



PROFESSIONAL LIABILITY
APPLICATION FOR ALLIED AND MISCELLANEOUS SERVICES
(Send submissions to midcsubmis@mid-continentga.com)

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 dba’s): _____

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 or _____ 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 \$ _____ /\$ _____

General Liability \$ _____ each occurrence

\$ _____ 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: _____

1.15 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)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Catheterization | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diagnostic tests | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| X-Rays | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reduction of Fracture | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shock Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prescribe medication | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Obstetric procedures | <input type="checkbox"/> Yes <input type="checkbox"/> 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, breakdown total estimated annual payments to contractors by professional category. _____

- 2.14 Do you provide any of the following services:
- | | | |
|--|------------------------------|-----------------------------|
| A) Blood Bank/Plasma Centers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B) Cemeteries/Funeral Homes/Morticians | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C) Medical Arts Schools and Colleges | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D) Pharmacies | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E) Nursing Homes | <input type="checkbox"/> Yes | <input type="checkbox"/> 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
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3.2 Does your Agency have a written credentializing policy and procedure for all individual's associated with or practicing within the Applicant? 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? Yes No

If yes, please attach a copy of each advertisement.

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 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws?

If no, attach explanation of any exception.

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 healthcare 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, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	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, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	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 Mid-Continent General Agency, 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/Title



MEDICAL PRODUCTS SALES OR EQUIPMENT RENTAL SUPPLEMENTAL APPLICATION

A. LIST EACH PRODUCT OR EQUIPMENT LINE INDIVIDUALLY and provide receipts for each. Attach 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 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	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Provide Certificates of Insurance for Products Liability to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Provide maintenance/service agreements for their product(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) Hold you harmless for loss arising from their products?	<input type="checkbox"/> Yes <input type="checkbox"/> 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