# URGENT CARE ORGANIZATION PROFESSIONAL AND GENERAL LIABILITY INSURANCE POLICY APPLICATION

**THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON A CLAIMS-MADE BASIS AND COMMERCIAL GENERAL LIABILITY COVERAGE WRITTEN ON EITHER A CLAIMS-MADE OR AN OCCURRENCE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THE APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED ACCURATELY AND COMPLETELY.**

Please include the following documents or underwriting supplements:

1. Loss History (supply the following):
   a. Five years of currently valued carrier loss runs
   b. Full details of allegation on all losses paid or outstanding in excess of $50,000

2. Most recent accrediting agency (AAUCM, NAFAC, UCAOA, JCAHO, AAAHC, etc) and state licensure report with recommendations and the clinic's response to any contingencies. Please provide a copy of the original report.

3. Schedule of Physicians to be covered:
   a. Active physician spreadsheet
   b. Departed physician spreadsheet

4. General Liability and Employee Benefits Supplement (if requesting these coverages)

5. Risk and Quality Plans

6. Exposure Schedule for Multi Locations

## Section I - General Information:

(A) Applicant Name: _____

(B) Contact Person: _____ Telephone: _____

(C) Business Address: _____ _____ _____ _____
Street City, State County ZIP

(D) Mailing Address: _____ _____ _____ _____
Street City, State County ZIP

(E) Website: _____ Years in Business: _____ Hours of Operation: _____

(F) **Please check the category which best describes your organization:**

| | |
|---|---|
| ☐ Retail Clinic | Locations are generally staffed by nurse practitioners and physician assistants. Physicians are not usually present at your locations. Medical treatment is typically offered at small offices with a limited level of non-emergent care relative to a physician's office. |
| ☐ Extended Hours Physician Walk –In | Urgent care services are not the primary services provided by your organization. Your regular office hours have been extended to include the addition of walk-in care services. Primary care givers during these hours could include physicians or mid-level providers, although physicians are available during the extended hours. |
| ☐ Urgent Care Center | Urgent care services are the primary activities performed by your organization. Physicians regularly staff your locations with the support of mid-level providers. Services provided are sometimes broader in scope than those typically found in a physician's office. Locations may offer a range of services including physical therapy, occupational therapy, occupational health (Workers Compensation exams), on site x-ray and clinical lab. |
| ☐ Other | Please provide a description of your organization on a separate sheet if it does not readily reflect one of the above categories. |

(G) **Please indicate ownership and operational structure:**

☐ Individually owned
☐ Corporation
☐ Partnership
☐ Joint Venture

☐ Profit
☐ Non-Profit
☐ Charitable
☐ Government

(H) **Please indicate the coverage being requested:**

☐ Professional Liability
☐ General Liability
☐ Employee Benenfits Liability

(I) Coverage Effective Dates: From:_____ To:_____

(J) Professional Liability (Claims Made Only):

(1) Limit: $_____per claim $_____aggregate
(2) Retroactive Date: _____
(3) Deductible: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other: _____

***If you would like General Liability or Employees Benefits coverage please complete GL/EBL supplement.***

(K) **Please list all other DBA's and affiliated entities associated with your organization within the last three years and indicate the percentage of ownership:**

| Name | Address | Nature of Operations | % of Ownership |
|---|---|---|---|
| | | | |
| Name | Address | Nature of Operations | % of Ownership |

## Section II – Professional Liability Exposure Data:

(A) **Please provide the following information for each location, on an excel spreadsheet if necessary.**

| **Type of Service Provided**<br><br>***The services listed below are not exclusive, and are only examples of the types of services an Applicant might provide.*** | **Projected visits next 12 Months** | **Current Year Visits** | **1st Year Prior Visits** |
|---|---|---|---|
| **Preventative/Diagnostic**<br>This includes but is not limited to Corporate Health, Immunizations, Allergy Shots, Occupational Health, Alcohol/Drug Testing and Blood Pressure Screenings. | | | |
| **Non-Emergent Care**<br>This includes but is not limited to the treatment of Abrasions, Animal and Insect Bites, Minor Burns, Cough, Earaches, Flu, Minor Fractures, Minor Lacerations, Sore Throat and Sprains | | | |
| **Emergent Care**<br>This includes but is not limited to the treatment of Moderate to Severe Burns, Fractures, Severe Allergic Reactions, Breathing Difficulties, Chest Pain or Pressure | | | |

