Instructions:

1. **Review the Common Application Form GL 1053** completed last year in conjunction with this Renewal Common Application. This renewal application should be used only if the applicant had completed the Form GL 1053 in a prior year and were not required to complete an Allied Health Supplemental Application as listed in item 11 of the Form GL 1053. All other Allied Health entities should complete the applicable Allied Health Supplemental Application.
2. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
3. This application must be completed, signed and dated by an authorized officer of the entity.
4. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

---

1. Name of applicant organization and names of legal entities past and present that are intended for coverage:
   _____

2. Do you want to change your current insurance structure? ☐ Yes ☐ No

3. Has the following occurred within the last 12 months or is the following planned within the next 12 months:
   a. Sold, discontinued or acquired any operations ☐ Yes ☐ No
   b. Added any locations/leases ☐ Yes ☐ No
   c. Signed new contracts to provide services to others or where others provide services to you ☐ Yes ☐ No
   d. Added any new procedure, products or services ☐ Yes ☐ No

4. Has there been a change in patient population served within the last 12 months or do you plan to have a change to the patient population in the next 12 months? ☐ Yes ☐ No

If Yes to questions 2 through 4, please provide details on a separate sheet of your letterhead.

5. Do you require physicians and contracted independent licensed practitioners to carry professional liability insurance with limits of at least $1,000,000 each claim/$3,000,000 aggregate? ☐ Yes ☐ No

6. Is the applicant accredited? ☐ Yes ☐ No
   If Yes, by whom? _____

Include all services, including new services and acquired operations below Include loss runs for acquired operations.

7. Gross Revenue: Projected: $_____ Current Year: $_____

8. Professional Services - Indicate all services provided by completing the information in the far right column. **This information is the basis for rating the submission.** Information given should be **projected numbers for the next 12 months**. The metrics reported will depend on the type of service. For example, if a Convenient Care Center projects the number of visits or actual beds over the next 12 months. **"Visits"** are defined as the number of patients entering the facility for health related services per year. DO NOT tally the number of departments visited or the number of procedures or treatments performed. **"Beds"** are defined as the average number of occupied beds. **"Receipts"** are defined as Gross Receipts.

Risk Classification	Projected next 12 months	Metrics
Convenient Care Center or Retail Health Clinic	# of Visits	
EmergiCenter Services	# of Visits	
Endoscopy Center	# of Visits	
Health Department Services	# of Patients/# of Beds	
Medical Administrative Services	# of Patients/# of Beds	
Optical Services	Annual Receipts	
Sleep Centers	# of patients/# of beds	
Telemedicine	# of patients/type of treatment	
Transport Non-Emergency	# of Transports	
Urgent Care Centers	# of Visits	

Risk Classification	Projected next 12 months	Metrics
Weight Loss Services	# of visits	
Other: (describe)	Annual Revenue/# of patients	

9. Is the applicant involved in Complementary and Alternative Medicine as defined by the National Institutes of Health? (CAM is a group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine.) ☐ Yes ☐ No
10. Does the applicant house patients overnight? ☐ Yes ☐ No
11. Have there been any changes with respect to the staffing of the Medical Director position? ☐ Yes ☐ No
12. Have there been any changes to staffing of licensed and non-licensed employees or contractors? ☐ Yes ☐ No
13. Have any physician/licensed practitioner's license employed by or contracted been suspended, revoked or voluntarily surrendered during the last 12 months? ☐ Yes ☐ No
14. Has the applicant's organization invoked limitations or conditions on any physician/licensed practitioner's privileges in the last 12 months? ☐ Yes ☐ No

If Yes to questions 9 thru 14 please provide details. _____

15. Does applicant sell any medical or therapeutic supplies and/or equipment? ☐ Yes ☐ No

    If Yes, Annual Receipts $ _____
16. Does applicant rent or lease any medical or therapeutic supplies and/or equipment to others: ☐ Yes ☐ No

    If Yes, Annual Receipts $ _____
17. Provide an updated loss history dated within 60 days for the past 5 years (including the current year) on a report-year basis. Loss data must include the incident/occurrence date, report date/claim made date, expense payments, indemnity payments, expense reserves, indemnity reserves, description of allegation and close date.

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: 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.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to $15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

Signature in full _____ Date _____

Name - please print _____

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation.