Allied Health Professional and General Liability
New Business Application

CLAIMS-MADE/OCCURRENCE DISCLOSURE NOTICE
THE POLICY YOU ARE APPLYING FOR MAY CONTAIN BOTH CLAIMS-MADE AND OCCURRENCE COVERAGES. PLEASE READ THE POLICY IN ITS ENTIRETY. SOME OF THE PROVISIONS CONTAINED IN THE POLICY RESTRICT COVERAGE, SPECIFY WHAT IS AND IS NOT COVERED AND DESIGNATE RIGHTS AND DUTIES.

Instructions:

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

This application must be completed, dated and signed by an authorized representative of the Applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

Supporting information:

Along with this completed and signed application, the Applicant must also submit the following information:

1. Loss experience details:
    a. A minimum of 5 years of loss runs.
    b. Incurred loss amounts: Breakdown of paid and outstanding loss amounts for indemnity and expenses.
    c. Loss descriptions: For all losses with incurred loss amounts.
    d. Scope of coverage: Loss experience for all Applicants and coverages to be considered under this application.
2. Organizational chart, including ownership percentage of each organization and relationship of each organization to one another.
3. Financial statements (audited, if available).

SECTION A. PRODUCER CONTACT INFORMATION

Company Name:	_____	Agent Name:	_____
Business Address:	_____	Business Address:	_____
Telephone Number:	_____	Telephone Number:	_____
Facsimile Number:	_____	License Number:	_____
Email Address:	_____		

SECTION B. APPLICANT

1. Legal name of the parent entity to be the first named insured exactly as it shall be shown on the Policy.

First Named Insured (Legal Corporate Name, Partnership or Sole Proprietor's Name)	DBA Name
___	___
Mailing Address	Date Established
___	___
County In Which Services Are Provided	FIN Number
_____	___
Telephone Number	Facsimile Number
___	___
Website Address	Email Address
___	___

2. Applicant is:
   - ☐ Individual
   - ☐ Partnership
   - ☐ Corporation
   - ☐ Joint Venture
   - ☐ Limited Liability Company
   - ☐ Profit
   - ☐ Non-Profit
   - ☐ Charitable
   - ☐ Government

3. Description of Operations (check all that apply):
   - ☐ Home Health Care Agency
   - ☐ Visiting Nurse Agency
   - ☐ Supplemental Staffing
   - ☐ Infusion Therapy Firm
   - ☐ Nurse Registry
   - ☐ Hospice
   - ☐ Physical Therapy
   - ☐ Medical Equipment Supplier
   - ☐ Other (specify): _____

4. List any subsidiary or affiliate to be insured exactly as it shall be shown on the Policy. Include its relationship to the parent entity shown in item B.1. above, a description of operations, date of acquisition or creation, percentage of ownership by the Applicant, and requested retroactive date. If the space below is inadequate, attach a list providing the same information for each Applicant.

Loc. #	Business Legal Name & Address	Relationship to Parent Entity	Description of Operations	Date Acquired	Ownership %	Retroactive Date
___	_____	_____	_____	_____	_____	_____
___	_____	_____	_____	_____	_____	_____
___	_____	_____	_____	_____	_____	_____
___	_____	_____	_____	_____	_____	_____
___	_____	_____	_____	_____	_____	_____

5. Has any Applicant acquired or sold another organization in the past 5 years? ☐ Yes ☐ No
   If Yes, describe: _____

6. Has any Applicant had a change in ownership or management in the past 12 months? ☐ Yes ☐ No
   If Yes, describe: _____

7. Is any Applicant managed by an independent management group? ☐ Yes ☐ No
   If Yes, describe: _____

8. Provide contact information for the following:

	Insurance Buyer	Risk Manager	Claims Contact
Name:	_____	_____	_____
Title:	_____	_____	_____
Telephone Number:	_____	_____	_____
Email Address:	_____	_____	_____
Mailing Address:	_____	_____	_____

SECTION C. COVERAGE REQUESTED –
COMPLETE APPLICABLE SECTIONS ONLY IF A QUOTATION FOR COVERAGE IS REQUESTED.

