☐ **Ace American Insurance Company**
☐ **Illinois Union Insurance Company**
☐ **Westchester Surplus Lines Insurance Company**

Healthcare/Miscellaneous Facilities Liability Application

Instructions:

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use ☒ for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

Supporting information:

Along with this completed and signed application, the applicant must also submit the following information:

1. Loss experience details:
   a. A minimum of 5 years of loss runs.
   b. Incurred loss amounts: Breakdown of paid and outstanding loss amounts for indemnity and expenses.
   c. Loss descriptions: For all losses with incurred loss amounts.
   d. Scope of Coverage: Loss experience for all applicants and coverages to be considered under this application.
2. Organizational chart including ownership percentage of each organization and relationship of each organization to one another.
3. Financial statements (audited, if available).

SECTION A. – PRODUCER CONTACT INFORMATION

Company Name:	_____	Surplus Lines Agent Name:	_____
Business Address:	_____	Surplus Lines Agent's Business Address:	_____
Telephone Number:	_____	Surplus Lines Agent's Telephone Number:	_____
Facsimile Number:	_____	Surplus Lines Agent's License Number:	_____

Email Address:	_____

SECTION B. – APPLICANT

1. Legal name of the parent entity to be the first named insured exactly as it shall be shown on the policy.

First Named Insured	Street Address
_____	_____
City, State, Zip Code	County
_____	_____

2. Applicant is:

☐ Individual
☐ Partnership
☐ Corporation
☐ Joint Venture
☐ Limited Liability Company

☐ Profit
☐ Non-Profit

3. List any subsidiary or affiliate to be insured exactly as it shall be shown on the policy. Include its relationship to the parent entity shown in item B.1. above, a description of operations, date of acquisition or creation, percentage of ownership by the applicant, and requested retroactive date. If the space below is inadequate, attach a list providing the same information for each applicant.

Loc. #	Business Legal Name & Address	Relationship to Parent Entity	Description of Operations	Date Acquired	Ownership %	Retroactive Date
_____	_____	_____	_____	_____	_____ %	_____
_____	_____	_____	_____	_____	_____ %	_____
_____	_____	_____	_____	_____	_____ %	_____
_____	_____	_____	_____	_____	_____ %	_____
_____	_____	_____	_____	_____	_____ %	_____

4. Has any applicant acquired or sold another organization in the past 5 years? ☐ Yes ☐ No
If Yes, describe: _____

5. Has any applicant had a change in ownership or management in the past 12 months? ☐ Yes ☐ No
If Yes, describe: _____

6. Is any applicant managed by an independent management group? ☐ Yes ☐ No
If Yes, describe: _____

7. Provide contact information for the following:

	Insurance Buyer	Risk Manager	Claims Contact
Name:	_____	_____	_____
Title:	_____	_____	_____
Telephone Number:	_____	_____	_____
Email Address:	_____	_____	_____
Mailing Address:	_____	_____	_____

SECTION C. – COVERAGE REQUESTED

1. Coverage Period Requested From: _____ To: _____

2. Date Quotation Desired: _____

3. Coverage/Limits/Deductible Requested – Healthcare Facilities Professional Liability:

☐ Claims-Made Only Retroactive Date: _____	Limit of Liability Requested: ☐ $1,000,000 Each Professional Incident $3,000,000 Aggregate ☐ Other: _____
Is any applicant currently enrolled in a Patient Compensation Fund? ☐ Yes ☐ No If Yes, in what state(s) and for what limits: State(s) - _____ Limits - $_____ Each Professional Incident $_____ Aggregate	Deductible (Each Professional Incident/Aggregate): ☐ $10,000/None ☐ $25,000/None ☐ $50,000/None ☐ Other: $_____

4. Coverage/Limits/Deductible Requested – General Liability

☐ Occurrence ☐ Claims-Made If Claims-Made, Retroactive Date: _____	Limit of Liability Requested: ☐ $1,000,000 Each Occurrence $3,000,000 Aggregate ☐ Other: $_____
Deductible (Each Occurrence/Aggregate): ☐ $10,000/None ☐ $25,000/None ☐ $50,000/None ☐ Other: $_____	

