



Healthcare Facility General Application for Liability Insurance New Business

Requested Effective Date _____

Instructions:

- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this application is completed and all required documents are provided.
- A supplemental application may be required as instructed under section L.

Required Documents

In addition to this application, the following information is required:

1. Loss runs, dated within 60 days of submission, covering the past ten years
2. Declarations page from current insurance carrier including retroactive date if claims-made coverage
3. Latest annual financial statements
4. Organizational chart
5. Marketing or advertising materials
6. Quality Improvement or Risk Management Plan
7. Most recent state survey reports, licensure reports and accreditation survey reports as applicable
8. Supplemental Application as required under Section L
9. Healthcare Umbrella Application if limits above \$1,000,000/\$3,000,000 are being requested
10. For Long Term Care Facilities, current CMS forms 671 Facility Staffing, 672 Resident Census, CMS 2567 and Quality Indicator Report for the past two six-month periods
11. Roles and responsibilities for volunteer workers as applicable

| | | | | |
|--|--------|--------------|-------------------|-----------------|
| A. Agent (Do not complete this section if you are insured directly with MMIC.) | | | | |
| Agent Name: | | Agency Name: | | Address: |
| City: | State: | Zip: | Telephone Number: | Fax Number: |
| B. Applicant Information (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.) | | | | |
| Legal Name of Applicant: | | | Website: | Tax ID Number: |
| Address (Street, City, State, Zip Code): | | | | County: |
| Telephone Number: | | Fax Number: | | E-mail Address: |
| Legal structure (Check all that apply): | | | | |
| <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> For Profit <input type="checkbox"/> Not for Profit <input type="checkbox"/> Government <input type="checkbox"/> Other (Specify): | | | | |
| Accreditations/Certifications (Check all that apply): | | | | |
| <input type="checkbox"/> JCAHO Accredited <input type="checkbox"/> CCAC Accredited <input type="checkbox"/> CCRC Accredited <input type="checkbox"/> AAAHC <input type="checkbox"/> Medicare/Medicaid Certified <input type="checkbox"/> Other (Specify): | | | | |
| Is the Applicant currently enrolled in a Patients' Compensation Fund or other state insurance fund? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| <input type="checkbox"/> Kansas Health Care Stabilization Fund <input type="checkbox"/> Nebraska Excess Liability Fund <input type="checkbox"/> Wisconsin Patients' Compensation Fund <input type="checkbox"/> Other (Specify): | | | | |
| Description of services provided: | | | | |
| Who may our Risk Management representative contact for a telephone or on-site review of your facility: | | | | |
| Name/Title: | | | | |
| Telephone Number: | | Fax Number: | | E-mail Address: |

C. General Information

1. Indicate the number of years the Applicant has been:
 Operating: _____ Owned by present owners: _____ Managed by present management: _____
2. Is the Applicant managed by a management company? Yes No
 If yes, provide the name of the management company: _____
 How many years in place with this management company? _____
3. Within the next 12 months, does the Applicant plan to:
- a. Obtain another operation/entity? Yes No
 - b. Add or reduce the number of employees? Yes No
 - c. Add or reduce the number of locations? Yes No
 - d. Add or reduce current services? Yes No
 - e. Operate in other states? Yes No
- Explain all "yes" answers in the Comments section.
4. Within the past 5 years, has the Applicant acquired, sold or discontinued any operations? Yes No
 If yes, use the Comments section to explain.

5. Gross Revenue

Provide gross revenue for the years indicated:

| | Projected | Current Year | 1 Year Prior | 2 Years Prior | 3 Years Prior |
|---------------|-----------|--------------|--------------|---------------|---------------|
| Gross Revenue | \$ _____ | \$ _____ | \$ _____ | \$ _____ | \$ _____ |

6. Financial Interest

List the following details for each medical professional that has a financial interest in the Applicant's business. Use the Comments section if more space is needed.

| Name | Profession | Policy No. | Interest (Owner/director/etc) | Patient Care | |
|------|------------|------------|----------------------------------|------------------|------------------|
| | | | | For the Facility | Outside Practice |
| | | | | % | % |
| | | | | % | % |
| | | | | % | % |
| | | | | % | % |
| | | | | % | % |

7. Subsidiaries and Affiliates

List all subsidiaries and affiliates of the Applicant.

| Name of Subsidiary/Affiliate | Description of Operations | Ownership Interest | Date Acquired | Current Insurance Carrier | Retroactive Date if Claims-Made | Coverage Desired? Y/N |
|------------------------------|---------------------------|--------------------|---------------|---------------------------|---------------------------------|-----------------------|
| | | % | | | | |
| | | % | | | | |
| | | % | | | | |
| | | % | | | | |

8. Licensing

List all licenses held by the Applicant including type and expiration dates.

| | |
|--|--|
| | |
| | |

- Has the Applicant's license been suspended, revoked or placed under probation? Yes No
 If yes, provide a detailed explanation in the Comments section, including the date the license was reinstated.

