Renewal Application for Insurance Coverages for Health Care Organizations

Coverage provided by:

Name of Insurance Company To Which Application is Made

INSTRUCTIONS:

1. Answer all questions completely for desired coverages.
2 For answers that require more space: Electronic adobe fields will provide multiple lines where the applicant may need more space.
   If this form is submitted by fax or printed copy, continue question on your company letterhead and indicate the question number.
4. This form must be electronically signed by a Principal or Officer of the firm.
5. Attach current annual financial statements.

Check here to Apply for the Following Coverages:

- ☐ Professional Liability
- ☐ General Liability
- ☐ Non-owned Auto Liability
- ☐ Products Liability
- ☐ Fidelity Bond
- ☐ Excess Coverage

Applications available upon request

- ☐ Worker's Compensation
- ☐ Director's and Officer's Liability / EPLI Liability
- ☐ Employee Benefits Liability
- ☐ Property - Acord Application
- ☐ EDP Coverage - Acord Application

I. APPLICANT INFORMATION

a) Firm Name:

(if more than one entity/subsidiary, please attach description and % owned for each)

b) Address: Street Address PO Box

City State Zip County

c) Total # of Employees: d) Total Annual Gross Receipts:

e) Medicare Provider Number (if applicable): f) FEIN Number:

Please advise if you have had any changes with Items II-IV **below** from the previous year:

II. HIRING/SCREENING AND CREDENTIALING PROCEDURES (may not be applicable in all states)

If changes, please explain:

III. ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS

If changes, please explain:

IV. RISK MANAGEMENT/QUALITY IMPROVEMENT

If changes, please explain:

V. CLAIMS HISTORY

Is the applicant aware of any circumstances which may result in any claim or suit being made (including requests for medical records)?

If yes, please explain:

PROFESSIONAL LIABILITY SECTION
(THIS SECTION MUST BE COMPLETED) *

I. EMPLOYEES - ANNUAL STAFFING:

Employee Type	# Full Time	# Part Time	Annual Hours	Annual Payroll
Nurse (RN)				
LPN/LVN				
Nurse Practitioner				
Physical Therapist				
Respiratory Therapist				
Speech Therapist				
Occupational Therapist				
Social Worker				
Pharmacist				
Home Health Aide/CNA				
Homemaker				
Sitter/Companion				
Physician				
X-Ray Technicians				
Medical Directors				
Pharmacy Ass't/Techs				
Doula				

other spec

II. INDEPENDENT CONTRACTORS - ANNUAL STAFFING:

Contractor Type	# 1099s	Annual Hours	Amount Paid per 1099s
Nurse (RN)			
LPN/LVN			
Nurse Practitioner			
Physical Therapist			
Respiratory Therapist			
Speech Therapist			
Occupational Therapist			
Social Worker			
Pharmacist			
Home Health Aide/CNA			
Homemaker			
Sitter/Companion			
Physician			
X-Ray Technicians			
Medical Directors			
Pharmacy Ass't/Techs			
Doula			

(other specify)

*** If applicant offers services in more than one state, please provide total annual hours and payroll by state.**

III. TYPES OF LOCATIONS WHERE SERVICES ARE PROVIDED (TOTAL MUST EQUAL 100%)

Service	%	Service	%
Private Homes		Clinics	
Nursing Homes/Asst/Independent Living		Doctor's Offices	
Hospitals		Laboratories	
Prison Facilities			
Schools		(specify other location)	
		Total must equal 100%	

GENERAL UNDERWRITING SECTION

(Please complete for ALL lines of coverage)

I. OWNED OR LEASED PREMISES

Please attach a separate list of any changes since the previous year to your other locations owned, rented, and operated (including those sold, acquired, or discontinued). Include occupancy of each and list: address of each location; state if you own or lease the location; and describe the occupancy of each building.

List all changes to entities to be named as Additional Insureds with names and insurable interest:

Name(s)	Address	Insurable Interest

a) Is the applicant considering any changes in operations or products handled in the next 12 months?

