GenStar

Reset Form

NEW BUSINESS APPLICATION

PROFESSIONAL LIABILITY
Miscellaneous Healthcare Facilities

NOTE - Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

INSTRUCTIONS TO THE APPLICANT:

- Please answer all questions on this application and on applicable supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The application must be signed and dated by an owner, partner, officer or director of your facility.
- Please attach the following to your completed application:
  - Brochures, pamphlets, advertisements or other descriptive literature of operations and services,
  - Copies of any surveys conducted by outside organizations within the past three years,
  - Copy of the current practice license(s),
  - Company loss runs, valued within the last 90 days, for past 5 years, or for as long as you have been in business if less than five years.
  - Current income statement and balance sheet.

I. GENERAL INFORMATION

1	Applicant/Entity Name:	
2	Mailing Address:	
	City:	County:
	State:	ZIP:
3	Business Address:	
	City:	County:
	State:	ZIP:
4	Telephone:	Web Site:
5	Applicant Is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other (describe):	
	Applicant Type: ☐ For Profit ☐ Not for Profit	
6	Years in Business:	Hours of Operation:
7	Description of Operation: (complete & attach the appropriate **Supplemental Application**)	
	☐ Blood / Donor Bank	☐ Air or Ground Ambulance Service
	☐ Home Health Care / Hospice Care	☐ Durable Medical Equipment Supplier
	☐ Laboratory / Imaging	☐ Birthing Center
	☐ Out-Patient Facility / Ambulatory Surgery Center	☐ Other (describe):
	Provide additional details as necessary:	

8 List below all subsidiaries, date acquired, description of operation and percentage of ownership:

Subsidiaries	Date Acquired	Description of Operation	% of Ownership
			%
			%
			%
			%

9	Within the next 12 months, does the applicant plan to: (check all that apply and provide details)	
	☐ Purchase or acquire another operation or entity?	☐ Expand the number of locations?
	☐ Add any services?	☐ Expand operation into other States?
	Provide details:	
10	Has the applicant sold, discontinued or acquired any operations since the retroactive date of your current policy? If **YES**, please provide details:	☐ Yes ☐ No

II. OPERATIONS

		Projected	Current Year	Past Year	2nd Previous Year
1	Provide applicant's total **gross** annual revenues:	$	$	$	$
2	If your operation is an outpatient facility, please provide the number of outpatient visits:	#	#	#	#

3		Is the applicant accredited by or a member of any professional organization or association? If **YES**, please name: If accredited, please provide a copy of the accreditation report.	☐Yes ☐No
4		Is applicant certified for Medicare reimbursement?	☐ Yes ☐No
5		Does the applicant maintain a current State license? If **YES**, please provide copy.	☐ Yes ☐No
6		Has applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any State or Federal licensing board or regulatory agency? This includes, but is not limited to, Medicare, Medicaid, or other reimbursement programs. If **YES**, please provide details:	☐ Yes ☐No
7		Are all operations provided out of the main location? If **NO**, please attach a listing of all locations including a description of services conducted at each location.	☐Yes ☐No
8		Are any services provided for or at Nursing Homes, Assisted Living Facilities, or Long Term Care Facilities? If **YES**, please describe:	☐Yes ☐No
9	a	Does applicant have any contractual agreements with independent contractors to provide services at the applicant's facility?	☐Yes ☐No
	b	Does contractual agreement contain a hold harmless or indemnification clause favorable to applicant?	☐Yes ☐No
	c	Does applicant obtain certificates of insurance in the amount of $1M/$3M (minimum) from all Healthcare Professionals (e.g. Resident, Intern, Physician, Surgeon, Dentist, Psychiatrist, Licensed or Certified Registered Nurse Anesthetist, Nurse, Midwife, Podiatrist and Chiropractor) rendering professional services at the facility?	☐Yes ☐No
10	a	Does applicant provide services to others on a contractual agreement? If **YES**, please describe services provided:	☐Yes ☐No
	b	Does the applicant agree to hold harmless or indemnify others under contract? If **YES**, please provide details:	☐Yes ☐No
11		Does applicant sell or lease any medical supplies and/or equipment to others? If **YES**, please complete and attach the Durable Medical Equipment Supplemental Application.	☐Yes ☐No
12		Does applicant provide any overnight bed facilities? If **YES**, advise number of beds:	☐Yes ☐No
13		Do you have written protocols and transfer agreements to transfer patients in the event of a life-threatening emergency? Please provide a copy of those documents and advise:	☐Yes ☐No
		Name of the facility:	
		Number of miles to the facility: Miles	
		Driving time to facility: Minutes	

