☐ New ☐Renewal Effective Date: _____

ALLIED HEALTH CARE FACILITIES
COMMON APPLICATION

Some of the coverages being applied for are Claims Made. If there are questions concerning these coverages, please contact your insurance agent.

Instructions:

A. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.

B. All application questions must be fully answered. If a question does not apply, please write "N/A".

C. If more space is needed, continue on a separate sheet of the applicant's letterhead and indicate the question number.

D. Please review Section VI. Professional Services on page 5 of this application. **You may be required to complete a supplemental application in addition to this Common Application in order to secure coverage**.

E. To this application, please attach copies of:

1. Marketing or Advertising brochures or descriptive materials provided to clients.
2. Latest annual financial statement.
3. Claim loss runs for the past 5 or more years for all coverages being applied for, in Excel if available
4. If the applicant is a new business submit professional qualifications (i.e. resume or c.v.) of each owner, partner, officer and key employee.
5. Most recent state survey reports, licensure reports and accreditation survey reports as applicable.
6. Quality Improvement/Risk Management plan

F. This application must be completed, signed and dated by a principal of the business.

I. GENERAL INFORMATION:

Name of Applicant (legal name): _____

Corporate Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Mailing Address: (if different) _____

Corporate Contact: _____ E-Mail Address: _____

Tel. Number: ( ) _____ Fax Number: ( ) _____ Website: _____

A. Named Insured: Provide names and descriptions of all legal entities that are intended for coverage under the policy being applied for. If more space is required, provide by attachment. Please fill in all sections.

Name	Description	% Owned	Date Acquired	Retroactive Date

B. Description of Services provided: _____

_____

C. Physical Premises: Please list below all buildings the applicant owns, controls or occupies. Attach a separate schedule if more space is needed. Address must include street address, city, state, zip code and county.

Address	Total Sq. Ft.	Usage/ Occup.	No. of Stories	Type of Construction (e.g., Frame / Fire Resistant / Brick)	Sprinkler System Y/N	Smoke Detectors Y/N	Central Alarm Y/N	Owned or Leased

D. What states is the applicant operating in? _____

E. If the applicant provides management services, describe in detail the management services performed for others:

_____

F Who has a financial interest in the applicant's facility? _____

G. Does the applicant own any other business not shown on this Application? ☐ Yes ☐ No

If Yes, explain: _____

H Gross Revenue:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Gross Revenue	$	$	$	$	$

I How many years has the applicant been in operation? _____ years

J Within the next 12 month period, does applicant plan to:

1. Obtain another operation or entity? ☐ Yes ☐ No
2. Add to the number of employees? ☐ Yes ☐ No
3. Expand the number of locations? ☐ Yes ☐ No
4. Eliminate/add current services? ☐ Yes ☐ No
5. Operate in other states? ☐ Yes ☐ No

K Within the past five years has the applicant acquired, sold, or discontinued any operations? ☐ Yes ☐ No

If the response was "Yes" to K. and L. provide details on a separate sheet of paper.

L. Where does the applicant provide services for the client? Must equal 100%

☐ Applicant's locations _____% ☐ Patient's Home _____% ☐ Long Term Care Facility _____%
☐ Hospital _____% ☐ Mobile Facility _____% ☐ Schools _____%
☐ Jail/Prison _____% ☐ Other _____% Explain _____

M.. Indicate percentage of children/adolescent patients: _____

N. Are all services provided by a medical prescription or physician order? ☐ Yes ☐ No.

If No, what services do not require medical prescription or a physicians order? _____

O. Applicant is: (check appropriate boxes)

☐ For Profit ☐ Non-Profit ☐ Governmental Entity ☐ Sole Partnership
☐ Corporation ☐ Professional Association ☐ Partnership ☐ Franchise
☐ Other: Describe: _____

P. Organizational Accreditation/Certification/Licensure

1. Accredited? ☐ Yes ☐ No

   If Yes, by whom and specific to what operation? _____

2. Certified? ☐ Yes ☐ No

   If Yes, by whom and specific to what operation? _____

3. Licensed? ☐ Yes ☐ No

   If Yes, by whom and specific to what operation? _____

4. Has the applicant's accreditation, certification or license been suspended or revoked? ☐ Yes ☐ No

   If Yes, explain: _____

II. COVERAGE REQUESTED: (check all that apply)

Coverage requested to be effective on: _____

A. Professional Liability:

☐ Claims Made - Retroactive Date: _____

Limits of Liability: $_____each claim / $_____aggregate

☐ Deductible or ☐ Self Insured Retention Amount $_____

Does the state the applicant is operating in have a Patient Compensation Fund? ☐ Yes ☐ No

If yes, is the applicant currently enrolled in the Patient Compensation Fund? ☐ Yes ☐ No