1. Effective Date Requested: _____ Coverage cannot be effective prior to the date the application is submitted.

2. ☐ Allied Healthcare Professional Liability:

☐ Claims-Made Only Retroactive Date: _____	Limit of Liability Requested: ☐ $1,000,000 Each Professional Incident $3,000,000 Aggregate ☐ Other: _____
Is any Applicant currently enrolled in a Patient Compensation Fund? ☐ Yes ☐ No If Yes, in what state(s) and for what limits: State(s) - _____ Limits - $_____ Each Professional Incident $_____ Aggregate	Deductible (Each Professional Incident/Aggregate): ☐ $2,500/None ☐ $5,000/None ☐ $10,000/None ☐ $25,000/None ☐ Other: $_____

3. ☐ General Liability

☐ Occurrence ☐ Claims-Made If Claims-Made, Retroactive Date: _____	Limit of Liability Requested: ☐ $1,000,000 Each Occurrence $3,000,000 Aggregate ☐ Other: $_____
Deductible (Each Occurrence/Aggregate): $_____/$_____ Will be the same as specified in Professional Liability section above.	

4. ☐ Employee Benefits Liability

Coverage trigger must be the same as the General Liability (either Claims-Made or Occurrence). If Claims-Made, specify EBL Retroactive Date: _____ Number of employees receiving benefits: _____	Limit of Liability Requested: ☐ $1,000,000 Each Employee $1,000,000 Aggregate ☐ Other: $_____

5. ☐ Non-Owned Automobile Liability

   a. Are personal automobiles owned by any Applicant's employees or are Independent Contractors used in any Applicant's business? ☐ Yes ☐ No
   If Yes, please complete the following:

      i. Does the Applicant(s) require all such employees and Independent Contractors to have auto liability insurance with limits at least equal to the state's minimum financial responsibility limits? ☐ Yes ☐ No

      If No, indicate the limits required: _____

ii. Does the Applicant(s) require evidence of auto liability insurance prior to allowing an employee or Independent Contractor to use a personal auto on company business? ☐ Yes ☐ No

iii. Does the Applicant(s) obtain a Motor Vehicle Report (MVR) prior to an employee or Independent Contractor to use a personal auto for company business? ☐ Yes ☐ No

b. Desired Limit of Liability for non-owned automobile liability coverage. (This limit may not be higher than General Liability limit.)
☐ $250,000 each claim/$250,000 aggregate
☐ $500,000 each claim/$500,000 aggregate
☐ $1,000,000 each claim/$1,000,000 aggregate

c. Does any Applicant own vehicles titled in the corporate name and used for business purposes? ☐ Yes ☐ No

d. Does any Applicant purchase and maintain in effect a business automobile policy? ☐ Yes ☐ No
If Yes, does the business auto policy include coverage for non-owned autos (covered auto symbol 1 or 9)? ☐ Yes ☐ No

e. Does any Applicant, employees and/or Independent Contractors regularly transport clients? ☐ Yes ☐ No

If Yes, please explain: _____

f. Is any Applicant aware of any accident, circumstance or loss related to auto liability, which may result in a claim? ☐ Yes ☐ No

6. ☐ Stop Gap (Employer's Liability – applicable only in ND, OH, WA, WV, and WY)

☐ Stop Gap (Employer's Liability) Requested
Payroll: $_____ State: _____

SECTION D. EXPOSURES

1. Provide historical and prospective annual gross revenue as follows:

	3 Years Prior (Annualized Data)	2 Years Prior (Annualized Data)	1 Year Prior (Annualized Data)	Projections for Current/Expiring Year (Annualized Data)	Projections for Requested Policy Period (Annualized Data)
Gross Revenue Excluding Durable Medical Equipment:	$_____	$___	$___	$___	$___
Gross Revenue Durable Medical Equipment Only:	$_____	$___	$___	$___	$___

2. Indicate the total projected number (annualized data) of patients to be served for the requested policy period and by location where the Applicant(s) provides services. (Total of all locations must equal 100%.)

Locations	% of Services	# of Patients	Locations	% of Services	# of Patients
☐ Applicants' Locations:	_____%	_____	☐ Hospitals:	_____%	_____
☐ Patients' Homes:	_____%	_____	☐ Long-Term Care Facilities:	_____%	_____
☐ Other: _____	_____%	_____	☐ Assisted Living Facilities:	_____%	_____

3. Indicate the percentage of the Applicants' patients in the following age groups. (Total of all age groups must equal 100%.)

18 and younger: _____%	19 to 65: _____%	65 and older: _____%

4. Does any Applicant provide management services to others? ☐ Yes ☐ No
   If Yes, describe: _____

5. Does any Applicant prescribe medications for patients? ☐ Yes ☐ No
   If Yes, describe: _____

6. Is methadone utilized in the treatment of patients? ☐ Yes ☐ No
   If Yes, describe: _____

7. Does any Applicant own or manage any residential facilities? ☐ Yes ☐ No
   If Yes, describe: _____

8. Does any Applicant offer recreational activities in the treatment of patients? ☐ Yes ☐ No
   If Yes, describe: _____

9. Will any new services be offered in the next 12 months? ☐ Yes ☐ No
   If Yes, describe: _____

10. Will any services be discontinued in the next 12 months? ☐ Yes ☐ No
    If Yes, describe: _____

11. Have any services been discontinued in the last 24 months? ☐ Yes ☐ No
    If Yes, describe: _____

SECTION E. COMPLETE THIS SECTION ONLY IF THE APPLICANT PROVIDES HOME HEALTH CARE AND/OR HOSPICE SERVICES. IF THESE SERVICES DO NOT APPLY, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION F.

1. Identify the referral sources by which patients are directed to the Applicant(s): _____

2. Are patients accepted for health care services only after receipt of a written plan by the attending physician? ☐ Yes ☐ No
   If No, explain any exceptions: _____

3. Do all patients receiving any level of skilled care have a current and regularly updated physician treatment plan on file? ☐ Yes ☐ No

4. Does the Applicant(s) have protocols when:

   a. patients no longer meet criteria for home/hospice care? ☐ Yes ☐ No
   b. providers should contact a physician? ☐ Yes ☐ No
   c. patients should be transferred to a hospital? ☐ Yes ☐ No

5. In-Home Services

   a. Does any Applicant provide "live-in" services? ☐ Yes ☐ No
      If Yes, please provide the percentage of Alzheimer, mentally incapacitated and quadriplegic patients: _____%
      What is the duration of care? _____

   b. Percentage of patients that are bed-bound: _____%

☐ Not Applicable

c. Do all visiting employees have training in transfer/lifting bed-bound patients? ☐ Yes ☐ No ☐ Not Applicable

d. Are employees required to complete daily work reports? ☐ Yes ☐ No

e. Does the Applicant(s) maintain a written clinical record showing the total number of visits by each category of staff for each patient? ☐ Yes ☐ No

f. Does the staff supervisor make regular and unannounced audit visits of staff in the field? ☐ Yes ☐ No

g. Estimate the percentage of services attributable to each of the following:

AIDS Therapy:	_____%	IV Therapy:	_____%
Chemotherapy:	_____%	Pediatric/Infant Childcare, including Babysitting:	_____%
High Tech Critical Care:	_____%	Tracheotomy/Ventilator Dependent – Adult:	_____%
Infant Monitoring (SIDS, etc.)	_____%	Tracheotomy/Ventilator Dependent – Pediatric:	_____%

6. Does any Applicant provide inpatient hospice care? ☐ Yes ☐ No
If Yes:

a. Indicate all locations where the Applicant(s) provides services. (Total of all locations must equal 100%.)

Hospitals:	_____%	Skilled Nursing Facilities:	_____%	Nursing Facilities(1):	_____%
Other:	_____%	Describe Locations: _____			

(1) Nursing Facilities that meet the special hospice standards regarding staffing and patient areas.

b. Are these services provided directly by the Applicant(s) or by a cooperative arrangement with a third party provider of inpatient care? _____

i. If inpatient hospice care is provided directly by the Applicant(s), indicate the number of projected occupied beds for the coverage period: _____ (annualized data)
☐ Not Applicable

ii. If inpatient hospice care is provided by a cooperative arrangement with a third party provider of inpatient care, does the agreement contain a mutual hold harmless and indemnification provision and requirements that the third party carry Professional and General Liability insurance with minimum limits of $1,000,000/$3,000,000? ☐ Yes ☐ No ☐ Not Applicable

SECTION F. COMPLETE THIS SECTION ONLY IF THE APPLICANT PROVIDES STAFFING AGENCY SERVICES. IF THESE SERVICES DO NOT APPLY, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION G.