5. Coverage/Limits Requested – Employee Benefits Liability

☐ Occurrence ☐ Claims-Made If Claims-Made, Retroactive Date: _____ Number of employees receiving benefits: _____	Limit of Liability Requested: ☐ $1,000,000 Each Employee $3,000,000 Aggregate ☐ Other: $_____

6. Coverage Requested – Non-Owned Automobile Liability

☐ Non-Owned Automobile Liability Coverage Requested Number of employees driving personal auto for work: _____

7. Coverage Requested – Stop Gap (Employer's Liability)

☐ Stop Gap (Employer's Liability) Requested Payroll: $_____ State: _____

8. Underlying Coverages/Limits Requested – Excess Liability

Underlying coverages: ☐ Healthcare Facilities Professional Liability Retroactive Date: _____ ☐ General Liability If Claims-Made, Retroactive Date: _____ ☐ Other: _____	Excess Limits of Liability Requested: ☐ $1,000,000 Each Occurrence or Each Professional Incident $1,000,000 Aggregate ☐ $2,000,000 Each Occurrence or Each Professional Incident $2,000,000 Aggregate ☐ $3,000,000 Each Occurrence or Each Professional Incident $3,000,000 Aggregate ☐ $4,000,000 Each Occurrence or Each Professional Incident $4,000,000 Aggregate ☐ $5,000,000 Each Occurrence or Each Professional Incident $5,000,000 Aggregate ☐ Other: $_____

SECTION D. – EXPOSURES

1. Provide census data for all exposures applicable to the applicants.

Service	Projections for Current or Expiring Year	Projections for Requested Coverage Period	Service	Projections for Current or Expiring Year	Projections for Requested Coverage Period
☐ Ambulatory Surgery Center (1)	_____ visits	_____ visits	☐ Hospice (in-patient services) (2)	_____ avg. occupied beds	_____ avg. occupied beds
☐ Clinic	_____ visits	_____ visits	☐ Imaging Center (1)	$_____ receipts	$_____ receipts
☐ Community Health Center or Health Department	_____ visits	_____ visits	☐ Laboratory (1)	$_____ receipts	$_____ receipts
☐ Dialysis (1)	_____ visits	_____ visits	☐ Lithotripsy (1)	_____ visits	_____ visits
☐ Durable Medical Goods (expendables such as bandages, hypodermic needles, etc.)	$_____ receipts	$_____ receipts	☐ Mental Health Counseling	_____ visits	_____ visits
☐ Durable Medical Goods (non-expendables – excluding diagnostic or treatment devices; includes beds, wheel chairs, etc.)	$_____ receipts	$_____ receipts	☐ Optical Establishment	$_____ receipts	$_____ receipts
☐ Durable Medical Goods (diagnostic or treatment devices; includes oxygen and medical gases, IV pumps, etc.)	$_____ receipts	$_____ receipts	☐ Pharmacy	$_____ receipts	$_____ receipts
☐ Durable Medical Goods (life sustaining or critical monitoring equipment; includes dialysis or heart lung machines, apnea monitors, etc.)	$_____ receipts	$_____ receipts	☐ Rehabilitation (physical, occupational, cardiac, trauma, etc.)	_____ visits	_____ visits
☐ Employee Health Center	_____ visits	_____ visits	☐ School (1)	Refer to Application Supplement	Refer to Application Supplement
☐ Health & Wellness Center	_____ visits	_____ visits	☐ Sleep Center	_____ visits	_____ visits
☐ Home Health (infusion therapy) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	☐ Staffing Agency (3)	Refer to Section F.	Refer to Section F.
☐ Home Health (professional care) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	☐ Student Health Center	_____ visits	_____ visits
☐ Home Health (homemaker/personal care/ companion) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	☐ Substance Abuse (including counseling & rehab)	_____ visits	_____ visits
☐ Hospice (professional care) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	☐ Weight Loss Center	_____ visits	_____ visits
☐ Hospice (homemaker/ personal care/companion) (2)	_____ visits; or _____ hours	_____ visits; or _____ hours	☐ Other – Describe: _____	_____	_____

(1) A separate ACE Application Supplement is required if the applicant provides this service.
(2) Complete SECTION E. for Home Health Care and/or Hospice services.
(3) Complete SECTION F. for Staffing Agency services.

