



CLAIMS-MADE/OCCURRENCE DISCLOSURE NOTICE

THE POLICY YOU ARE APPLYING FOR MAY CONTAIN BOTH CLAIMS-MADE AND OCCURRENCE COVERAGES. PLEASE READ THE POLICY IN ITS ENTIRETY. SOME OF THE PROVISIONS CONTAINED IN THE POLICY RESTRICT COVERAGE, SPECIFY WHAT IS AND IS NOT COVERED AND DESIGNATE RIGHTS AND DUTIES.

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.

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:	_____	Agent Name:	_____
Business Address:	_____	Business Address:	_____
Telephone Number:	_____	Telephone Number:	_____
Facsimile Number:	_____	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.



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First Named Insured (Legal Corporate Name, Partnership or Sole Proprietor's Name) _____	DBA Name _____
Mailing Address _____	Date Established _____
County In Which Services Are Provided _____	FIN Number _____
Telephone Number _____	Facsimile Number _____
Website Address _____	Email Address _____

2. Applicant is:

- | | |
|---|--|
| <input type="checkbox"/> Individual
<input type="checkbox"/> Partnership
<input type="checkbox"/> Corporation
<input type="checkbox"/> Joint Venture
<input type="checkbox"/> Limited Liability Company | <input type="checkbox"/> Profit
<input type="checkbox"/> Non-Profit
<input type="checkbox"/> Charitable
<input type="checkbox"/> Government |
|---|--|

3. Description of Operations (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Home Health Care Agency
<input type="checkbox"/> Visiting Nurse Agency
<input type="checkbox"/> Supplemental Staffing
<input type="checkbox"/> Infusion Therapy Firm
<input type="checkbox"/> Nurse Registry | <input type="checkbox"/> Hospice
<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Medical Equipment Supplier
<input type="checkbox"/> Other (specify): _____ |
|---|---|

4. 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

5. Has any Applicant acquired or sold another organization in the past 5 years? Yes No
 If Yes, describe: _____
6. Has any Applicant had a change in ownership or management in the past 12 months? Yes No
 If Yes, describe: _____
7. Is any Applicant managed by an independent management group? Yes No
 If Yes, describe: _____

8. Provide contact information for the following:



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- ii. Does the Applicant(s) require evidence of auto liability insurance prior to allowing an employee or Independent Contractor to use a personal auto on company business? Yes No
 - iii. Does the Applicant(s) obtain a Motor Vehicle Report (MVR) prior to an employee or Independent Contractor to use a personal auto for company business? Yes No
 - b. Desired Limit of Liability for non-owned automobile liability coverage. (This limit may not be higher than General Liability limit.)
 - \$250,000 each claim/\$250,000 aggregate
 - \$500,000 each claim/\$500,000 aggregate
 - \$1,000,000 each claim/\$1,000,000 aggregate
 - c. Does any Applicant own vehicles titled in the corporate name and used for business purposes? Yes No
 - d. Does any Applicant purchase and maintain in effect a business automobile policy? Yes No
If Yes, does the business auto policy include coverage for non-owned autos (covered auto symbol 1 or 9)? Yes No
 - e. Does any Applicant, employees and/or Independent Contractors regularly transport clients? Yes No
If Yes, please explain: _____
 - f. Is any Applicant aware of any accident, circumstance or loss related to auto liability, which may result in a claim? Yes No
6. Stop Gap (Employer's Liability – applicable only in ND, OH, WA, WV, and WY)
- Stop Gap (Employer's Liability) Requested
 Payroll: \$ _____ State: _____

SECTION D. EXPOSURES

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

	3 Years Prior	2 Years Prior	1 Year Prior	Projections for Current/Expiring Year	Projections for Requested Policy Period
	(Annualized Data)	(Annualized Data)	(Annualized Data)	(Annualized Data)	(Annualized Data)
Gross Revenue Excluding Durable Medical Equipment:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Gross Revenue Durable Medical Equipment Only:	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

2. Indicate the total projected number (annualized data) of patients to be served for the requested policy period and by location where the Applicant(s) provides services. (Total of all locations must equal 100%.)

