _____

5. What impact do you expect the virus to have on your business? Check all of the answers that you expect during the next 12 months.
   a. Increase in revenue ____
   b. Decrease in revenue ____
   c. An unmanageable flow of new patients ____
   d. A manageable flow of new patients ____
   e. The need to hire new employees ____
   f. The need to add via agency staffing ____
   g. The need to reduce employee count ____
   h. No change in operations ____

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Any person who, with intent to defraud or knowing that he/she 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.

This application does Not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

Applicant's Name: _____

Applicant's Title: _____

(Please Type or Print Name and Title)

Applicant's Signature: _____ Date: _____

(Must be signed by an active Owner, Partner or Executive Officer.)

Producer's Signature: _____ Date: _____

Agent/Broker Information:

Agency Name: _____

Contact Name: _____

Address: _____

Telephone: _____ Date: _____

Agent/Broker E-Mail: _____

Agent/Broker License# (required):_____

*Please Note – All Applicants, Agents or Brokers may be eligible for our program.