2. Provide historical and prospective annual gross revenue as follows:

	3 Years Prior	2 Years Prior	1 Year Prior	Projections for Current or Expiring Year	Projections for Requested Coverage Period
Gross Revenue:	$_____	$_____	$_____	$_____	$_____

3. Indicate all locations where the applicant(s) provides services. (Total of all locations must equal 100%.)

☐ Applicants' Locations: _____%	☐ Hospital: _____%	☐ Long Term Care Facility: _____%
☐ Patients' Homes: _____%	☐ Prison/Jail Facility: _____%	☐ Mobile Facility: _____%
☐ Other: _____%	☐ Other: _____%	☐ Other: _____%
Describe location: _____	Describe location: _____	Describe location: _____

4. Indicate the percentage of the applicants' patients in the following age groups. (Total of all age groups must equal 100%.)

18 and younger: _____%	19 to 65: _____%	65 and older: _____%

5. Does any applicant provide management services to others? ☐ Yes ☐ No
If Yes, describe: _____

6. Does any applicant engage in the following services?

a. Formal clinical research under the auspices of an institutional review board: ☐ Yes ☐ No
If Yes, describe: _____

b. Administration or distribution of non-FDA approved pharmaceuticals (experimental drugs): ☐ Yes ☐ No
If Yes, describe: _____

c. Biomedical device research and development: ☐ Yes ☐ No
If Yes, describe: _____

7. Does any applicant sell, rent or lease medical supplies and/or equipment to others? ☐ Yes ☐ No
If Yes, describe: _____

8. Does any applicant perform maintenance or repairs on equipment sold or leased? ☐ Yes ☐ No
If Yes, describe: _____

9. Is all equipment checked and documented as to its condition prior to release? ☐ Yes ☐ No ☐ Not Applicable

10. Do all applicants perform preventive maintenance on all equipment according to a written schedule? ☐ Yes ☐ No ☐ Not Applicable

11. Does any applicant modify products in any way from their original use/form? ☐ Yes ☐ No
If Yes, describe: _____

12. Does any applicant repackage or re-label any items obtained from suppliers? ☐ Yes ☐ No
If Yes, describe: _____

13. Is any equipment sold under the applicants' name? ☐ Yes ☐ No
If Yes, describe: _____

14. Does the applicant have a sales staff? ☐ Yes ☐ No
    If Yes, is the sales staff trained by the manufacturer? ☐ Yes ☐ No

15. Does any applicant repair or sell used equipment to others? ☐ Yes ☐ No
    If Yes, describe: _____

16. Does any applicant distribute oxygen cylinders? ☐ Yes ☐ No
    If Yes, are the oxygen cylinders pre-filled? ☐ Yes ☐ No
    If Yes, does any applicant fill oxygen cylinders at the applicants' premises? ☐ Yes ☐ No

17. Do all applicants follow FDA and DOT regulations for the sterilization and transportation of oxygen?
    ☐ Yes ☐ No
    ☐ Not Applicable

18. Does any applicant prescribe medications for patients? ☐ Yes ☐ No
    If Yes, describe: _____

19. Is methadone utilized in the treatment of patients? ☐ Yes ☐ No
    If Yes, describe: _____

20. Does any applicant own or manage any residential facilities? ☐ Yes ☐ No
    If Yes, describe: _____

21. Does any applicant offer recreational activities in the treatment of patients? ☐ Yes ☐ No
    If Yes, describe: _____

22. Will any new services be offered in the next 12 months? ☐ Yes ☐ No
    If Yes, describe: _____

23. Will any services be discontinued in the next 12 months? ☐ Yes ☐ No
    If Yes, describe: _____

24. Have any services been discontinued in the last 24 months? ☐ Yes ☐ No
    If Yes, describe: _____

SECTION E. – COMPLETE THIS SECTION ONLY IF THE APPLICANT PROVIDES HOME HEALTH CARE AND/OR HOSPICE SERVICES. IF THESE SERVICES DO NOT APPLY, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION F.