Locations	% of Services	# of Patients	Locations	% of Services	# of Patients
<input type="checkbox"/> Applicants' Locations:	_____ %	_____	<input type="checkbox"/> Hospitals:	_____ %	_____
<input type="checkbox"/> Patients' Homes:	_____ %	_____	<input type="checkbox"/> Long-Term Care Facilities:	_____ %	_____
<input type="checkbox"/> Other: _____	_____ %	_____	<input type="checkbox"/> Assisted Living Facilities:	_____ %	_____



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3. 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: ___%

4. Does any Applicant provide management services to others? [] Yes [] No
If Yes, describe: _____

5. Does any Applicant prescribe medications for patients? [] Yes [] No
If Yes, describe: _____

6. Is methadone utilized in the treatment of patients? [] Yes [] No
If Yes, describe: _____

7. Does any Applicant own or manage any residential facilities? [] Yes [] No
If Yes, describe: _____

8. Does any Applicant offer recreational activities in the treatment of patients? [] Yes [] No
If Yes, describe: _____

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

10. Will any services be discontinued in the next 12 months? [] Yes [] No
If Yes, describe: _____

11. 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. Identify the referral sources by which patients are directed to the Applicant(s): _____

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(s) 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 "live-in" services? [] Yes [] No
If Yes, please provide the percentage of Alzheimer, mentally incapacitated and quadriplegic patients: _____%
What is the duration of care? _____

b. Percentage of patients that are bed-bound: _____%



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Not Applicable

- c. Do all visiting employees have training in transfer/lifting bed-bound patients? Yes No
 Not Applicable
- d. Are employees required to complete daily work reports? Yes No
- e. Does the Applicant(s) maintain a written clinical record showing the total number of visits by each category of staff for each patient? Yes No
- f. Does the staff supervisor make regular and unannounced audit visits of staff in the field? Yes No
- g. 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:	_____ %

- 6. Does any Applicant provide inpatient hospice care? Yes No
If Yes:

- a. Indicate all locations where the Applicant(s) provides services. (Total of all locations must equal 100%.)

Hospitals:	_____ %	Skilled Nursing Facilities:	_____ %	Nursing Facilities(1):	_____ %
Other:	_____ %	Describe Locations: _____			

(1) Nursing Facilities that meet the special hospice standards regarding staffing and patient areas.

- b. Are these services provided directly by the Applicant(s) or by a cooperative arrangement with a third party provider of inpatient care? _____
 - i. If inpatient hospice care is provided directly by the Applicant(s), indicate the number of projected occupied beds for the coverage period: _____ (annualized data) Not Applicable
 - ii. If inpatient hospice care is provided by a cooperative arrangement with a third party provider of inpatient care, does the agreement contain a mutual hold harmless and indemnification provision and requirements that the third party carry Professional and General Liability insurance with minimum limits of \$1,000,000/\$3,000,000? Yes No
 Not Applicable

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:	_____ %



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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:	____%
Operating Room:	____%	Psychiatric:	____%
General Medical Services:	____%	All Other Units – Describe Services: _____	____%