PRODUCTS LIABILITY SECTION I. MEDICAL

EQUIPMENT/SUPPLIERS.

a) Does the applicant SELL any medical supplies and or/ equipment? ○ Yes ○ No

Total Annual Sales:

b) Does the applicant provide pharmaceutical products? ○ Yes ○ No

Total Annual Sales:

c) Does the applicant RENT or LEASE any medical supplies and/or equipment? ○ Yes ○ No

Total Annual Lease/Rental Receipts:

d) Does the applicant REPAIR or DO MAINTENANCE on any medical supplies or equipment? ○ Yes ○ No

Total Annual Repair/ Maintenance Receipts:

Total Annual Repair/ Maintenance Payroll:

PRODUCTS LIABILITY SECTION

I. MEDICAL EQUIPMENT/SUPPLIERS CONTINUED

e) Does the applicant manufacture any products? ◯ Yes ◯ No

f) In the past twelve months, has the applicant gone through a change as a medical equipment supplier or is planning to change in the next twelve months? ◯ Yes ◯ No

If yes, please explain

II. MAINTENANCE AND/OR REPAIR OF EQUIPMENT

a) Does the applicant SELL other supplier's used equipment? ◯ Yes ◯ No

If yes, please list the gross revenue derived from this operation:

b. Does the applicant REPAIR other supplier's used equipment? ◯ Yes ◯ No

If yes, please list the gross revenue derived from this operation:

c. Please list all types of equipment you repair:

FIDELITY COVERAGE SECTION

I. LIMIT REQUESTED: $ (minimum limit is $10,000)

II. INTERNAL CONTROLS:

Have there been any changes to the internal control procedures since last year? ◯ Yes ◯ No

Non-Owned Automobile SECTION

1) Does the applicant have any company owned vehicles? ◯ Yes ◯ No

2) How many of the applicant's employees drive their own vehicles during the course of business other than driving to and from a single work site? Please include those employees which drive to multiple work-sites in a single work day.

◯ Yes ◯ No

3) Does the applicant require ***Employees*** to carry their own automobile liability insurance coverage?

a) If yes, what personal automobile liability limits does the applicant require employee drivers to carry?

b) How does the applicant verify the ***Employee*** owned automobile liability insurance coverage is in force?

Non-Owned Automobile SECTION Continued

4) Do any of the applicant's employees drive ***Client*** owned vehicles during the course of your business? ◯ Yes ◯ No

a) How does the applicant verify ***Client*** owned automobile liability insurance coverage is in force

5) Does the applicant access and review Motor Vehicle Reports as a condition of employment? ◯ Yes ◯ No

a) If yes, how frequently is this review conducted

b) What standards are applied to qualify an acceptable employee driver?

6) Do any of the applicant's employees provide client transportation services? ◯ Yes ◯ No

7) What protocols has the applicant put in place to manage the use of employees and client owned vehicles during the course of applicant's business (i.e., written authorization for us of vehicle, specified acceptable use of vehicles radius of use, frequency of use, passenger restrictions)?
Please provide a copy of your firm's protocols.

8) Does the applicant require evidence of regular preventative maintenance? ◯ Yes ◯ No

9) Does the applicant require participation in a safe/defensive driver training/education program? ◯ Yes ◯ No

10) Does the applicant provide or require completion of medical emergency training for transportation of clients? ◯ Yes ◯ No

THE NEXT SECTION TO BE COMPLETED BY ALL APPLICANTS

NOTICE TO APPLICANTS: AN Y P ERSON WHO K NOWINGLY A ND WITH I NTENT TO DE FRAUD A NY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM C ONTAINING ANY M ATERIALLY FALSE INFORMATION O R, CONCEA LS, FO R TH E PU RPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FAL SE O R FRAU DULENT CLA IM FOR PA YMENT OF A LO SS OR BENE FIT, OR KNOWINGLY PRESEN TS FA LSE IN FORMATION IN AN APPLICA TION FOR I NSURANCE I S GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT I S U NLAWFUL T O KNOWINGLY PROVIDE F ALSE, INCOMPLETE, OR M ISLEADING FACTS OR INFORMATION TO AN INSURANCE CO MPANY F OR TH E PURPOSE O F DE FRAUDING OR A TTEMPTING TO DEFRAUD THE C OMPANY. PE NALTIES M AY I NCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT O F AN IN SURANCE COM PANY WHO KNO WINGLY PRO VIDES FAL SE, INCOMPLETE, OR MISLEADING FACTS OR INFORM ATION TO A POL ICYHOLDER OR CLAIM ANT F OR THE PURP OSE O F DEFRAUDING OR ATTEMPTING TO DEFR AUD THE POL ICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD P AYABLE FROM INSURANCE PROCEEDS S HALL BE R EPORTED TO T HE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT I S A CRIME TO P ROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENA LTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INS URANCE BE NEFITS IF F ALSE INF ORMATION M ATERIALLY RELATE D TO A CL AIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: AN Y PER SON WHO KNOWINGLY AN D WITH I NTENT TO INJURE, DEFRAUD, OR DECE IVE AN Y I NSURER FIL ES A STA TEMENT O F CLAIM OR AN APPLICATION CONTAINING ANY FAL SE, INC OMPLETE OR MISLEADING INF ORMATION IS GUIL TY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWEDLGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY A N IN SURER, PURP ORTED INS URER, BROKER OR ANY A GENT THEREO F, ANY WRITTEN STATEMENT A S PART OF, OR IN SU PPORT OF, AN APPL ICATION FOR THE ISSUANCE O F, OR THE RA TING OF A N I NSURANCE P OLICY F OR P ERSONAL OR COM MERCIAL INSURANCE, OR A CLAIM FOR P AYMENT OR OTHER BENEF IT PURS UANT TO AN IN SURANCE POL ICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SU CH PERSON KNOWS TO CO NTAIN MATERI AL FA LSE IN FORMATION CONCERNING AN Y FAC T MATERIAL THERETO; OR C ONCEALS, F OR T HE P URPOSE OF MIS LEADING, INFORMATION C ONCERNING ANY F ACT M ATERIAL T HERETO COM MITS A FRA UDULENT I NSURANCE ACT.