1. Who/what are the referral sources by which patients are directed to the applicant: _____

2. Are patients accepted for health care services only after receipt of a written plan by the attending physician?
   ☐ Yes ☐ No
   If No, explain any exceptions: _____

3. Do all patients receiving any level of skilled care have a current and regularly updated physician treatment plan on file? ☐ Yes ☐ No

4. Does the applicant have protocols when:

   a. patients no longer meet criteria for home/hospice care? ☐ Yes ☐ No

   b. providers should contact a physician? ☐ Yes ☐ No

c. patients should be transferred to a hospital? ☐ Yes ☐ No

5. In-Home Services.

a. Does any applicant provide 24-hour services? ☐ Yes ☐ No
If yes, describe: _____

b. Does any applicant provide "live-in" services? ☐ Yes ☐ No
If yes, describe: _____

c. Percentage of patients that are bed-bound: _____%
☐ Not Applicable

d. Do all visiting employees have training in transfer/lifting bed-bound patients? ☐ Yes ☐ No
☐ Not Applicable

e. Are employees required to complete daily work reports? ☐ Yes ☐ No

f. Does the applicant maintain a written clinical record showing the total number of visits by each category of staff for each patient? ☐ Yes ☐ No

g. Does the staff supervisor make regular and unannounced audit visits of staff in the field? ☐ Yes ☐ No

h. Estimate the percentage of services attributable to each of the following.

AIDS Therapy:	_____%	IV Therapy:	_____%
Chemotherapy:	_____%	Pediatric/Infant Childcare including Babysitting:	_____%
High Tech Critical Care:	_____%	Tracheotomy/Ventilator Dependent – Adult:	_____%
Infant Monitoring (SIDS, etc.):	_____%	Tracheotomy/Ventilator Dependent – Pediatric:	_____%

SECTION F. - COMPLETE THIS SECTION ONLY IF THE APPLICANT PROVIDES STAFFING AGENCY SERVICES. IF THESE SERVICES DO NOT APPLY, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION G.

1. Total projected annual revenues for the requested coverage period derived from supplemental staffing services: $_____

2. Indicate the percentage of total projected annual revenues by specialized service. (Total services must equal 100%).

Adult Day Care Facilities:	_____%	Industrial Facilities:	_____%
Correctional Facilities:	_____%	Long Term Care Facilities:	_____%
Clinics:	_____%	Physician Offices:	_____%
Hospice:	_____%	Psychiatric Facilities:	_____%
Hospitals:	_____%	Other:	_____%
		Describe services: _____	

3. If supplemental staffing is provided to hospitals, specify services:

Coronary Care Unit:	_____%	Neonatal:	_____%
Emergency Department:	_____%	Obstetrical:	_____%
Intensive Care Unit:	_____%	Pediatric:	_____%
Medical/Surgical Unit:	_____%	Psychiatric:	_____%
		All Other Units:	_____%
		Describe services: _____	

SECTION G. – PROFESSIONAL EMPLOYEES AND STAFF

1. Provide the following for Employed or Contracted Medical Directors.

☐ Not Applicable

Name	Specialty	Employed	Contracted	Number of Hours Worked Per Week for the Applicant	Number of Years of Experience as Medical Director
_____	_____	☐	☐	_____ hours per week	_____ years
_____	_____	☐	☐	_____ hours per week	_____ years
_____	_____	☐	☐	_____ hours per week	_____ years

2. Provide the following for Employed or Contracted Physicians.

☐ Not Applicable

Name	Specialty	Employed	Contracted (4)	Number of Hours Worked Per Week for the Applicant	Does Physician carry own Professional Liability insurance? If Yes, indicate limits.
_____	_____	☐	☐	_____ hours per week	☐ Yes ☐ No If Yes, limits: $_____ / $_____
_____	_____	☐	☐	_____ hours per week	☐ Yes ☐ No If Yes, limits: $_____ / $_____
_____	_____	☐	☐	_____ hours per week	☐ Yes ☐ No If Yes, limits: $_____ / $_____
_____	_____	☐	☐	_____ hours per week	☐ Yes ☐ No If Yes, limits: $_____ / $_____

(4) These independent contractors will not be Insureds and will not have coverage under the policy for which the applicants are applying. Such independent contractors should obtain their own insurance.

3. Provide the following for Professional Employees/Independent Contractors.

Professional Classification	Number of Employees		Number of Contractors (5)		Number of Volunteers	
	FTEs (6)	Hours (annual)	FTEs (6)	Hours (annual)	FTEs (6)	Hours (annual)
Aides/Assistants Indicate type: _____						
Companion/Personal Care Asst/ Homemaker						
Dentist						
Dialysis Technician						
Dietician/Nutritionist						
Mental Health Counselor						
Nurse Practitioner						
Nurse/R.N./L.P.N.						
Occupational Therapist						
Pastoral Counselor						
Pharmacist						
Physical Therapist						
Physician Assistant						
Psychologist						
Radiological Technologist						
Rehabilitation Counselor/ Therapist						
Respiratory Therapist						
Social Worker						
Speech Therapist						
Technicians						
Other (specify) _____						
Other (specify) _____						
GRAND TOTAL:						

(5) These independent contractors will not be Insureds and will not have coverage under the policy for which the applicants are applying. Such independent contractors should obtain their own insurance.

(6) FTE means Full Time Equivalents. 1 Full Time Equivalent = 2,000 annual hours.

SECTION H. – LICENSE/CERTIFICATION INFORMATION

1. Licensed Specialty: _____

2. Licensing Agency(ies): _____

3. Applicant Accreditation: _____
   Date Surveyed: _____
   Score: _____

4. Has any applicant's license or certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? ☐ Yes ☐ No
   If Yes, describe: _____

5. Are there any charges pending against any applicant? ☐ Yes ☐ No
   If Yes, describe: _____

6. Has any applicant ever been investigated by a state health department, state licensing board or other governmental body? ☐ Yes ☐ No
   If Yes, describe: _____

7. Are all applicants licensed in all states in which they are operating? ☐ Yes ☐ No
   If No, explain: _____

8. List all memberships in professional organizations: _____

SECTION I. – RISK MANAGEMENT

1. Are patient records protected in accordance with HIPPA (Health Insurance Portability and Accountability Act of 1996)? ☐ Yes ☐ No
   If No, explain: _____

2. Has any applicant ever had an incident that resulted in an allegation of sexual abuse? ☐ Yes ☐ No
   If Yes, explain: _____

3. Is an informed consent process in place? ☐ Yes ☐ No

4. Are copies of informed consent forms maintained in patient files? ☐ Yes ☐ No

5. Does the applicant conduct patient/client surveys? ☐ Yes ☐ No

6. Is a formal written Quality Assurance and Risk Management program in place? ☐ Yes ☐ No

7. Are written policies and procedures in place regarding the following:

Advance Directives/Living Wills:	☐ Yes ☐ No
Acceptance of Verbal Physician Orders:	☐ Yes ☐ No
Chain of Command:	☐ Yes ☐ No
Drug Administration Procedures:	☐ Yes ☐ No
Employee Training:	☐ Yes ☐ No
Emergency Management:	☐ Yes ☐ No
Food Preparation:	☐ Yes ☐ No
Handling of Complaints:	☐ Yes ☐ No
Incident Reporting:	☐ Yes ☐ No
Lifting Requirements:	☐ Yes ☐ No
Medical Equipment Training:	☐ Yes ☐ No
Medical Record Documentation:	☐ Yes ☐ No
Patient Acceptance:	☐ Yes ☐ No
Patient Discharge Procedures:	☐ Yes ☐ No
Patient Rights:	☐ Yes ☐ No
Reporting Suspected Abuse:	☐ Yes ☐ No

   Is compliance with these policies and procedures enforced and monitored? ☐ Yes ☐ No

8. Do all contracts for clinical services include mutual hold harmless and indemnification agreements? ☐ Yes ☐ No
   If No, describe the contracted services where these provisions do not exist: _____

9. Do all contracts for clinical services contain minimum Professional Liability insurance requirements for the other party? ☐ Yes ☐ No
   If Yes, what is the minimum amount required? $_____ Each Professional Incident/$_____ Annual Aggregate
   If No, describe the contracted services where this provision does not exist: _____

10. Does the applicant require certificates of insurance from all independent contractors: ☐ Yes ☐ No

SECTION J. – EMPLOYMENT PRACTICES

1. Does the applicant perform criminal background checks on prospective employees? ☐ Yes ☐ No

2. Are job descriptions provided for all professional and nonprofessional employees? ☐ Yes ☐ No

3. Do employees actively participate in continuing educational programs? ☐ Yes ☐ No

4. Does the applicant verify employment related references? ☐ Yes ☐ No

5. Does the applicant verify certification and/or professional licensure status of employees and independent contractors? ☐ Yes ☐ No

6. Are independent contractors and volunteers subject to employment screening practices including criminal background checks and reference checks? ☐ Yes ☐ No
   If No, explain: _____

7. Does the applicant confirm in writing any of the following related to prospective employees:

Whether their medical Professional Liability insurance has been denied or canceled? (Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)	☐ Yes ☐ No
Whether they have been involved in any Professional Liability claims or litigation?	☐ Yes ☐ No
Whether any action has ever been taken on their clinical privileges?	☐ Yes ☐ No

8. Does the applicant screen employees for drug and alcohol abuse? ☐ Yes ☐ No

9. Does the applicant screen employees for any previous allegations against them involving sexual abuse or molestation? ☐ Yes ☐ No

10. Does the applicant have a written crisis management plan for dealing with staff, victims, family, authorities, and the media if there is an incident of abuse? ☐ Yes ☐ No

SECTION K. – GENERAL LIABILITY EXPOSURES

1. Provide the following information for each area owned, occupied, or leased by the applicant.

Location	Square Footage	Year Built	Construction	Number of Floors	Type of Fire Protection (7)

(7) Fire Protection Key: AS = Approved Sprinkler; H = Heat Detector; S = Smoke Detector; A = Automatic Alarm

2. Has the applicant planned any new construction and/or abatement for the prospective coverage period? ☐ Yes ☐ No
   If Yes, describe: _____

3. Does any applicant sponsor sporting or social events? ☐ Yes ☐ No
   If Yes, describe: _____

4. Does any applicant own, operate or control a day care facility? ☐ Yes ☐ No
   If Yes, are day care services open to the public? ☐ Yes ☐ No
   If Yes:
   a. Number of Children: _____
   b. Number of Adults: _____
   c. Days and hours of operation: _____

SECTION L. – NON-OWNED/HIRED AUTOMOBILE LIABILITY EXPOSURES - COMPLETE THIS SECTION ONLY IF PRIMARY NON-OWNED/HIRED AUTOMOBILE LIABILITY COVERAGE IS REQUESTED. IF THIS COVERAGE IS NOT REQUESTED, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION M.

1. Is Hired and Non-Owned Automobile Liability coverage provided by the applicants' primary Automobile coverage? ☐ Yes ☐ No
2. Does the applicant have a policy and procedures to secure motor vehicle records for all drivers who frequently use their personal autos for business use? ☐ Yes ☐ No
3. Does the applicant secure evidence of personal Automobile Liability insurance from all drivers who frequently use their personal automobile for business use? ☐ Yes ☐ No

SECTION M. – EXCESS LIABILITY UNDERLYING SCHEDULE - COMPLETE THIS SECTION ONLY IF EXCESS LIABILITY COVERAGE IS REQUESTED. IF THIS COVERAGE IS NOT REQUESTED, DISREGARD THIS ENTIRE SECTION AND PROCEED TO SECTION N.

