



**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:**

<input type="checkbox"/> Abortion/Family Planning _____ %	<input type="checkbox"/> Crisis Intervention _____ %	<input type="checkbox"/> Occupational _____ %
<input type="checkbox"/> Alcohol/Drug _____ %	<input type="checkbox"/> Family/Marital _____ %	<input type="checkbox"/> School/Youth _____ %
<input type="checkbox"/> Child Abuse/Sexual Offenders _____ %	<input type="checkbox"/> General Guidance _____ %	<input type="checkbox"/> Other _____ %
<input type="checkbox"/> Criminal _____ %	<input type="checkbox"/> 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. \_\_\_\_\_

5. Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following?	<b>Yes</b>	<b>No</b>	<b>N/A</b>
General Liability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Professional Liability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?  Yes  No  
If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?  Yes  No

7. Have you entered into any contractual agreements?  Yes  No  
If yes, is legal advice sought to write and approve?  Yes  No  
Does the agreement require you to hold any third party harmless?  Yes  No

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. \_\_\_\_\_



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
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

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
			<input type="checkbox"/>	
			<input type="checkbox"/>	
			<input type="checkbox"/>	

**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