B. Commercial General Liability

Check one: ☐ Occurrence ☐ Claims Made – Retroactive Date: _____

Limit - Each Claim (cannot exceed PL limit) $_____

Limit - Fire Damage Limit of Liability (Any one Fire) $_____

Limit - Products-Completed Ops Aggregate Limit $_____

Limit - General Aggregate (Other than Products) $_____

☐ Deductible or ☐ Self Insured Retention Amount $_____

C. Umbrella Liability *

☐ Yes ☐ No Limit: $ _____ CSL

*Submit Umbrella Accord Application for this coverage

D. Employee Benefit Liability

Limits of Liability: $_____each claim / $_____aggregate

1. Is this optional coverage desired? ☐ Yes ☐ No
2. Are benefit plans administered jointly by management and union? ☐ Yes ☐ No

   If yes, indicate type of plan: _____
3. On programs permitting the option to enroll, does the applicant require a signed written acceptance or rejection from each employee? ☐ Yes ☐ No

   If No explain: _____
4. Is the business corporation or organization subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) ☐ Yes ☐ No

   a. If the response was "No" and there are more than 20 employees explain on a separate sheet of paper why not.

   b. If the response was "Yes", has the applicant, to the best of your knowledge, complied with the written notice requirements of that act? ☐ Yes ☐ No
5. Total number of Employees? _____

III. PREVIOUS PROFESSIONAL LIABILITY COVERAGE:

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible ☐ Self-Insured Retention $_____	☐ Deductible ☐ Self-Insured Retention $_____	☐ Deductible ☐ Self-Insured Retention $_____
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date			
Policy Period			
Premium			

IV. PREVIOUS COMMERCIAL GENERAL LIABILITY COVERAGE

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible ☐ Self-Insured Retention $_____	☐ Deductible ☐ Self-Insured Retention $_____	☐ Deductible ☐ Self-Insured Retention $_____
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date			
Policy Period			
Premium			

V. PREVIOUS UMBRELLA LIABILITY COVERAGE

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible ☐ Self-Insured Retention $_____	☐ Deductible ☐ Self-Insured Retention $_____	☐ Deductible ☐ Self-Insured Retention $_____
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date			
Policy Period			
Premium			

VI. PROFESSIONAL SERVICES

A. Indicate all services provided by providing the information in the right column. **This information is the basis for rating the submission.** If the response was "Other", provide receipts and treatments. Information given should be **projected numbers for the next 12 months**. "Visits" are defined as the number of patients entering the facility for health related services per year. DO NOT tally the number of departments visited or the number of procedures or treatments performed. "Beds" are defined as the average number of occupied beds.

Risk Classification	**PROJECTED NEXT 12 MONTHS**
Ambulatory Surgery Center – Complete Supplemental Application	N/A
Behavioral Health Services - Complete Supplemental Application	N/A
Blood/Plasma Bank Services – Complete Supplemental Application	N/A
Camp – Complete Supplementary Application	N/A

Risk Classification	PROJECTED NEXT 12 MONTHS
Cancer Treatment Services – Complete Supplemental Application	N/A
Crisis Stabilization Services – Complete Supplemental Application	N/A
Dialysis Services - Complete Supplemental Application	N/A
EmergiCenter Services	# of Visits
Fertility Services	# of Visits
Health Department Services- Including Community Health Centers	# of Visits/Beds
Home Health Care/DME Services – Complete Supplemental Application	N/A
Hospice Care Services - Complete Supplemental Application	N/A
Imaging Services – Complete Supplemental Application	N/A
Laboratory Services – Complete Supplemental Application	N/A
Lithotripsy Services – Complete Supplemental Application	N/A
Medical Administrative Services	# of Patients/# of Beds
Medical Registry/Staffing/Medical Employee Contract – Complete Home Health Care Supplement	N/A
Medical Spas	# of treatments/type of treatments
Mobile Equipment Services/Diagnostic and Therapeutic-Complete Common Application	N/A
Optical Services	Annual Receipts
Organ Bank Services (delete)	# of procurements
Patient Transport Non-Emergency	# of Transports
Pharmacy Services (no retail)	Annual Receipts by State
Recovery Center	# of visits
Rehabilitation Services – Complete Supplemental Application	N/A
Schools - Complete Supplemental Application	N/A
Sleep Centers	# of patients/# of beds
Student Health Services - Complete Supplemental Application	N/A
Substance Abuse Services	# of visits/# of beds
Telemedicine	# of patients and type of treatment
UrgiCenters	# of Visits
Weight Loss Services	# of visits
All Other NOC Services: Describe	Annual Revenue/# of patients

B. Is the applicant involved in Alternative/Complementary Medicine? ☐ Yes ☐ No

If Yes, please explain: _____

C. Does the applicant house patients overnight? ☐ Yes ☐ No

If yes, please explain: _____

D. Does the applicant participate in clinical research trials? ☐ Yes ☐ No

If yes, list active trials: _____

Provide total number of participants in active trials: _____

E. Medical Director/Physician/Surgeon. Provide information for the Medical Director and each physician/surgeon providing services at applicant's facility.