SECTION G. PROFESSIONAL EMPLOYEES AND STAFF

1. Provide the following for Employees/Independent Contractors/Leased Workers/Volunteers:

Professional Classification	# of Employees		# of Independent Contractors(2)		# of Leased Workers(3)		# of Volunteers	
	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)
Addiction Counselor (certified member of NAADAC)	____	____	____	____	____	____	____	____
Addiction Counselor (Non-member of NAADAC)	____	____	____	____	____	____	____	____
Addiction Interventionist	____	____	____	____	____	____	____	____
Administrative/Clerical	____	____	____	____	____	____	____	____
Aide/Assistant Identify type: _____	____	____	____	____	____	____	____	____
Art, Music, Dance, Pet, & Recreation Therapist	____	____	____	____	____	____	____	____
Audiologist	____	____	____	____	____	____	____	____
Auricular Acupuncture Therapist & Counselor	____	____	____	____	____	____	____	____
Auricular & Full Body Acupuncture Therapist & Counselor	____	____	____	____	____	____	____	____
Behavioral Analyst	____	____	____	____	____	____	____	____
Blood Bank Technician	____	____	____	____	____	____	____	____
Cardiology Technician	____	____	____	____	____	____	____	____
Case Worker & Case Manager	____	____	____	____	____	____	____	____
Certified Employee Assistance Professional	____	____	____	____	____	____	____	____
Certified Tech./Assistant	____	____	____	____	____	____	____	____
Companion/Homemaker	____	____	____	____	____	____	____	____
Cytotechnologist	____	____	____	____	____	____	____	____
Dental Assistant	____	____	____	____	____	____	____	____
Dental Hygienist	____	____	____	____	____	____	____	____
Dialysis Technician	____	____	____	____	____	____	____	____
Dietician/Nutritionist	____	____	____	____	____	____	____	____



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Professional Classification	# of Employees		# of Independent Contractors(2)		# of Leased Workers(3)		# of Volunteers	
	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)
EKG/EEG Technician	___	___	___	___	___	___	___	___
Health Educator	___	___	___	___	___	___	___	___
Home Health Aide	___	___	___	___	___	___	___	___
Homemaker	___	___	___	___	___	___	___	___
Intern Mental Health/Addiction Counselor	___	___	___	___	___	___	___	___
Lab Technician	___	___	___	___	___	___	___	___
Licensed or Certified Mental Health Counselor	___	___	___	___	___	___	___	___
LPN	___	___	___	___	___	___	___	___
Marriage & Family Therapist & Counselor	___	___	___	___	___	___	___	___
Massage Therapist	___	___	___	___	___	___	___	___
Medical Office Assistant	___	___	___	___	___	___	___	___
Medical Records Technician	___	___	___	___	___	___	___	___
Medical Technologist	___	___	___	___	___	___	___	___
Mental Health Counselor	___	___	___	___	___	___	___	___
MRI Technician	___	___	___	___	___	___	___	___
Nurse Aide	___	___	___	___	___	___	___	___
Nurse/L.P.N.	___	___	___	___	___	___	___	___
Nurse Practitioner	___	___	___	___	___	___	___	___
Nurse/R.N.	___	___	___	___	___	___	___	___
Occupational Therapist	___	___	___	___	___	___	___	___
Paramedic/EMT Student	___	___	___	___	___	___	___	___
Pastoral Counselor	___	___	___	___	___	___	___	___
Pathology Assistant	___	___	___	___	___	___	___	___
Patient Intake Technician	___	___	___	___	___	___	___	___
Personal Coach	___	___	___	___	___	___	___	___
Pharmacist (Mail Order, Nuclear)	___	___	___	___	___	___	___	___
Pharmacist (Non-Mail Order – Non-Nuclear)	___	___	___	___	___	___	___	___
Pharmacy Assistant	___	___	___	___	___	___	___	___
Pharmacy Technician (dispensing)	___	___	___	___	___	___	___	___
Phlebotomist	___	___	___	___	___	___	___	___
Physical Therapist	___	___	___	___	___	___	___	___
Physician Assistant Student	___	___	___	___	___	___	___	___
Physician – Hospice & Palliative Care	___	___	___	___	___	___	___	___
Psychological Assistant (Master's Degree)	___	___	___	___	___	___	___	___