(B) **Auxiliary Services**

(1) Check any auxiliary services provided by this Urgent Care Facility or any of its subsidiaries.
(If checked, please provide annual number of procedures)

☐ Radiology (Please complete Imaging Supplement) ☐ Laboratory ☐ GYN or Prenatal Care

☐ Pain Management ☐ Pharmacy ☐ PT/OT ☐ Other: _____

Please attach details regarding the extent of the auxiliary services checked above, or please provide a patient pamphlet.

(2) Is your facility designated as a Dedicated Emergency Department (DED) ☐ Yes ☐ No

(3) Are the auxiliary services check above limited to patients treated at your clinics? ☐ Yes ☐ No

(4) If there are no auxiliary services provided, are patients referred for diagnostic testing from physicians outside of your organization? ☐ Yes ☐ No

(5) Please provide the annual number of patients referred for these services from outside of your organization.
#:_____

(6) Does the state require that you be licensed to provide the auxiliary services checked above? ☐ Yes ☐ No

(7) Do you provide Drug Screens? ☐ Yes ☐ No

(a) If "Yes," do you interpret the results? ☐ Yes ☐ No

(b) If "Yes," does the provider have their MRO designation? ☐ Yes ☐ No

(8) Do you have a Pharmacy? ☐ Yes ☐ No

(a) If you have a Pharmacy, do you have a policy and procedure for dispensing, stocking and documentation? ☐ Yes ☐ No

(9) Does your organization maintain beds for overnight occupancy? ☐ Yes ☐ No

(10) Do you endorse any products or participate in offering professional advice to the public? (i.e. newspaper columns, broadcasts, etc.) If "Yes" please provide details. ☐ Yes ☐ No

## (C) Annual Revenues

(1) Please state sources and amounts of annual revenues below:

| Source | Current | Projected |
|---|---|---|
| Medicare/Medicaid | | |
| Fee for Service | | |
| HMO/PPO/POS | | |
| Occupational Medicine | | |
| Other: _____ | | |

## (D) Contractual Services

**"Yes" answers to any of the questions below require a separate written explanation and supporting documentation.**

(1) Does the Urgent Care Facility or any of its subsidiaries participate in any experimental, investigational or other unconventional therapies including any alternative medicine activities? ☐ Yes ☐ No

(2) Does the Urgent Care Facility or any of its subsidiaries participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? ☐ Yes ☐ No

(3) Does the Urgent Care Facility or any of its subsidiaries contract to provide services to any federal or non-federal prisons? ☐ Yes ☐ No

(4) Does the Urgent Care Facility or any of its subsidiaries contract to provide services to any nursing home or long term care facility? ☐ Yes ☐ No

(5) Does the Urgent Care Facility or any of its subsidiaries contract to provide teaching services or the supervision of residents or mid level practitioners? ☐ Yes ☐ No

(6) Has an allegation or claim ever been made against the Corporation/Partnership, any of its subsidiaries, owners, shareholders, employees or employed or contracted physicians, regarding sexual harassment, sexual intimacy, exploitation or sexual assault in the performance of services for the Corporation/Partnership or otherwise? ☐ Yes ☐ No