Medical Directors Name	Specialty Board Certified Y/N	Insurance Carrier & Policy Number/Limits	State of Licensure	License Number	Employee/ Contractor	Hours per Month

Other Physicians/ Surgeons Names	Specialty Board Certified Y/N	Insurance Carrier & Policy Number/Limits	State of Licensure	License Number	Employee/ Contractor	Hours per Month

F. Do any of the physicians named in question "E." above have direct patient care responsibilities at the applicant's facility? ☐ Yes ☐ No

If yes, what is the physician's role in providing services for the applicant's facility? _____

_____

G. Are physicians and licensed independent practitioners credentialed? ☐ Yes ☐ No

H. Is credentialing and privileging formalized and documented? ☐ Yes ☐ No

I. Is new technology included in the delineation of privileges? ☐ Yes ☐ No

J. Does the applicant require

1. Health care professionals providing services for the facility to carry professional liability insurance? ☐ Yes, in by-laws ☐ Yes, in contract ☐ No
2. Employed or contracted physicians or surgeons providing services for the facility to carry professional liability insurance? ☐ Yes, in by-laws ☐ Yes, in contract ☐ No

K. Indicate the minimum professional liability insurance limits required for:

1. Employed or Contracted physicians or surgeons $ _____ each claim $ _____ aggregate
2. Contracted Allied Health Care Professionals $ _____ each claim $ _____ aggregate
3. Is proof of coverage required? ☐ Yes ☐ No If No, explain: _____

L. Has there been any review by a state medical board or other federal, state, or non-governmental oversight entity of any physician with privileges at the organization? ☐ Yes ☐ No

M. Has any physician/practitioner's license with privileges in the applicant's organization been suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No

N. Has any physician/practitioner's license with privileges in the applicant's organization been suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No

O. Has any limitations or conditions on any physician/practitioner's privileges in the applicant's organization been implemented? ☐ Yes ☐ No

P. List the following details for each medical professional that has a financial interest in the applicant's facility.

Name	Profession	Interest (owner, director, etc.)	Patient Care	
			For the Facility %	Outside Practice %

V. EMPLOYEES/INDEPENDENT CONTRACTORS INFORMATION – Review A and B

A. LICENSED

LICENSED	Number Full-Time	Number Part-Time	Annual Payroll	Number of 1099's
Nurses (RN, LPN, LVN)				
Advanced Practice Nurses/Nurse Practitioners/Midwives				
Physician Assistants/Surgeon Assistants				
Pharmacists				
Residents				
Interns				
Other (Specify)				
Other (Specify)				

B. NON-LICENSED

NON-LICENSED	Number Full-Time	Number Part-Time	Annual Payroll	Number of 1099's
Students				
Certified Nurse Assistants				
Certified Medical Assistants				
Phlebotomists				
Therapy Aides/Assistants				
Technicians - Explain				
Technologists				
Other (Specify)				
Other (Specify)				

C. Independent Contractors

1. Does applicant want coverage to include independent contractors? ☐ Yes ☐ No
   If no, what limits does applicant require them to carry? $ _____
2. Does applicant obtain certificates of insurance from independent contractors? ☐ Yes ☐ No

If no, how does applicant verify that the required insurance is maintained? _____

D. Percentage of turnover for licensed staff _____% Non-licensed staff _____ %

E. Percentage of total licensed staff that is agency workers? _____ %

F. Hiring/Screening and Employment Procedures

1. Are employees/contractors references contacted before hiring or placement? ☐ Yes ☐ No
2. How are references checked? ☐ Written ☐ Verbal ☐ Both
3. Are job descriptions provided for all staff members? ☐ Yes ☐ No
4. Does applicant verify any pending license suspensions, revocations, or pending disciplinary actions by other facilities? ☐ Yes ☐ No
5. Does the applicant utilize criminal background checks? ☐ Yes ☐ No

   If Yes, check those applicable: ☐ Pre-hire ☐ Current employees

   If Yes, what level are criminal searches conducted?