14 Please provide the following information for each medical director providing services at the applicant's facility:

Medical Director's Name	Specialty	Insurance Carrier & Policy Number	Limits	Employee/ Contractor	Hours per Month

Please note: Coverage for Medical Director is limited to administrative duties as described in the policy form.

15 Identify the number of other employed health care professionals providing services at the applicant's facility:

Type of Professional	# Full Time Employees	# Part Time Employees	# Full Time Contractors	# Part Time Contractors	Contractors Annual Hours
EMT					
Nurse					
Nurse Aid					
Nurse Practitioner					
Occupational Therapist					
Paramedic					
Pharmacist					
Phlebotomist					
Physical Therapist					
Physician Assistant					
Radiation Technician					
Respiratory Therapist					
Social Worker					
Speech Therapist					

III. RISK MANAGEMENT/LOSS CONTROL

1		Does applicant utilize a formal written Risk Management Program? If **YES**, attach a written summary of the Table of Contents or a copy of the written policy/procedure document.	☐Yes ☐No

2	Who has the overall responsibility for Risk Management & Loss Control?		
	Name:		
	Title:		
	Telephone:		
3	Who is to be contacted for loss control survey, if different than above?		
	Name:		
	Title:		
	Telephone:		
4	a	Does applicant own any equipment used for diagnosis, monitoring or treatment purposes?	☐ Yes ☐ No
	b	Is there a written procedure followed for the inspection and maintenance of any equipment that is owned or leased?	☐ Yes ☐ No
	c	Who is responsible for inspecting and maintaining the equipment: ☐ Employees ☐ Independent Contractors	
	d	If Independent Contractors are utilized, are certificates of insurance obtained?	☐ Yes ☐ No
	e	Is inspection and maintenance performed according to the manufacturer's recommendations?	☐ Yes ☐ No
5	Indicate which hiring/screening procedures are used for employees and contractors: (check all that apply)		
	☐ References checked: ☐ In writing ☐ By telephone		
	☐ Criminal records checked		
	☐ Require information on any professional liability or work-related claim or suit		
	☐ Verify any pending license suspensions, revocations or pending disciplinary actions by other facilities		
6	Are "Informed Consent" forms used? If **YES**, please provide a copy.		☐ Yes ☐ No
7	Is there a written policy or procedure document describing:		
	a	Employee training?	☐ NA ☐ Yes ☐ No
	b	Incident reporting?	☐ NA ☐ Yes ☐ No
	c	Medical equipment training?	☐ NA ☐ Yes ☐ No
	d	Infection control?	☐ NA ☐ Yes ☐ No
	e	Patient acceptance?	☐ NA ☐ Yes ☐ No
	f	Patient evaluations?	☐ NA ☐ Yes ☐ No
	g	Safety for workers in offsite locations?	☐ NA ☐ Yes ☐ No
	h	Lifting requirements?	☐ NA ☐ Yes ☐ No
	i	Drug administration procedures?	☐ NA ☐ Yes ☐ No
	j	Food preparation?	☐ NA ☐ Yes ☐ No
	k	Patient discharge procedures?	☐ NA ☐ Yes ☐ No
	l	Advance directives such as a "Living Will"?	☐ NA ☐ Yes ☐ No
8	Does applicant have written job descriptions in place for:		
	a	All professionals?	☐ Yes ☐ No
	b	All clinical support staff?	☐ Yes ☐ No