NOTICE TO KENTUCKY APPLICANTS: A NY PERSO N W HO K NOWINGLY AN D W ITH INTENT TO DEFRAUD A NY I NSURANCE COM PANY OR OTH ER PERSO N FILE S AN APPLICATION FOR INS URANCE CONTAINING AN Y MATERIALLY FALS E INFORMATION, OR CONC EALS F OR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOW INGLY PRESEN TS A FALSE O R FRAUDULENT CLAIM F OR PA YMENT OF A L OSS OR BENEF IT OR KNOWINGLY PRESE NTS FALS E INFORMATION IN AN APPLICATION FOR INSURANCE IS G UILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PR OVIDE FAL SE, INC OMPLETE OR MISLEADING IN FORMATION TO AN I NSURANCE CO MPANY FO R THE PU RPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR F RAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WH O K NOWINGLY AN D

WILLFULLY PRESE NTS FALSE I NFORMATION IN A N APPLICATION F OR INS URANCE IS GUILTY O F A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PER SON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO IN CLUDES AN Y FA LSE O R MISLEAD ING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WH O KNOWINGLY AN D W ITH IN TENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CL AIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF M ISLEADING, I NFORMATION CO NCERNING ANY F ACT MATERIAL THE RETO, C OMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE T HOUSAND DOLL ARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUC H VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS F ACILITATING A FR AUD AGAINST AN I NSURER, SUBM ITS AN APPLICATION OR FILES A CLAI M CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJ URE, DEFR AUD O R DECEIVE AN Y IN SURER, MAKES AN Y CLAIM FOR THE P ROCEEDS O F AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KN OWINGLY AN D WITH INT ENT TO DEFRAUD ANY INSURANCE C OMPANY OR OTHER PER SON FI LES AN APPLICATION F OR INS URANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING AN Y FACT M ATERIAL THERET O, M AY BE GUILTY OF A FRA UDULENT ACT , WH ICH M AY BE A CRIM E AN D M AY S UBJECT SUCH PER SON T O CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH IN TENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CL AIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCE ALS FOR THE PURPOSE OF M ISLEADING, I NFORMATION CO NCERNING ANY FACT M ATERIAL THE RETO COM MITS A FRAUDULENT IN SURANCE ACT, WHICH IS A CRI ME AN D S UBJECTS S UCH PERS ON T O CRIM INAL AN D CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIM E TO KNOWINGLY PROVIDE F ALSE, INCOMPLETE OR MISLE ADING INFORMATION TO AN INS URANCE COMPANY F OR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN A PPLICATION F OR INS URANCE M AY B E GU ILTY OF A CRIM INAL OF FENSE AND S UBJECT TO PENALTIES UNDER STATE LAW.

It is understood and agreed that the completion of this application does not bind the company to issue, nor the applicant to purchase the insurance.

Applicant Firm Name:

Signature: Date:

(Must be signed and dated by Principal or Officer of Firm):

Title:

PRINT NAME (Required if printed/faxed and not signed/submitted electronically)

Agent/Broker Information:

Agency Name:

Contact Name:

Street Address:

City, State, Zip:

Telephone: Fax:

Agent/Broker Email: Agent/Broker License: