Surplus Insurance Brokers Agency Inc.

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P O Box 749, South Bend IN 46624-0749

APPLICATION - HEALTH CARE PROVIDER

BUSINESS INFORMATION

1. Named Insured ______________________________
2. Mailing Address ______________________________
   Street City County State ZIP Code
3. Location of Premises: ❒ Same as mailing address
   ❒ Other ______________________________
4. Telephone ( ) ________________ Fax ( ) ________________
5. Contact person/phone #: Inspection ______________________________
   Accounting/Records ______________________________
6. Business type: ❒ Individual ❒ Partnership ❒ Corporation ❒ LLC
   ❒ Trust ❒ Other (specify) ________________
7. Operating as: ❒ For Profit ❒ Nonprofit ❒ Other ________________
8. Interest of Named Insured in premises: ❒ Owner ❒ General Lessee ❒ Tenant ❒ Other ________
9. Part occupied by Named Insured: ❒ Entire ❒ Portion (____ %) ❒ Other (Lessor's Risk Only)
10. Date business established ________________

DESIRED TERMS AND CONDITIONS

1. Coverage Desired: ❒ General Liability ❒ Professional Liability
2. Limit of Liability Desired: ❒ $100,000/$300,000 ❒ $300,000/$600,000 ❒ $500,000/$1,000,000
   ❒ $1,000,000/$1,000,000 ❒ Other ________________

Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Personal and Advertising Injury	Same as Occurrence Limit
Medical Payments	$5,000

3. ❒ Contractual Liability
4. Effective Date Desired ________________ Term Desired ________________

TYPE OF FIRM

1. Check your specific professional occupation:
   - ❒ Aide/Homemaker
   - ❒ Artificial Limb Fitter
   - ❒ Audiologist *Do you operate a mobile unit?* ❒ Yes ❒ No
   - ❒ Counselor ❒ Psychiatrist ❒ Psychologist ❒ Social Worker

   Indicate type of services performed and percentage:

❒ Abortion/Family Planning	______ %	❒ Crisis Intervention	______ %	❒ Occupational	______ %
❒ Alcohol/Drug	______ %	❒ Family/Marital	______ %	❒ School/Youth	______ %
❒ Child Abuse/Sexual Offenders	______ %	❒ General Guidance	______ %	❒ Other	______ %
❒ Criminal	______ %	❒ Hot Line	______ %	________________	______ %

   Do you utilize shock and/or drug therapy? ❒ Yes ❒ No
   - ❒ Dental Hygienist
   - ❒ Dietician/Nutritionist *Do you market products under your own label?* ❒ Yes ❒ No
   - ❒ Druggist/Pharmacist *Do you prescribe medications?* ❒ Yes ❒ No
   - ❒ Hearing Aid Specialist
   - ❒ Massage Therapist

❒ Nurse: *Type* ______________________ *Check if appropriate:* ❒ *X-ray specialist* ❒ *Midwife* ❒ *Nurse anesthetist*

❒ Occupational Therapist
❒ Optician
❒ Optometrist
❒ Physical Therapist
❒ Respiratory Therapist
❒ Speech Therapist
❒ X-Ray Technician
❒ Other ____

2. Description of operations____

____

____

____

____

OPERATIONS

1. Do you treat children exclusively? ❒ Yes ❒ No
2. Indicate percentage of time spent in the following work locations:

Administrative Office	________ %	Hospice	________ %	Professional Office	________ %
Classroom	________ %	Outpatient Clinic	________ %	Nursing Home	________ %
Emergency Dept. of Hosp.	________ %	Laboratory	________ %	Other __________	________ %
Hospital Ward (Specify) ______________________			________ %	Patient's Home	________ %

3. Are you engaged in, associated with, or involved in any other enterprises? ❒ Yes ❒ No
   If yes, explain. ____
4. Are you self-employed? ❒ Yes ❒ No
   If no, provide name of employer.____

	Yes	No	N/A
5. Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following? General Liability	❒	❒	❒
Professional Liability	❒	❒	❒
6. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?	❒	❒	
If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?	❒	❒	
7. Have you entered into any contractual agreements?	❒	❒	
If yes, is legal advice sought to write and approve?	❒	❒	
Does the agreement require you to hold any third party harmless?	❒	❒	

8. Indicate: Receipts __________ Payroll __________ Outpatient Visits __________
   (Number of patient encounters per year)
9. How are funds obtained? (i.e. Medicare, donations, fees, government grants, etc.) ____________________
10. Do you have recordkeeping procedures? ❒ Yes ❒ No
11. Do you practice: ❒ Full Time (30+ hours/week) ❒ Part Time (30 hours or less/week)
12. Do you have independent contractors working for you? ❒ Yes ❒ No
    Describe, including number of contractors, type, total hours per month worked by all contractors, and in what capacity the independent contractor is working. ____

    ____
13. Do you require independent contractors working for you to carry their own professional insurance and provide proof of this coverage? ❒ Yes ❒ No
14. Do you use the services of volunteers or students? ❒ Yes ❒ No
    If yes, describe selection, duties, training, and extent to which they are used.____________________

    ____

EMPLOYEE PROCEDURES & STAFFING

1. Check the highest level of education you have completed relating to practice in your field:
   - ❐ None required
   - ❐ Associate Degree
   - ❐ Master's Degree
   - ❐ Bachelor's Degree
   - ❐ Doctorate Degree
   - ❐ Post-Doctorate Degree
   - ❐ Other

   School where degree was obtained: ______________________________

   For multiple employees, attach list with names, degree(s), and school(s).
2. Describe any professional training, licensing, or certification needed for this operation. ______________________________
____
3. Are you certified/licensed? ❐ Yes ❐ No
   If yes, name of board/licensing body. ______________________________

	Yes	No	N/A
4. Has your license ever been: Restricted?	❐	❐	❐
Suspended?	❐	❐	❐
Revoked?	❐	❐	❐
a. Have you ever been denied a license or board certification?	❐	❐	❐
b. Have you ever been a patient in any chemical dependency program?	❐	❐	❐
c. Have your privileges ever been restricted, suspended, or revoked by any heath care facility?	❐	❐	❐
d. Do you prescribe drugs?	❐	❐	❐
e. Do you participate in any peer review or utilization review activities?	❐	❐	❐

Explain all YES answers. ______________________________
____

5. Years practicing current professional occupation ___________
6. Years in business under the above name ___________
7. List any professional association or organization of which you are a member. Show complete name.
   ❐ None ______________________________

	Yes	No
8. Do you have employees?	❐	❐
9. Do you conduct criminal background checks of employees?	❐	❐
If yes, are copies kept on file?	❐	❐

10. Check all procedures you use when hiring professional, paraprofessional, or any other employee providing patient care services at your facility:

	None	Written	Verbal
a. Educational background or residency program check, when applicable.	❐	❐	❐
b. Previous employers check.	❐	❐	❐
c. Personal references check.	❐	❐	❐
d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals?	❐	❐	❐

PREVIOUS EXPERIENCE

1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities? ❐ Yes ❐ No
   If yes, explain. ______________________________
   ____

2. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
   Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years?
   ❐ Yes ❐ No *If yes, give name of company, date and reason.*

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	**Carrier**	**Policy Number**	**Coverage**	**Check if Claims-Made**	**Premium**
				❐	
				❐	
				❐	

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years.
   Attach separate sheet if necessary.

Dates (Month/Year)	Allegations	Amount	Paid	Reserve
			❐	
			❐	
			❐	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or 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 and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address