(E) **Staffing**

(1) **List the total number of active healthcare professionals associated with your organization:**

| Position | Full - Time | | Part - Time | | Total Full Time Equivalent |
|---|---|---|---|---|---|
| | Employed | Contracted | Employed | Contracted | |
| Physicians | | | | | |
| Radiologists | | | | | |
| Nurse Practitioners | | | | | |
| Physician Assistants | | | | | |
| RN's/LPNs/ LVNs | | | | | N/A |
| PT/ST/OT | | | | | N/A |
| Pharmacists | | | | | N/A |
| X-Ray Tech | | | | | N/A |
| Medical Assistants | | | | | N/A |
| EMT's | | | | | N/A |
| Other | | | | | N/A |

(2) Is a physician onsite during hours of operation? ☐ Yes ☐ No

(3) Have any of the facilities' services or procedures changed in the past 10 years?

(a) If "Yes," explain what services or procedures have been added or deleted and the dates these changes were effective:

_____

_____

_____

_____

## Section III – Risk Management

(A) **Quality Assurance**

(1) Does any proposed Insured have the following accreditations?

☐ **AAUCM**

☐ **NAFAC**

☐ **UCAOA**

☐ **JCAHO**

☐ **AAAHC**

☐ **OTHER**, PLEASE LIST: _____.

(2) List the date of the most recent survey: _____

(3) Is there a committee that performs quality reviews? ☐ Yes ☐ No

(4) Are chart audits performed? ☐ Yes ☐ No

(5) Are medical records reviewed against specific outcome criteria on a regular basis (admission to the acute care setting after being discharged, patients who return within a consistent amount of time with the same complaint)? ☐ Yes ☐ No

(6) Is there more than one facility or location? ☐ Yes ☐ No

(a) If there is more than one facility or location, are there common P&Ps, Credentialing Criteria, RM and QA plans? ☐ Yes ☐ No

(7) Do you use Electronic Medical Records? ☐ Yes ☐ No

## (B) Policies and Procedures

(1) Please indicate which of the following policies and procedures are a required part of your organization:

(a) Written treatment guidelines for chest pain? ☐ Yes ☐ No

(b) Protocols for Diagnosis for fractures that include written patient instructions to return for re-examination if pain persists for 12 hours, over read by radiologists, and notifying patients of any latent abnormal findings? ☐ Yes ☐ No

(c) Are only a PAs, NPs or Physicians accountable for conducting triage, determining acuity level / appropriateness for transfer to in-patient facility? ☐ Yes ☐ No

(d) Restrictions regarding telephone orders and advice without being seen by physician? ☐ Yes ☐ No

(e) All patients presenting to the facility with a respiratory complaint or shortness of breath require vital signs (temp, bp, respiration) and pulse oximetry? ☐ Yes ☐ No

(f) Written discharge instructions provided to the patient upon check out? ☐ Yes ☐ No

(2) Do the Credentialing Policies ensure:

(a) Application criteria are applied consistently? ☐ Yes ☐ No

(b) Primary source verification is performed initially and at least every two years thereafter? ☐ Yes ☐ No

(3) Do you maintain current certificates of insurance on file for all employed or contracted practitioners and non-physician employees? ☐ Yes ☐ No

(4) Do you maintain current licensure on file for all employed or contracted practitioners and non-physician employees? ☐ Yes ☐ No

(5) Does the Medical Director and/or Governing Board review all recommendations from the Credentialing Committee and the credentialing file? ☐ Yes ☐ No

(6) Are credentialing criteria are specific to the facility's scope of services? ☐ Yes ☐ No

(7) Do written protocols and guidelines for disclosure of a Provider's Quality Outcome data exist? ☐ Yes ☐ No

(8) Do all credentialing policies include anesthesia services and allied health professionals? ☐ Yes ☐ No

(9) Do you obtain a provider's loss history before hiring/contacting them? ☐ Yes ☐ No

(10) Are background checks performed on all employees? ☐ Yes ☐ No

(11) Are current licenses kept on file? ☐ Yes ☐ No

(12) Are there written job descriptions for each category of employee? ☐ Yes ☐ No

