



Healthcare Facility Liability Protection Renewal Application

Name of Applicant: _____ **Policy Number:** _____
 (Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

A. General Information

1. Please use the Comments section to advise us of any changes to the contact information we have for you including the following:

- Address Phone/Fax Number Email Address Contact Person

2. Please use the Comments section to advise us of any desired changes to your insurance program including the following:

- Deductible Limits Umbrella Coverage Physician Coverage Other

For the following questions, please explain all "yes" answers in the Comments section.

3. Have there been any changes to the Applicant's operation within the past 12 months related to the following?

- Obtaining another operation/entity? Yes No
- Selling or discontinuing any operation/entity? Yes No
- Adding or reducing the number of employees? Yes No
- Adding or reducing the number of locations? Yes No
- Adding or reducing current services? Yes No
- Operating in new states? Yes No
- Entering into any joint ventures or limited partnerships? Yes No
- New construction or renovation projects? Yes No

4. Are future operational changes anticipated related to the items listed in question #3? Yes No

5. Have there been any changes to the Applicant's additional named insureds? Yes No

6. Does the Applicant provide management services to other entities for a fee? Yes No

7. Does the Applicant sell or rent any equipment to others? Yes No

8. Has the Applicant employed any new physicians in the past 12 months that are not currently listed on the schedule? If yes, please complete an individual application for each person. Yes No

9. Please specify exposure information based upon the following:

Type	Number	Exposure
Total Number of Employees	_____	Employees
Adult or Child Care Center	_____	Individuals
HMO/PPO/IPA or other Managed Care Services	_____	Members
Vacant Land	_____	Acres
Pay Parking Areas	_____	Receipts
Fitness Center Open to the Public	_____	Receipts

***Please attach a listing of locations or a copy of your statement of values.**

B. Professional Services

DIRECTIONS: Check each box that applies, giving the requested information for each classification using the most recent 12 months. Use the Comments section for additional classifications not listed or for further explanation.

Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed. Include visits made to a client's home when home health care is provided.
Annual Receipts	Use annual gross revenues resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Beds	Use the average number of occupied beds by dividing the total annual inpatient days by 365.
FTE	Use the full-time equivalent based upon 2080 annual hours.
Donations	Rate for each unit received from a donor.
Sub-Acute Care	Applicable to facilities offering ventilator care, wound management, post-operative care/trauma recovery, intravenous/antibiotic/hydration therapy, spinal cord/head injury care, oncology, total parenteral nutrition (TPN), blood/plasma transfusion, central line care, tracheostomy and dialysis.
Skilled Care	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings.
Intermediate Care	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living - bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation.
Assisted Living	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self administration and/or assistance with medication.
Independent Living	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication.

Behavioral Health	Visits	Beds
<input type="checkbox"/> Mental Health Counseling	_____	_____
<input type="checkbox"/> Substance Abuse Counseling	_____	_____
<input type="checkbox"/> Developmental Disability	_____	_____
<input type="checkbox"/> Crisis Center	_____	_____

Rehabilitation	Visits	Beds
<input type="checkbox"/> Cardiac Rehabilitation	_____	_____
<input type="checkbox"/> Physical or Occupational Rehab	_____	_____
<input type="checkbox"/> Trauma Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Trauma Rehab/Transitional Living	_____	_____

Surgical/Specialized Services	Visits	Beds
<input type="checkbox"/> Birthing Center	_____	_____
<input type="checkbox"/> Endoscopy	_____	_____
<input type="checkbox"/> Lithotripsy	_____	_____
<input type="checkbox"/> Surgicenter	_____	_____
<input type="checkbox"/> X-Ray/Imaging	_____	Receipts

Home Care/Hospice/Medical Registry	Visits	Beds
<input type="checkbox"/> Hospice Care	_____	_____
<input type="checkbox"/> Intravenous Therapy	_____	_____
<input type="checkbox"/> Personal/Companion Care	_____	_____
<input type="checkbox"/> Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Respiration Therapy	_____	_____
<input type="checkbox"/> Skilled Care	_____	_____
<input type="checkbox"/> Durable Medical Equipment	_____	Receipts
<input type="checkbox"/> Pharmacy	_____	Receipts
<input type="checkbox"/> Medical Registry	Refer to supplemental application.	

Ambulance Companies	FTE
<input type="checkbox"/> Ambulance Service Company	_____ EMT _____ Paramedical

Schools for Healthcare Professionals			
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Dental	<input type="checkbox"/> Medical	<input type="checkbox"/> Optometry
<input type="checkbox"/> CRNA	<input type="checkbox"/> EMT	<input type="checkbox"/> Nursing	<input type="checkbox"/> Other

Non-Direct Healthcare Services	Number
<input type="checkbox"/> Dental Laboratory	_____ Receipts
<input type="checkbox"/> Medical Laboratory	_____ Receipts
<input type="checkbox"/> Ocular Laboratory	_____ Receipts
<input type="checkbox"/> Pathology Laboratory	_____ Receipts
<input type="checkbox"/> Pharmacy	_____ Receipts
<input type="checkbox"/> Durable Medical Equipment	_____ Receipts
<input type="checkbox"/> Blood/Plasma Bank	_____ Donations
<input type="checkbox"/> Organ Bank - direct processing	_____ Donations
<input type="checkbox"/> Organ Bank - no direct processing	_____ Donations

Treatment Centers	
<input type="checkbox"/> College/University Health Center	_____ Visits
<input type="checkbox"/> Community Health Center	_____ Visits
<input type="checkbox"/> Convenience Care/Retail Clinic	_____ Visits
<input type="checkbox"/> Dialysis Center	_____ Visits
<input type="checkbox"/> Medi-Spa	_____ Visits
<input type="checkbox"/> Municipal Health Department	_____ Visits
<input type="checkbox"/> Oncology Services	_____ Visits
<input type="checkbox"/> Optical Establishment	_____ Receipts
<input type="checkbox"/> Sleep Lab	_____ Beds
<input type="checkbox"/> UrgiCenter	_____ Visits
<input type="checkbox"/> Weight Loss Center	_____ Visits

Long Term Care	Total Licensed Beds	Average Occupancy
<input type="checkbox"/> Sub Acute Care	_____	_____
<input type="checkbox"/> Skilled Care	_____	_____
<input type="checkbox"/> Intermediate Care	_____	_____
<input type="checkbox"/> Assisted Living	_____	_____
<input type="checkbox"/> Home Health Care	_____ Visits	_____
<input type="checkbox"/> Independent Living	_____ Units	_____ Total
		Number of Residents at Full Occupancy