1. Provide the following information for each coverage to be included as scheduled underlying insurance.

Coverage	Company	Policy Number	Policy Period	Limits of Liability	Premium
Automobile Liability Attach loss runs.	_____	_____	_____	$_____ / $_____	$_____
Employer's Liability	_____	_____	_____	$_____ / $_____ / $_____	$_____
General Liability	_____	_____	_____	$_____ / $_____	$_____
Professional Liability	_____	_____	_____	$_____ / $_____	$_____
Other (specify): _____	_____	_____	_____	$_____ / $_____	$_____

2. Does any applicant own motor vehicles? ☐ Yes ☐ No
   If Yes, provide a schedule by vehicle type and principal garaging location.
3. Does any applicant own or operate ambulances or provide emergency patient transport services? ☐ Yes ☐ No
   If Yes:
   a. Annual number of emergency runs: _____
   b. Annual number of non-emergency runs: _____
4. Does the applicant have a policy and procedures to secure motor vehicle records for all drivers? ☐ Yes ☐ No

5. Does any applicant own, lease or operate any aircraft? ☐ Yes ☐ No
   If Yes, describe: _____

6. Does any applicant have employees flying owned or non-owned aircraft? ☐ Yes ☐ No
   If Yes, describe: _____

7. Are any fuel services provided for aircraft? ☐ Yes ☐ No
   If Yes, describe: _____

8. Does any applicant own or lease watercraft? ☐ Yes ☐ No
   If Yes, describe: _____

9. Has any applicant rejected a state Workers' Compensation Act? ☐ Yes ☐ No
   If Yes, indicate organization name and state: _____

SECTION N. – PREVIOUS INSURANCE

1. Professional Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence

2. General Liability Insurance Coverage Information: Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence

3. Excess Liability Insurance Coverage Information. Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability	Retention/Deductible	Premium	Claims-Made/Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence
_____	_____	$_____ / $_____	$_____ / $_____	$_____	☐ Claims-Made Retro Date: _____ ☐ Occurrence

4. Missouri Applicants Disregard This Question and Proceed to Section O.
Has any Primary or Excess Liability insurer refused, canceled or non-renewed insurance for any applicant in the past? ☐ Yes ☐ No
If Yes, explain: _____

SECTION O. – PRIOR ACTS WARRANTY

1. If this application is for new Claims-Made coverage including prior acts with ACE, will all current Primary and Excess Claims-Made policies accept claims for (a) a written notice, demand or service of suit against any applicant, and (b) specific circumstances reasonably likely to give rise to a written notice, demand or service of suit against any applicant? ☐ Yes ☐ No
If Yes, does the applicant have a process to identify claims and specific circumstances regarding loss events reasonably likely to give rise to a written notice, demand or service of suit, for purposes of timely reporting to the applicants' Claims-Made insurers before expiration? ☐ Yes ☐ No

2. Have all such claims or specific circumstances reasonably likely to give rise to a claim been made under all the applicants' current Claims-Made policies and accepted by all current insurers for coverage there under? ☐ Yes ☐ No

If No, explain: _____

Note: Written notice, demand, service of suit, and specific circumstances reasonably likely to give rise to a written notice, demand or service of suit, known to any applicant or any insurer prior to the requested effective date for any applicant will be excluded.

SECTION P. – FRAUD WARNING, DECLARATION & CERTIFICATION, AND SIGNATURE

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMAITON IN AN APPICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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 information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, 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.

NOTICE TO OHIO APPLICANTS: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE & VIRGINIA AND WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO WEST VIRGINIA APPLCIANTS: Any person who knowingly presents a false or fraudulent claims for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS ATTACHED HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS

WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE APPLICANT AGREES TO COOPERAT WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant	Signature of Broker/Agent
Title	Date
Date	Signed by Licensed Resident Agent (Where Required By Law)