9. Has the Applicant ever filed for bankruptcy? Yes No
 If yes, please give name of the corporation and details of the arrangement in the Comments section.

10. Medicare/Medicaid

- a. Is the Applicant approved for Medicare or Medicaid? Yes No
- b. Has the Applicant been denied a Medicare or Medicaid certification? Yes No
- c. Has the Applicant had its Medicare or Medicaid certification limited, suspended or revoked? Yes No
 If yes, please explain in the Comments section.
- d. Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations or paid any fines or penalties? Yes No
 If yes, please explain in the Comments section.

11. Inspection/Surveys

- a. When was the last inspection/survey of the Applicant by an outside entity? _____
- b. Who performed the inspection? _____
- c. Indicate total number of deficiencies: _____
 For long term care applicants, indicate the following: D,E,F,G deficiencies: _____ F,H,I,J,K,L deficiencies: _____
- d. Was a Corrective Action Plan accepted? Yes No
- e. How many patient/family complaints were investigated in the past three (3) years? _____
- f. How many complaints were substantiated? _____

D. Premises and Operations

1. List all premises owned, rented, leased, occupied or used by the Applicant. Attach a separate schedule if more space is needed.

| Address | Use | Year Built | Constr. Type Number* | Fire Class | Number of Stories | Sprinkler System Y/N | Total Area |
|---------|-----|------------|----------------------|------------|-------------------|----------------------|------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

*Construction Type Number: 1 = Frame, 2 = Joisted Masonry, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive

- 2. Does each location meet applicable NFPA building codes? Yes No
- 3. Does the Applicant have a written emergency evacuation plan? If yes, please attach a copy of the plan. Yes No
- 4. If an inpatient care facility location is more than 15 years old, when was the last qualified inspection of electric, heating and plumbing? _____
- 5. List any planned major fund-raising activities or sporting events which will be sponsored by the Applicant during the next year:

- 6. Are there any construction projects planned for the next year? Yes No
 If yes, provide a description of the project in the Comments section, including estimated cost and duration of the project.
- 7. Does the Applicant operate a child daycare facility? Yes No If yes, specify the following:
 Total licensed: _____ Average Participants: _____ Hours of Operation: _____ Number of Employees: _____
 Does the Applicant provide transportation of children? Yes No
 If yes, describe:

8. Does the Applicant operate an adult daycare facility? Yes No

If yes, specify the following:

Total licensed: _____ Average Participants: _____ Hours of Operation: _____ Number of Employees: _____

Does the Applicant provide transportation? Yes No

If yes, describe:

Are medical services provided? Yes No

If yes, describe:

9. Does the Applicant operate a fitness center? Yes No

If yes, what are the hours of operation? _____

Is there an attendant on duty during hours of operation? Yes No Annual Receipts: \$ _____

E. Current Coverage

Professional Liability Carrier Information:

Limit of Coverage:

Deductible/Retention:

Policy Period:

Policy Premium:

Coverage Type: Occurrence Claims-Made

If Claims-Made, retroactive date is: _____

General Liability Carrier Information:

Limit of Coverage:

Deductible/Retention:

Policy Period:

Policy Premium:

Coverage Type: Occurrence Claims-Made

If Claims-Made, retroactive date is: _____

Has any insurer canceled or declined to issue any of the coverages being applied for under this application?* Yes No

If yes, include an explanation in the Comments section.

*Missouri applicants do not answer this question.

F. Coverage Requested

1. Limits of Liability (Limits are expressed as per claim/aggregate)

Professional Liability Limit: \$1,000,000/\$3,000,000* Other: _____

General Liability Limit: \$1,000,000/\$3,000,000* Other: _____

Employee Benefits Liability Limit: \$1,000,000/\$3,000,000* Other: _____

If Employee Benefits Liability coverage is desired, please specify total number of employees: _____

*For limits above \$1,000,000/\$3,000,000, please complete a Healthcare Umbrella Application.

2. Deductibles

No Deductible \$5,000/\$25,000 \$10,000/\$50,000 \$25,000/\$125,000 Other-Specify: _____

3. Form of Insurance

Is retroactive coverage being applied for? Yes No Retroactive Date: _____

G. Medical Equipment/Products

1. Does the Applicant sell, rent, lease or distribute any of the following? Yes No

Durable Medical Equipment/Supplies Expendable Medical Equipment/Supplies Medical Products

If yes, check the appropriate category and answer the following questions:

a. Does the Applicant provide service or maintenance for the equipment/products? Yes No

b. If an outside vendor provides maintenance, what limits of liability insurance are required? \$ _____

c. Does the Applicant repackage or redesign the equipment/products? Yes No

Describe the type of equipment/products sold or leased in the Comments section.