   ☐ State/County ☐ Federal ☐ Misdemeanor Convictions
6. Are criminal checks done for all employees/contractors? ☐ Yes ☐ No

   If No, describe employee/contractor categories not checked: _____

   _____

VIII. CONTRACTUAL AGREEMENTS:

A. Does the applicant have written agreements with third parties? ☐ Yes ☐ No

1. If the response was Yes, does each agreement include the following?
   a. Mutual indemnification and hold harmless clause. ☐ Yes ☐ No
   b. A requirement the other party carry liability insurance with liability limits equal to or exceeding the applicant's. ☐ Yes ☐ No
   c. A requirement that the other party supply the applicant with a current copy of a certificate of insurance. ☐ Yes ☐ No

IX. MEDICAL EQUIPMENT/SUPPLIES SALES AND LEASING OPERATIONS

A. Does applicant sell any medical or therapeutic supplies and/or equipment? ☐ Yes ☐ No

If Yes, Annual Receipts $_____

B. Does applicant rent or lease any medical or therapeutic supplies and/or equipment to others: ☐ Yes ☐ No

If Yes, Annual Receipts $_____

If the response was "No" to both A and B, please skip this section and go on. ***If the response was "Yes" to either A or B, please check the appropriate categories below and indicate the receipts.***

Category I: EXPENDABLE ITEMS - Intended for one-time usage and disposed (i.e. adhesive tape, bandages, hypodermic needles, etc.)

Annual Sales $_____ Annual Lease/Rental Receipts $_____

Category II: NON-EXPENDABLE ITEMS - Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids, walkers, strollers, canes, crutches, wheelchairs, and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.

Annual Sales $_____ Annual Lease/Rental Receipts $_____

Category III: DIAGNOSTIC OR TREATMENT DEVICES - This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment **NOT** used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.

Annual Sales $_____ Annual Lease/Rental Receipts $_____

Category IV: LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES - This category includes dialysis or heart/lung machines, apnea monitors or any other life dependent monitors or any other equipment or devices where malfunction/failure or improper function could result in death or serious deterioration in health condition.(Please attach list of Category IV equipment or devices).

Annual Sales $_____ Annual Lease/Rental Receipts $_____

X. BIOMEDICAL EQUIPMENT PREVENTIVE MAINTENANCE

A. Is biomedical equipment: ☐ Serviced by an in-house certified technician? ☐ Serviced by an outside vendor?

B. If the preventative maintenance is provided by an outside vendor does the contract for maintenance include a hold harmless indemnification? ☐ Yes ☐ No

C. Are user manuals available in-house for every piece of medical equipment? ☐ Yes ☐ No

D. Is there a formal, documented recall and hazard alert program? ☐ Yes ☐ No

XI. RISK MANAGEMENT/QUALITY ASSURANCE

A. Does applicant utilize a formal written Quality Improvement Plan? ☐ Yes ☐ No

B. Does the applicant utilize a formal written Risk Management Program? ☐ Yes ☐ No

C. Is there a formal, documented peer review process in place? ☐ Yes ☐ No

D . Medical/Patient Records:

1. Are records stored: ☐ electronically or ☐ paper files or ☐ both?
   a. If electronic, how often are backups made? _____
   b. If paper, where are records stored? ☐ on site ☐ off site?
   c. Are the buildings in which paper records stored sprinkled? ☐ Yes ☐ No

E. Who has the overall responsibility for Risk Management & Quality Assurance?

Name: _____

Title: _____

Telephone Number: _____

E-Mail Address: _____

XII. GENERAL LIABILITY

A. Does applicant sponsor any sporting or special events? ☐ Yes ☐ No

If Yes, please explain? _____

B. Does the applicant provide alcoholic beverages at any of these events? ☐ Yes ☐ No

If Yes, please explain? _____

C. Is all advertising/public relations media/website reviewed by legal counsel or risk management? ☐ Yes ☐ No

XII. LITIGATION/CLAIMS HISTORY SANCTIONS/FINES

If the response is yes to any question below additional information must be provided on the applicant's letterhead. Please submit actual loss runs from the previous carriers for the past five or more years.

A.	Has the applicant had any Professional, General Liability, Employee Benefits or Umbrella claims or suits brought against them in the past 5 years?	☐ Yes ☐ No
B.	Is the applicant aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier?	☐ Yes ☐ No
C.	Has the facility/operational license ever been suspended, revoked or voluntary suspended?	☐ Yes ☐ No
D.	Has any Insurance Company or Lloyd's declined, canceled, or refused to renew or accept any of the applicant's liability insurance?	☐ Yes ☐ No
E.	Has any Company with whom the applicant been previously affiliated with become insolvent?	☐ Yes ☐ No
F.	Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the applicant's organization?	☐ Yes ☐ No
G.	Has the applicant ever been sanctioned or decertified by Medicare?	☐ Yes ☐ No
H.	Has the organization or any of its officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional medical society, accreditation agency or other governmental or non-governmental oversight entity?	☐ Yes ☐ No

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

_____ _____/_____/_____

Signature in full Date

_____

Name - please print

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

Agency Name and Address	Person submitting application	Telephone Number	E-Mail