RENEWAL APPLICATION for: **Miscellaneous Medical Malpractice Insurance**

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

1. Name of Applicant: _____

2. Physical Address: _____ Phone: _____

   City: _____ County: _____ State: _____ Zip: _____

   No. of Locations: _____ **(If multiple names and locations, please attach list.)**

3. a) Date Established: _____

   Corporation ☐ Partnership ☐ Professional Assoc. ☐ Individual ☐ For Profit ☐ Not for Profit ☐

   b) In what states is the Applicant registered and licensed to practice? _____

4. Have there been any changes to the Applicant's operations in the past 12 months? ☐ Yes ☐ No
   If "Yes", attach explanation.

5. If the Applicant is an entity:

   a) Is the entity engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No

   b) Is the entity owned by any physician? ☐ Yes ☐ No

   c) Is the entity owned by any hospital or are any services hospital-based? ☐ Yes ☐ No

   d) Have there been any changes in ownership of the business since the date the entity was established? ☐ Yes ☐ No

   If "Yes", to any of the above, please provide details:

   _____

   _____

   _____

6. Professional Activities and Specialty: **(Attach narrative description, if necessary)**

   Check all that apply:

   _____ Acupuncturist/Naturopathic Medicine
   _____ Alcohol/Drug/Psychiatric Rehabilitation
   _____ Ambulance Services
   _____ Ambulatory Surgery Center
   _____ Diagnostic Imaging
   _____ Dialysis Center
   _____ Health/Fitness Center
   _____ Home Healthcare Agency
   _____ Hospice
   _____ Medical Spa (Please complete Medical Spa Supplemental)
   _____ Medical Testing/Laboratory
   _____ Nurse Registry
   _____ Optometry
   _____ Out-Patient Medical Clinic
   _____ Out-Patient Mental Health Clinic
   _____ Pharmacy (Please complete Pharmacy Supplemental)
   _____ Residential Facility
   _____ Speech Therapy
   _____ Other (Specify): _____

7. State approximate division of Applicant's patients among:

a)	Alcoholics	(%)		k)	Obstetrical	(%)	
b)	Counseling/Family Planning	(%)		l)	Pediatric	(%)	
c)	Communicable Disease	(%)		m)	Prisoners	(%)	
d)	Dental	(%)		n)	Psychiatric	(%)	
e)	Drug Addicts	(%)		o)	Research or Experimental	(%)	
f)	General	(%)		p)	Senile or Aged	(%)	
g)	Hemodialysis	(%)		q)	Stress Testing	(%)	
h)	Holistic Medicine	(%)		r)	Surgical	(%)	
i)	Medical	(%)		s)	Tubercular	(%)	
j)	Mentally Retarded	(%)		t)	Other: _____	(%)	

8. a) List the number and type of Applicant's employees and volunteers below: If "None", state None. _____

Number	Type of Profession		Number	Type of Profession
i) _____	Acupuncturist		xv) _____	Opticians
ii) _____	Counselor		xvi) _____	Optometrist
iii) _____	Chiropractor		xvii) _____	Paramedics
iv) _____	Dentist		xviii) _____	Perfusionist
v) _____	Dental Assistant		xix) _____	Pharmacist
vi) _____	EMT		xx) _____	Pharmacist Tech
vii) _____	Home Health Aide		xxi) _____	Physician Assistant
viii) _____	Inhalation Therapist		xxii) _____	Physician/Surgeon
ix) _____	Laboratory Technician		xxiii) _____	Physiotherapist
x) _____	Licensed Practical, Nurse		xxiv) _____	Psychologist
xi) _____	Massage Therapist		xxv) _____	Registered Nurse
xii) _____	Medical Director		xxvi) _____	Social Worker
xiii) _____	Nurse Anesthetist		xxvii) _____	Speech Therapist
xiv) _____	Nurse Practitioner		xxviii) _____	Other: _____

b) List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet, if necessary. If "None", state None. _____

_____

_____

_____

c) Are all of the individuals listed in questions 8.a. and 8.b. licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

If "No", attach explanation.

d) Are all employed/contracted physicians board certified in their specialty? ☐ Yes ☐ No ☐ N/A

e) Do all employed/contracted physicians carry their own Med Mal coverage with limits of at least 1million/$3million? ☐ Yes ☐ No ☐ N/A

If "No", attach explanation.

f) 1) Are criminal background checks conducted on all employees, volunteers and independent contractors? ☐ Yes ☐ No

If "No", attach explanation.