(13) Do all employees and providers sign confidentiality agreements? ☐ Yes ☐ No

(14) Do you have a chaperone policy for the treatment of female patients by male providers? ☐ Yes ☐ No

(15) Does the Incident Reporting Procedure include:

(a) Documenting only objective information? ☐ Yes ☐ No

(b) The reporting of near misses? ☐ Yes ☐ No

(c) Investigation procedures? ☐ Yes ☐ No

(d) Methods for tracking and trending incident /claim reports? ☐ Yes ☐ No

(e) Follow-up in performance improvement or quality committee? ☐ Yes ☐ No

(16) Indicate whether or not the Patient Follow-up/Call-back Procedure includes:

(a) Criteria to make the call/follow up? ☐ Yes ☐ No

(b) Time frames for making the call? ☐ Yes ☐ No

(c) Documentation requirements? ☐ Yes ☐ No

(d) Parameters for physician communication? ☐ Yes ☐ No

(e) Tracking and trending of data? ☐ Yes ☐ No

(f) A tickler system to ensure that all diagnostic tests are performed and the results have been received and communicated to the patient? ☐ Yes ☐ No

**If "No" to any of the above, please explain your procedure on a separate sheet.**

(17) Please indicate who is responsible for making the follow-up/call-back phone calls:

_____

## Section V – Coverage History

(A) Provide insurance history for a minimum of the last five years. Start with the most recent and attach an additional sheet if necessary.

| Insurer | Policy Period | Limits of Liability | Coverage Type | Claims Trigger | Retroactive Date | Deductible Amount | Tail Purchased | Policy Premium |
|---|---|---|---|---|---|---|---|---|
| | | | ☐ Claims Made<br>☐ Occurrence | ☐ Incident Driven<br>☐ Written Demand | | | ☐ Yes<br>☐ No | |
| | | | ☐ Claims Made<br>☐ Occurrence | ☐ Incident Driven<br>☐ Written Demand | | | ☐ Yes<br>☐ No | |

(B) Has any insurance company ever declined, failed to renew, restricted or canceled your insurance? ☐ Yes ☐ No
If yes, please complete the following:

| Insurer | Date | Reason |
|---|---|---|
| | | |
| | | |

(C) Has the facility ever operated without insurance? ☐ Yes ☐ No

## Section VI – Claims History

(A) Are you involved, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? ☐ Yes ☐ No

(1) If "Yes," how many? _____

**(Please complete attached Claims History Questionnaire for each claim.)**

(B) Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim? ☐ Yes ☐ No

(1) If "Yes," how many? _____

(2) If "Yes," have these been reported to your current insurer, or any prior insurer? ☐ Yes ☐ No

**(Please provide details on a separate sheet.)**

**Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in response to this Section VI is excluded from the proposed coverage.**

## Section VII - Signature

I hereby certify that all of the information provided in this application, including any supplemental information requested and provided, is true and correct. I authorize the release and exchange of all information considered relevant by the company to the underwriting of this application and authorize any exchange of information between agents, government licensing agencies, any professional society or association of which I am a member, hospitals, health insurers, managed care organizations. I agree to indemnify and hold harmless from liability or expense any organization or individual supplying information to the company in good faith.

I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. Any information supplied that is found to be intentionally false and misleading may result in the voiding of coverage.

**THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.**

**NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: 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, WHICH IS A CRIME.**

**NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.**

**NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND 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 MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.**

**NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECIEVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.**

**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 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 AND 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 MARYLAND APPLICANTS: 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 MAY BE GUILTY OF INSURANCE FRAUD.**

**NOTICE TO NEW JERSEY APPLICANTS: 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 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 SUCH VIOLATION.**

**NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.**

**NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.**

**NOTICE TO PENNSYLVANIA APPLICANTS: 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 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 WASHINGTON 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.**

Signature: _____ Date: _____/_____/_____

Printed Name & Title:_____

Insurance is not effective until application is approved by us; a premium quotation with policy terms is issued by us and accepted by you.