1. Total projected annual revenues for the requested coverage period derived from supplemental staffing services: $_____

2. Indicate the percentage of total projected annual revenues by specialized service. (Total services must equal 100%).

Adult Day Care Facilities:	_____%	Industrial Facilities:	_____%
Correctional Facilities:	_____%	Long Term Care Facilities:	_____%
Clinics:	_____%	Physician Offices:	_____%

Hospice:	_____%	Psychiatric Facilities:	_____%
Hospitals:	_____%	Other – Describe Services: _____	_____%

3. If supplemental staffing is provided to hospitals, specify services:

Coronary Care Unit:	_____%	Neonatal:	_____%
Emergency Department:	_____%	Obstetrical:	_____%
Intensive Care Unit:	_____%	Pediatric:	_____%
Operating Room:	_____%	Psychiatric:	_____%
General Medical Services:	_____%	All Other Units – Describe Services: _____	_____%

SECTION G. PROFESSIONAL EMPLOYEES AND STAFF

1. Provide the following for Employees/Independent Contractors/Leased Workers/Volunteers:

Professional Classification	# of Employees		# of Independent Contractors(2)		# of Leased Workers(3)		# of Volunteers	
	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)
Addiction Counselor (certified member of NAADAC)								
Addiction Counselor (Non-member of NAADAC)								
Addiction Interventionist								
Administrative/Clerical								
Aide/Assistant Identify type: _____								
Art, Music, Dance, Pet, & Recreation Therapist								
Audiologist								
Auricular Acupuncture Therapist & Counselor								
Auricular & Full Body Acupuncture Therapist & Counselor								
Behavioral Analyst								
Blood Bank Technician								
Cardiology Technician								
Case Worker & Case Manager								
Certified Employee Assistance Professional								
Certified Tech./Assistant								
Companion/Homemaker								
Cytotechnologist								
Dental Assistant								
Dental Hygienist								
Dialysis Technician								
Dietician/Nutritionist								

Professional Classification	# of Employees		# of Independent Contractors(2)		# of Leased Workers(3)		# of Volunteers	
	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)
EKG/EEG Technician								
Health Educator								
Home Health Aide								
Homemaker								
Intern Mental Health/Addiction Counselor								
Lab Technician								
Licensed or Certified Mental Health Counselor								
LPN								
Marriage & Family Therapist & Counselor								
Massage Therapist								
Medical Office Assistant								
Medical Records Technician								
Medical Technologist								
Mental Health Counselor								
MRI Technician								
Nurse Aide								
Nurse/L.P.N.								
Nurse Practitioner								
Nurse/R.N.								
Occupational Therapist								
Paramedic/EMT Student								
Pastoral Counselor								
Pathology Assistant								
Patient Intake Technician								
Personal Coach								
Pharmacist (Mail Order, Nuclear)								
Pharmacist (Non-Mail Order – Non-Nuclear)								
Pharmacy Assistant								
Pharmacy Technician (dispensing)								
Phlebotomist								
Physical Therapist								
Physician Assistant Student								
Physician – Hospice & Palliative Care								
Psychological Assistant (Master's Degree)								

Professional Classification	# of Employees		# of Independent Contractors(2)		# of Leased Workers(3)		# of Volunteers	
	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)
Psychologist (Bachelor's, Master's or Doctorate Degree)	____	____	____	____	____	____	____	____
Psychologist (Post-Doctoral Student)	____	____	____	____	____	____	____	____
Radiological Technologist	____	____	____	____	____	____	____	____
Rehabilitation Counselor/Therapist	____	____	____	____	____	____	____	____
Rehabilitation Counselor/Therapist Assistant	____	____	____	____	____	____	____	____
Respiratory Assistant	____	____	____	____	____	____	____	____
Respiratory Therapist	____	____	____	____	____	____	____	____
Social Worker	____	____	____	____	____	____	____	____
Speech Therapist	____	____	____	____	____	____	____	____
Surgical Assistant Student	____	____	____	____	____	____	____	____
Surgical Technologist	____	____	____	____	____	____	____	____
Surgical Technologist/First Assistant	____	____	____	____	____	____	____	____
Technician – Other (specify) ____	____	____	____	____	____	____	____	____
Ultrasound Technician	____	____	____	____	____	____	____	____
Utilization Review Technician	____	____	____	____	____	____	____	____
Volunteer	____	____	____	____	____	____	____	____
Wellness Counselor	____	____	____	____	____	____	____	____
X-Ray Machine Technician/Operator	____	____	____	____	____	____	____	____
Other: ____	____	____	____	____	____	____	____	____
Other: ____	____	____	____	____	____	____	____	____

(2) Independent Contractor means a 1099 contractor. The standard ACE policy does not include Independent Contractors as Insureds. Such Independent Contractors should obtain their own insurance.
(3) Leased Worker means a person leased to the Applicants by a labor leasing firm under an agreement between the Applicants and the labor leasing firm, to perform duties related to the conduct of the Applicants' business. Leased Worker does not include a temporary worker. The standard ACE policy does not include Leased Workers as Insureds. Such Leased Workers should obtain their own insurance.
(4) FTE means Full Time Equivalents. 1 Full Time Equivalent = 2,000 annual hours.

2. Provide the following for each employed or contracted Physician Medical Director or Related Professional Staff Director performing administrative duties on the Applicants' behalf: ☐ Not Applicable

Name	Specialty	Employee	Contractor	# Hours Worked Per Year for the Applicant(s)	# Years of Experience as Medical Director
____	☐ Physician ☐ Other: ____ Specialty: ____	☐	☐	____ hours/year	____ years
____	☐ Physician ☐ Other: ____ Specialty: ____	☐	☐	____ hours/year	____ years

The standard ACE Professional Liability policy includes medical, surgical, nursing or related professional staff director or department head as an Insured but only while acting within the scope of their administrative duties and on the Applicants' behalf. Such directors or department heads should obtain their own Professional Liability insurance for other services.

3. Provide the following for each employed, contracted or leased Physician (other than Medical Directors). This information must be provided regardless of whether or not employed, contracted or leased Physicians are to be included for individual coverage. ☐ Not Applicable

Name	Specialty	Employee	Independent Contractor(2)	Leased Worker(3)	#f Hours Worked Per Year for the Applicant(s)
_____	_____	☐	☐	☐	_____ hours/year
_____	_____	☐	☐	☐	_____ hours/year

The standard ACE Professional Liability policy does not include any Physician as an Insured. The standard ACE General Liability policy does not include Independent Contractors or Leased Workers as Insureds. Physicians should obtain their own insurance.

SECTION H. LICENSE/CERTIFICATION INFORMATION

1. Licensed Specialty: _____

2. Licensing Agency(ies): _____

3. Applicant Accreditation: _____ Date Surveyed: _____
   Score: _____

4. Has any Applicant's license or certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? ☐ Yes ☐ No
   If Yes, describe: _____
   Date action taken: _____

5. Are there any charges pending against any Applicant? ☐ Yes ☐ No
   If Yes, describe: _____

6. Has any Applicant ever been investigated by a state health department, state licensing board or other governmental body? ☐ Yes ☐ No
   If Yes, describe: _____
   Date investigation commenced: _____

7. Are all Applicants licensed in all states in which they are operating? ☐ Yes ☐ No
   If No, explain: _____

8. List all memberships in professional organizations: _____

SECTION I. RISK MANAGEMENT

1. Are patient records protected in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996)? ☐ Yes ☐ No
   If No, explain: _____

2. Has any Applicant ever had an incident that resulted in an allegation of sexual abuse? ☐ Yes ☐ No
   If Yes, explain: _____

3. Is an informed consent process in place? ☐ Yes ☐ No

4. Are copies of informed consent forms maintained in patient files? ☐ Yes ☐ No

5. Does any Applicant conduct patient/client surveys? ☐ Yes ☐ No

6. Is a formal written Quality Assurance and Risk Management program in place? ☐ Yes ☐ No

7. Are written policies and procedures in place regarding the following:

Advance Directives/Living Wills:	☐ Yes ☐ No
Acceptance of Verbal Physician Orders:	☐ Yes ☐ No
Chain of Command:	☐ Yes ☐ No
Drug Administration Procedures:	☐ Yes ☐ No
Employee Training:	☐ Yes ☐ No
Emergency Management:	☐ Yes ☐ No
Food Preparation:	☐ Yes ☐ No
Handling of Complaints:	☐ Yes ☐ No
Incident Reporting:	☐ Yes ☐ No
Lifting Requirements:	☐ Yes ☐ No
Medical Equipment Training:	☐ Yes ☐ No
Medical Record Documentation:	☐ Yes ☐ No
Patient Acceptance:	☐ Yes ☐ No
Patient Discharge Procedures:	☐ Yes ☐ No
Patient Rights:	☐ Yes ☐ No
Reporting Suspected Abuse:	☐ Yes ☐ No

8. Is compliance with these policies and procedures enforced and monitored? ☐ Yes ☐ No

9. Do all contracts for clinical services include the following provisions:

   a. Mutual hold harmless and indemnification agreements? ☐ Yes ☐ No

   b. Require third parties to carry Professional and General Liability insurance with limits of at least $1,000,000/$3,000,000? ☐ Yes ☐ No

   c. Require the third party to provide the Applicant(s) with a Certificate of Insurance? ☐ Yes ☐ No

   d. Require the third party to be named as an Additional Insured on the Applicants' Professional and/or General Liability policy? ☐ Yes ☐ No

      If Yes:

      i. Please provide the name and details of the third party and their relationship to the Applicant(s): _____

      ii. Does the Applicant(s) require third parties to carry their own Professional Liability and General Liability insurance with limits of at least $1,000,000/$3,000,000? ☐ Yes ☐ No

10. Does the Applicant(s) require Certificates of Insurance from all Independent Contractors: ☐ Yes ☐ No

SECTION J. EMPLOYMENT PRACTICES

Does the Applicant(s) perform criminal background checks on:
☐ prospective employees ☐ independent contractors ☐ leased workers ☐ volunteers?

If Yes, what level of background check is performed (select all that apply):
☐ County
☐ State
☐ Federal

1. Are job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No

2. Do employees actively participate in continuing educational programs? ☐ Yes ☐ No

3. Does the Applicant(s) verify employment related references? ☐ Yes ☐ No

5. Does the Applicant(s) verify certification and/or professional licensure status of employees, Independent Contractors and Leased Workers? ☐ Yes ☐ No

6. Does the Applicant(s) confirm in writing any of the following related to prospective employees:

   a. Whether their medical Professional Liability insurance has been denied or canceled? ☐ Yes ☐ No
   (Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)

   b. Whether they have been involved in any Professional Liability claims or litigation? ☐ Yes ☐ No

   c. Whether any action has ever been taken on their clinical privileges? ☐ Yes ☐ No

   d. Does the Applicant(s) screen employees for drug and alcohol abuse? ☐ Yes ☐ No

   e. Does the Applicant(s) screen employees for any previous allegations against them involving sexual abuse or molestation? ☐ Yes ☐ No

   f. Does the Applicant(s) have a written crisis management plan for dealing with staff, victims, family, authorities, and the media if there is an incident of abuse? ☐ Yes ☐ No

SECTION K. GENERAL LIABILITY EXPOSURES

1. Provide the following information for each area owned, occupied, or leased by the Applicant(s).

Location	Square Footage	Year Built	Construction	Number of Floors	Type of Fire Protection(5)

(5) Fire Protection Key: AS = Approved Sprinkler; H = Heat Detector; S = Smoke Detector; A = Automatic Alarm