IV. BUILDING INFORMATION

1	Building Construction: Year Built:	
2	Number of Stories: Number of Exits per Floor:	
3	Are there smoke detectors and fire extinguishers?	☐ Yes ☐ No
4	Is the building completely sprinklered?	☐ Yes ☐ No
5	Are there fire alarms? If **YES**, advise number and type	☐ Yes ☐ No
6	Fire Department is: ☐ Paid ☐ Volunteer	
7	Are the electrical, heating, and plumbing systems up to code and regularly inspected?	☐ Yes ☐ No

V. PRIOR POLICY and LOSS INFORMATION

1 Please provide the following information pertaining to applicant's past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	

2	Has the applicant ever had any insurance company decline, cancel, rescind, or non-renew any Professional and/or General Liability Insurance Policy? If **YES**, please provide details:		☐ Yes ☐ No
3	Is the applicant aware of any of the following:		
	a	Known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made?	☐ Yes ☐ No
	b	Knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that have not been reported to a prior insurance	☐ Yes ☐ No

		carrier?	
	c	Knowledge of any request for medical records by a patient or his/her attorney which might result in a claim?	☐Yes ☐No
	d	Knowledge or information relating to service(s) on a Board which might result in a claim?	☐Yes ☐No
	e	Knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact?	☐Yes ☐No
	If **YES** to any of the above, please provide details:		

VI. COVERAGE REQUESTED

NOTE: The Company may not offer or quote requested coverage.

Effective Date: Retroactive Date:

Important: *Declarations Page of your current policy must be attached if a retroactive date is requested.*

Primary Liability: ☐ Professional Liability Claims Made
☐ General Liability Claims Made Occurrence

Important: *Limits for Professional Liability and General Liability must be the same when both provided, even though they apply separately.*

Limits of Liability:	☐ $250,000 / $750,000	**Deductible:**	☐ $5,000 (minimum)
	☐ $500,000 / $1,500,000		☐ $7,500
	☐ $1,000,000 / $1,000,000		☐ $10,000
	☐ $1,000,000 / $3,000,000		☐ Other: $
Excess Limit of Liability:	☐ $1,000,000 / $1,000,000		
	☐ $2,000,000 / $2,000,000		
	☐ $3,000,000 / $3,000,000		
	☐ $4,000,000 / $4,000,000		
	☐ $5,000,000 / $5,000,000		

VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.
By signing this Application, you represent and agree to each of the following five (5) items:

1	You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and	
2	This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):	
	☐ Ambulance Service Supplemental Application	☐ Durable Medical Equipment Supplemental Application
	☐ Out-Patient / Ambulatory Surgery Center Supplemental Application	☐ Home Health Care and Hospice Care Supplemental Application
	☐ Blood / Donor Banks Supplemental Application	☐ Laboratory & Imaging Supplemental Application
	☐ Birthing Center Supplemental Application	☐ Other (specify):
	☐ Claim Information Supplemental Application	
3	Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:	
	a	Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
	b	Representations you are making on behalf of all persons and entities proposed to be insured;
	c	A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4	This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.	
5	You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.	

FRAUD WARNING

Notice to Applicants of all states except California, Kentucky, Louisiana, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Puerto Rico, Virginia and Washington D.C.:

Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

Notice to California Applicants: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for 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 knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Notice to New York Applicants: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each provision.

Notice to Oregon Applicants: Any person who knowingly and with intent to defraud or deceive any insurance company or other person who files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto upon which the insurance company or any other person relies may be a crime and may provide grounds for criminal or civil penalties.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person who, files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Puerto Rico Applicants: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established by be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Notice to Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Notice to Washington D.C. Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

An authorized representative who is an active owner, officer, or partner of your organization must sign this Application within thirty (30) days prior to the policy inception date.

Signature of Owner, Officer or Partner:	Date:
Print or Type Name and Title:	

ADDITIONAL INFORMATION

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

Section # and Question #	**Comments**

Signature:	Date: