# Professional Liability Application for Allied and Miscellaneous Services

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired. If the answer is none, state none. If the answer is not applicable, state not applicable (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

**Note:** Application must be dated and signed by owner, partner, officer, or administrator.

**Please type or print in ink.**

## Part I. General Information

1.1 Applicant Name (including DBAs): _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of Each Location: _____

1.5 Telephone Number: Office: _____ Fax: _____

1.6 Person to Contact for Survey: Name: _____ Title: _____

1.7 Year Entity Established: _____

1.8 Entity is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Professional Association/Corporation
☐ Other; Describe: _____

1.9 Entity is: ☐ For Profit ☐ Non-Profit
Describe Source of Funds: _____

1.10 If an individual, what is your profession? _____ as ☐ Employee ☐ Student
How many years have you been practicing? _____
In which branch of profession do you specialize? _____

1.11 Name, address and type of operation of employer, or school, if student: _____

_____

_____

_____

Is your employer/employment by or through a registry or temporary employment? ☐ Yes ☐ No
Agency? ☐ Yes ☐ No

1.12 Proposed Effective Date: _____

1.13 Requested Limits of Liability (if available): $_____ /$_____
Professional Liability $_____ Each Occurrence
General Liability $_____ General Aggregate

1.14 Annual Gross Receipts: Estimated Next Twelve Months $_____
Last Twelve Months $_____

1.15 Total premises square footage occupied by applicant: _____

1.16 List applicant entity's memberships in professional organizations: _____

_____

_____

1.17 Is the applicant eligible for certification or accreditation? ☐ Yes ☐ No
If yes, is applicant certified and/or accredited? ☐ Yes ☐ No
If no, explain the reason: _____

_____

**Part II. Exposures**

2.1 Service is licensed as: _____

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted:

_____

_____

2.3 What was your total number of patient/client visits last year?_____ Estimated next year?_____

2.4 Breakdown of patient services:

| | | |
|---|---|---|
| ___% AIDS | ___% Alcoholic | ___% Bariatric |
| ___% Communicable | ___% Dental | ___% Disability |
| ___% Drug Addiction | ___% Emergency Medical | ___% Family Planning |
| ___% General Exams | ___% Gynecological | ___% Hemodialysis |
| ___% Holistic Medicine | ___% Major Surgery | ___% Minor Surgery |
| ___% Nutritional (Diet) | ___% Obstetric | ___% Occupational Medical |
| ___% Optometry/Ophthalmology | ___% Orthopedic | ___% Pediatric |
| ___% Psychiatric | ___% Rehabilitative Therapy | ___% Research/Experimental |
| ___% Stress Testing | ___% Substance Abuse | ___% Other; Describe: _____ |

2.5 Are any of the following performed?

| | |
|---|---|
| Administer anesthesia (general or local)? | ☐ Yes ☐ No |
| Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)? | ☐ Yes ☐ No |
| Cardiac Catheterization | ☐ Yes ☐ No |
| Diagnostic tests | ☐ Yes ☐ No |
| Chemotherapy | ☐ Yes ☐ No |
| X-Rays | ☐ Yes ☐ No |
| Radiation Therapy | ☐ Yes ☐ No |
| Reduction of Fracture | ☐ Yes ☐ No |
| Shock Therapy | ☐ Yes ☐ No |
| Prescribe medication | ☐ Yes ☐ No |
| Obstetric procedures | ☐ Yes ☐ No |

For all yes answers, give detailed description on separate page or back of application.

2.6 Total number of all staff: _____

Total payroll or remuneration paid last year (E&C): $_____

Estimated payroll or remuneration next year (E&C): $_____
If you contract for services of any outside health care staff, break down total estimated annual payments to contractors by professional category: _____

_____

_____

2.7 Do you desire coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)? ☐Yes ☐No

Do you require:

a) contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐Yes ☐No
If yes, indicate minimum limits required: _____

b) employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐Yes ☐No
If yes, indicate minimum limits required: _____

2.8 Number of Professional Staff: E = Employed; C = Contracted

Show total number of hours of client service provided by all categories of staff: _____

| E | C | | Annual Hours | E | C | |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Aides or Orderlies | _____ | ☐ | ☐ | EEG or EKG Operators |
| ☐ | ☐ | Audiologists | _____ | ☐ | ☐ | Electrologists |
| ☐ | ☐ | Chiropractors | _____ | ☐ | ☐ | Hearing Aid Fitters |
| ☐ | ☐ | Dentists | _____ | ☐ | ☐ | Inhalation/Respiratory Therapists |
| ☐ | ☐ | Dental Hygienists/Technicians | _____ | ☐ | ☐ | Laboratory Technicians |
| ☐ | ☐ | Dental Assistants | _____ | ☐ | ☐ | LPNs |
| ☐ | ☐ | Dietitians/Nutritionists | _____ | ☐ | ☐ | Medical Technicians |
| ☐ | ☐ | Nurse Anesthetists | _____ | ☐ | ☐ | Physio/Physical Therapists |
| ☐ | ☐ | Nurse Midwives | _____ | ☐ | ☐ | Podiatrists |
| ☐ | ☐ | Nurse Practitioners | _____ | ☐ | ☐ | Prosthetic Device Fitters |
| ☐ | ☐ | Occupational Therapists | _____ | ☐ | ☐ | Psychologists/Psychotherapists |
| ☐ | ☐ | Optometrists | _____ | ☐ | ☐ | RNs |
| ☐ | ☐ | Opticians | _____ | ☐ | ☐ | Social Workers |
| ☐ | ☐ | Paramedics or EMTs | _____ | ☐ | ☐ | Speech Therapists |
| ☐ | ☐ | Pharmacy Technicians | _____ | ☐ | ☐ | X-Ray or Radiologist Techs |
| ☐ | ☐ | Physicians or Surgeons* | _____ | ☐ | ☐ | X-Ray or Radiologist Therapists |
| ☐ | ☐ | Physician Assistants | _____ | ☐ | ☐ | Other; Describe: _____ |

*Attach list and indicate specialty.