2. Has the Applicant(s) planned any new construction and/or abatement for the prospective coverage period? ☐ Yes ☐ No

   If Yes, describe: _____

3. Does any Applicant sponsor sporting or social events? ☐ Yes ☐ No
   If Yes, describe: _____

4. Does any Applicant own, operate or control a day care facility? ☐ Yes ☐ No
   If Yes:
   a. Are day care services open to the public? ☐ Yes ☐ No
   b. Number of Children: _____
   c. Number of Adults: _____
   d. Days and hours of operation: _____
5. Does any Applicant sell, rent or lease medical supplies and/or equipment to others? ☐ Yes ☐ No
   If Yes, describe: _____
6. Does any Applicant perform maintenance or repairs on equipment sold or leased? ☐ Yes ☐ No
   If Yes, describe: _____
7. Is all equipment checked and documented as to its condition prior to release? ☐ Yes ☐ No ☐ Not Applicable
8. Do all Applicants perform preventive maintenance on all equipment according to a written schedule? ☐ Yes ☐ No ☐ Not Applicable
9. Does any Applicant modify products in any way from their original use/form? ☐ Yes ☐ No
   If Yes, describe: _____
10. Does any Applicant repackage or re-label any items obtained from suppliers? ☐ Yes ☐ No
    If Yes, describe: _____
11. Is any equipment sold under the Applicants' name? ☐ Yes ☐ No
    If Yes, describe: _____
12. Does any Applicant have a sales staff? ☐ Yes ☐ No
    If Yes, is the sales staff trained by the manufacturer? ☐ Yes ☐ No
13. Does any Applicant repair or sell used equipment to others? ☐ Yes ☐ No
    If Yes, describe: _____
14. Does any Applicant distribute oxygen cylinders? ☐ Yes ☐ No
    If Yes:
    a. Are the oxygen cylinders pre-filled? ☐ Yes ☐ No
    b. Does any Applicant fill oxygen cylinders at the Applicants' premises? ☐ Yes ☐ No
15. Do all Applicants follow FDA and DOT regulations for the sterilization and transportation of oxygen? ☐ Yes ☐ No
16. Product Categories: Complete for all products sold/leased by the Applicant(s): ☐ Not Applicable

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

    Sales Receipts: $_____

☐ Category II NON-EXPENDABLE ITEMS (DME) - Durable Medical Equipment, 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, prosthetic devices and IV stands.

Sales Receipts: $_____ Lease Receipts: $_____

☐ Category III DIAGNOSTIC OR TREATMENT DEVICES – This category includes treatment devices or equipment not used to sustain life or perform critical life monitoring functions. This category includes items such as blood pressure gauges, IV pumps, portable EKG machines or sensing devices.

Sales Receipts: $_____ Lease Receipts: $_____

☐ Category IV LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES. This category includes oxygen and other medical gases used in conjunction with respiratory therapy, dialysis or heart/lung machines, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction. Failure or improper function of which, could result in the death or serious deterioration of the patients' health condition.

Sales Receipts: $_____ Lease Receipts: $_____

SECTION L. PREVIOUS INSURANCE

1. Professional Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability Each Claim/ Aggregate	Retention/Deductible Each claim/aggregate	Premium	Claims-Made/Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence

2. General Liability Insurance Coverage Information: (Complete only if GL coverage is requested.) Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability Each Claim/ Aggregate	Retention/Deductible Each Claim/ Aggregate	Premium	Claims-Made/Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____

Company	Policy Period	Limits of Liability Each Claim/ Aggregate	Retention/Deductible Each Claim/ Aggregate	Premium	Claims-Made/Occurrence
					☐ Occurrence

3. MISSOURI APPLICANTS SKIP THIS QUESTION
Has any primary or excess liability insurer refused canceled or non-renewed insurance for any Applicant in the past?
☐ Yes ☐ No
If Yes, explain: _____

SECTION M. PRIOR ACTS

1. If this application is for new Claims-Made coverage, including prior acts with ACE, will all current Primary and Excess Claims-Made policies accept claims for (a) a written notice, demand or service of suit against any Applicant, and (b) specific circumstances reasonably likely to give rise to a written notice, demand or service of suit against any Applicant? ☐ Yes ☐ No

   If Yes, does the Applicant(s) have a process to identify claims and specific circumstances regarding loss events reasonably likely to give rise to a written notice, demand or service of suit for purposes of timely reporting to the Applicants' Claims-Made insurers before expiration? ☐ Yes ☐ No

2. Have all such claims or specific circumstances reasonably likely to give rise to a claim been made under all the Applicants' current Claims-Made policies and accepted by all current insurers for coverage there under? ☐ Yes ☐ No

   If No, explain: _____

Note: Written notice, demand, service of suit and specific circumstances reasonably likely to give rise to a written notice, demand or service of suit known to any Applicant or any insurer prior to the requested effective date for any Applicant will be excluded.

SECTION N. FRAUD WARNING, DECLARATION & CERTIFICATION, AND SIGNATURE

NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND & WEST VIRGINIA 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 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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 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.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive 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 KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

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 MAINE 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 MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 MINNESOTA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 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 such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: 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 APPLICANTS: WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

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 TENNESSEE, VIRGINIA & 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.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND CERTIFICATION:

BY SIGNING THIS APPLICATION, THE APPLICANT REPRESENTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS AND ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRENSENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH

PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant	Signature of Broker/Agent
Title	Date
Date	Signed by Licensed Resident Agent (Where Required By Law)