2) Does the Applicant conduct pre-employment screenings and background investigations prior to hiring all employees, volunteers and independent contractors? ☐ Yes ☐ No

If "No", attach explanation.

g) Has the Applicant or any of the individuals listed in questions 8.a. and 8.b:

i) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

ii) Ever been convicted of an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

iii) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered same? ☐ Yes ☐ No

If "Yes", to any of the above, attach explanation.

9. a) Does the Applicant have a written/formalized risk management/quality assurance program? ☐ Yes ☐ No

b) Does the Applicant have a written credentialing process for employees and all staff? ☐ Yes ☐ No

c) Does the Applicant have written procedures for reporting all incidents? ☐ Yes ☐ No

If "No", to any of the above, attach explanation.

10. State approximate division of services being provided among the following settings:

a)	Assisted Living Facilities (%)	e)	Nursing Homes	(	%)
b)	Clinics (%)	f)	Physician Offices	(	%)
c)	ER/ ICO/Labor: Delivery (%)	g)	Private Homes	(	%)
d)	Hospitals (%)	h)	Other:_____	(	%)

11. a) State sources and amounts of the Applicant's total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
1. Charitable Contributions:	$_____	$_____
2. Government Funding:	$_____	$_____
3. Fee for Services:	$_____	$_____
4. Products Sales: (attach a list of products)	$_____	$_____
5. Other:_____	$_____	$_____
TOTAL GROSS REVENUE	$ 0.00	$ 0.00

b) For PHARMACIES, state sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
1. Prescription Sales:	$_____	$_____
2. Non-Prescription Sales:	$_____	$_____
3. Other:_____	$_____	$_____

c) Are all drugs dispensed by the Applicant approved by the FDA? ☐ Yes ☐ No

If "No", attach explanation.

12. Number of estimated patient encounters and patient tests in the next 12 months: (Note: "patient encounters" refers to number of visits – not number of patients.)

    Patient encounters: _____

    Patient Tests: _____

13 a) Have any claims, lawsuits, proceedings, actions, complaints, demand letters, administrative proceedings, formal or informal governmental investigations or inquiries been made against you or any other person or entity proposed for this insurance within the last twelve (12) months? ☐ Yes ☐ No

   b) If "**Yes**", to question 13a), have all such claims, lawsuits, proceedings, actions, complaints, demand letters, or investigations/inquiries been reported to NAS? ☐ Yes ☐ No ☐ N/A

   c) If "**No**", to question 13b), please provide full details on a separate page of each matter received within the last twelve (12) months.

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISION.

1. **The undersigned represents that the statements, representations and information contained herein, or attached to this application, are true and complete, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this application.**
2. **The undersigned acknowledges that the signing of this application does not bind the undersigned to complete the insurance. The undersigned further acknowledges that the statements, representations, and information contained herein, or submitted with this application (which shall be retained on file by the Underwriters and shall be deemed attached hereto, as if physically attached hereto), are material to the risk assumed by the insurer; that any policy will have been issued in reliance upon the truth thereof; and that this application and all written statements and materials furnished to the Insurer in conjunction with this application shall be deemed incorporated into and made a part of the policy, should a policy be issued.**
3. **The Underwriters are hereby authorized to make any investigation and inquiry in connection with this application as they may deem necessary.**
4. **The undersigned acknowledges and agrees that if the information supplied on this application, or in any attachments, changes between the date of the application and the effective date of the policy period, the Applicant will immediately notify the Underwriters of such change, and the Underwriters may withdraw or modify any outstanding quotations and/or agreement to bind the insurance.**
5. **For purposes of creating a binding contract of insurance by the Application, or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall have the same force and effect as an original signature, and that the original and any such copies shall be deemed one and the same document.**

For Kentucky residents:
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.

Authorized Director or Officer, Partner or Principal of the Applicant	Title
Signature	Date

AR1861M-0712