2.9 Give name of Administrator/Supervisor and describe his/her training and experience:

_____

2.10 Do you sell any products? ☐Yes ☐No
If yes, describe and indicate estimated annual sales for each: _____

_____

2.11 Do you rent or otherwise provide any equipment or products to others? ☐Yes ☐No
If yes, describe and indicate estimated annual sales for each: _____

_____

_____

2.12 Describe any "fundraising" or other special events activities conducted: _____

_____

2.13 Does the applicant maintain any beds for overnight occupancy? ☐Yes ☐No
If yes, indicate the number _____, type _____ and the number of patient days the last 12 months _____.

2.14 Do you provide any of the following services:

A) Blood Bank/Plasma Centers ☐Yes ☐No
B) Cemeteries/Funeral Homes/Morticians ☐Yes ☐No
C) Medical Arts Schools and Colleges ☐Yes ☐No
D) Pharmacies ☐Yes ☐No
E) Nursing Homes ☐Yes ☐No

If yes, complete the appropriate supplement application.

**Part III. Risk Management**

3.1 Name, qualifications, and number or years of experience of the Medical Director:

Name Title Experience/Training Association Membership

_____

3.2 Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? ☐Yes ☐No

3.3 Do you conduct pre-employment screening and investigation? ☐Yes ☐No

3.4 Do you prepare job descriptions and instructional manuals for your staff? ☐Yes ☐No
If so, enclose a copy of each.

3.5 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ☐Yes ☐No

3.6 Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? ☐Yes ☐No

Explain any exceptions: _____

_____

_____

_____

3.7 Are you equipped with an emergency 24-hour telephone call line for all of staff and patients: ☐Yes ☐No

3.8 Do you enter into any contractual agreements (other than lease of premises agreements)? ☐Yes ☐No
If yes, attach explanation.

3.9 Does the applicant advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. ☐Yes ☐No

3.10 Do you require staff to report all incidents (accidents) which might result in a liability claim **and** are records of such reports kept on file by you? ☐Yes ☐No
If not, are you agreeable to instituting this procedure? ☐Yes ☐No

3.11 Are the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. ☐Yes ☐No

3.12 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? ☐Yes ☐No
b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐Yes ☐No
c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No

**If the answer to any of 3.12 is yes, please attach a detailed explanation.**

3.13 Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. ☐None ☐Description Attached

## Part IV. History

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, state none.

| | Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made Yes | Claims-Made No |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

If claims-made, what is the most recent retroactive date? _____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, state none.

| | Insurer | Policy Number | Limits of Liability | Premium | Eff. Date | Claims-Made Yes | Claims-Made No |
|---|---|---|---|---|---|---|---|
| 1. | | | | | | | |
| 2. | | | | | | | |
| 3. | | | | | | | |
| 4. | | | | | | | |
| 5. | | | | | | | |

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐ Yes ☐ No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary): _____

4.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? ☐ Yes ☐ No

If yes, describe the event and indicate the reason for anticipation of a claim: _____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

**Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.**

| Date | Applicant Signature/Title |
|---|---|

# Medical Products Sales or Equipment Rental Supplemental Application

A. List each product or equipment line individually and provide receipts for each. Attach a copy of your products/equipment brochures.

| Describe Product/Equipment Line | Annual Receipts From Rental | From Sales |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

B. Describe clients applicant sells/rents to, and % each:

_____% Individuals using products in their home
_____% Individuals in nursing homes*
_____% Nursing homes or similar residential facilities*
_____% Hospitals*
_____% Clinics/labs*
_____% Physicians*
_____% Other*; Describe _____

* If other than individuals in their home, is there a financial/ownership relationship between applicant and client or facility? ☐ Yes ☐ No If Yes, explain: _____

C. Who does the servicing and repair of the products? _____

Who does the servicing and repair of rental equipment? _____

D. Are any products manufactured by others and sold under your entity's label? ☐ Yes ☐ No

If yes, which products? _____

E. Are any additional products planned in the next twelve months? ☐ Yes ☐ No

If yes, include them under question A, and estimate the receipts in the next 12 months.

F. How are products marketed? (attach ad copy or brochures) _____

_____

G. Is a rental/lease agreement signed by customers prior to releasing any rental equipment? ☐ Yes ☐ No
If yes, please enclose a copy of the rental agreement.

H. Is formal written inspection program for rental equipment conducted prior to each rental? ☐ Yes ☐ No

I. Are manufacturer's labels/directions/instructions provided to customers for all rentals? ☐ Yes ☐ No

J. Do the manufacturers or distributors of any of the above listed items:

1) Name your entity as an additional insured under their products liability policies? ☐ Yes ☐ No
2) Provide Certificates of Insurance for Products Liability to you? ☐ Yes ☐ No
3) Provide maintenance/service agreements for their product(s)? ☐ Yes ☐ No
4) Hold you harmless for loss arising from their products? ☐ Yes ☐ No

If the answer is yes for some products, please specify which product line and which answers: _____

_____

K. Are all manufacturers/suppliers well-known U.S. firms? ☐ Yes ☐ No If no, give details of which are not and any foreign products: _____

L. If sales of medicines or drugs are made by applicant, is a licensed pharmacist employed or contracted? ☐ Yes ☐ No

If, yes indicate number: _____ Employed (W-2) _____ Contracted (1099)

Does pharmacist carry his/her own professional liability insurance? ☐ Yes (Limits: _____) ☐ No

_____ _____

Date Signature/Title