2. Does the Applicant manufacture any type of medical equipment and/or products? Yes No

If yes, describe type of equipment and/or products in the Comments section.

H. Administration and Staff

I. Medical Director

- a. Does the Applicant employ or contract a medical director? Yes No
 If yes, please answer the following questions.
- b. What is the name of the medical director? _____
- c. What is the employment status of the medical director? Employee Contractor
- d. What is the medical specialty of the medical director? _____
- e. How many hours per month, on average, is the medical director on-site at the facility? _____
- f. Does the medical director have direct patient contact? Yes No
 If yes, indicate the insurance carrier and limits of liability carried.
 Insurance Carrier: _____ Limits of Liability: _____
- Is the medical director involved in credentialing facility medical staff? Yes No
- g. Is the medical director an active participant in the facility's quality improvement program? Yes No
- h. Is the medical director responsible for hiring and firing? Yes No
- i. Is the medical director involved with peer review of physicians? Yes No

2. Physicians and Surgeons

| Physicians and Surgeons | Specialty | Insurance Carrier and Policy Number | Check one: | Hours/Month* |
|-------------------------|-----------|-------------------------------------|--|--------------|
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |
| | | | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer | |

*Hours/Month – Indicate the total number of hours per month, on average, that each individual works for the Applicant.

3. Allied Health Care Professionals – Indicate the number of personnel in each applicable category:

| | Employees | | Contractors | | Volunteers | |
|------------------------------------|-----------|-----------|-------------|-----------|------------|-----------|
| | Full-Time | Part-Time | Full-Time | Part-Time | Full-Time | Part-Time |
| Dentists | | | | | | |
| Chiropractors | | | | | | |
| Podiatrists | | | | | | |
| Oral Surgeons | | | | | | |
| Nurse Anesthetists/CRNAs | | | | | | |
| Nurse Midwives | | | | | | |
| Nurse Practitioners | | | | | | |
| Phys Assist/Surgical First Assist. | | | | | | |
| EMTs/Paramedics | | | | | | |
| Occupation Therapists | | | | | | |
| Therapists | | | | | | |
| RNs/LPNs/LVNs | | | | | | |
| Social Workers | | | | | | |
| Psychologists | | | | | | |
| Lab Technicians | | | | | | |
| Optometrists | | | | | | |
| Pharmacists | | | | | | |
| Estheticians | | | | | | |
| Other (describe) | | | | | | |

4. Insurance Requirements – Please explain any “No” answers in the Comments section.

Does the Applicant require the following health care professionals to carry professional liability insurance?

- Physicians or Surgeons Yes No Limits \$ _____
- Allied Healthcare professionals Yes No Limits \$ _____

5. Hiring/Screening Procedures

- a. Are hiring/screening procedures in place for all workers providing patient care services? Yes No
- b. Do the procedures apply to: Employees Contractors Volunteers
- c. Please indicate if the following procedures are included in the hiring and screening process:
 - 1) Verification of educational background, including licensure and/or certification? Yes No
 - 2) Confirm hospital privileges for physicians, oral surgeons and dentists? Yes No
How often is the list of specific privileges updated? _____
 - 3) Check for any license suspensions, revocations or any disciplinary actions? Yes No
 - 4) Check criminal history? Yes No
 - 5) Require information regarding medical professional claims history? Yes No
- d. Does the Applicant have a formal/documented orientation program in place? Yes No
- e. Does the Applicant have a formal/documented credentialing program in place? Yes No
- f. Are workers transporting patients? Yes No
If yes, are driving records (MVRs) verified? Yes No How often? _____

6. Risk Management

Is the overall responsibility for Quality Improvement/Risk Management designated to one individual? Yes No

If no, please describe how these functions are monitored:

| |
|----------------------------------|
| I. Contractual Agreements |
|----------------------------------|

- 1. Does the Applicant have an attorney review all contracts before signing? Yes No
If no, who reviews the contracts? _____
- 2. Has the Applicant signed any contractual agreements to provide services to others? Yes No
If yes, describe the types of services:
- 3. Has the Applicant signed any contractual agreements where others are providing healthcare services on behalf of the Applicant? Yes No
If yes, describe the types of service:

Specify the minimum limits of liability that are required: \$ _____

Is proof of this coverage verified? Yes No

Does the contract contain an indemnification (hold harmless) clause? Yes No

J. 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 |