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Professional Classification	# of Employees		# of Independent Contractors(2)		# of Leased Workers(3)		# of Volunteers	
	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)	FTEs(4)	Hours (annual)
Psychologist (Bachelor's, Master's or Doctorate Degree)	_____	_____	_____	_____	_____	_____	_____	_____
Psychologist (Post-Doctoral Student)	_____	_____	_____	_____	_____	_____	_____	_____
Radiological Technologist	_____	_____	_____	_____	_____	_____	_____	_____
Rehabilitation Counselor/Therapist	_____	_____	_____	_____	_____	_____	_____	_____
Rehabilitation Counselor/Therapist Assistant	_____	_____	_____	_____	_____	_____	_____	_____
Respiratory Assistant	_____	_____	_____	_____	_____	_____	_____	_____
Respiratory Therapist	_____	_____	_____	_____	_____	_____	_____	_____
Social Worker	_____	_____	_____	_____	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____	_____	_____	_____	_____
Surgical Assistant Student	_____	_____	_____	_____	_____	_____	_____	_____
Surgical Technologist	_____	_____	_____	_____	_____	_____	_____	_____
Surgical Technologist/First Assistant	_____	_____	_____	_____	_____	_____	_____	_____
Technician – Other (specify) _____	_____	_____	_____	_____	_____	_____	_____	_____
Ultrasound Technician	_____	_____	_____	_____	_____	_____	_____	_____
Utilization Review Technician	_____	_____	_____	_____	_____	_____	_____	_____
Volunteer	_____	_____	_____	_____	_____	_____	_____	_____
Wellness Counselor	_____	_____	_____	_____	_____	_____	_____	_____
X-Ray Machine Technician/Operator	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____	_____	_____

(2) Independent Contractor means a 1099 contractor. The standard ACE policy does not include Independent Contractors as Insureds. Such Independent Contractors should obtain their own insurance.

(3) Leased Worker means a person leased to the Applicants by a labor leasing firm under an agreement between the Applicants and the labor leasing firm, to perform duties related to the conduct of the Applicants' business. Leased Worker does not include a temporary worker. The standard ACE policy does not include Leased Workers as Insureds. Such Leased Workers should obtain their own insurance.

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

2. Provide the following for each employed or contracted Physician Medical Director or Related Professional Staff Director performing administrative duties on the Applicants' behalf: Not Applicable

Name	Specialty	Employee	Contractor	# Hours Worked Per Year for the Applicant(s)	# Years of Experience as Medical Director
_____	<input type="checkbox"/> Physician <input type="checkbox"/> Other: _____ Specialty: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/year	_____ years
_____	<input type="checkbox"/> Physician <input type="checkbox"/> Other: _____ Specialty: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/year	_____ years



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The standard ACE Professional Liability policy includes medical, surgical, nursing or related professional staff director or department head as an Insured but only while acting within the scope of their administrative duties and on the Applicants' behalf. Such directors or department heads should obtain their own Professional Liability insurance for other services.

3. Provide the following for each employed, contracted or leased Physician (other than Medical Directors). This information must be provided regardless of whether or not employed, contracted or leased Physicians are to be included for individual coverage. Not Applicable

Name	Specialty	Employee	Independent Contractor(2)	Leased Worker(3)	# Hours Worked Per Year for the Applicant(s)
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/year
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____ hours/year

The standard ACE Professional Liability policy does not include any Physician as an Insured. The standard ACE General Liability policy does not include Independent Contractors or Leased Workers as Insureds. Physicians should obtain their own insurance.

SECTION H. LICENSE/CERTIFICATION INFORMATION

- Licensed Specialty: _____
- Licensing Agency(ies): _____
- Applicant Accreditation: _____ Date Surveyed: _____
Score: _____
- Has any Applicant's license or certification ever been revoked, suspended, refused, canceled or voluntarily surrendered? Yes No
If Yes, describe: _____
Date action taken: _____
- Are there any charges pending against any Applicant? Yes No
If Yes, describe: _____
- Has any Applicant ever been investigated by a state health department, state licensing board or other governmental body? Yes No
If Yes, describe: _____
Date investigation commenced: _____
- Are all Applicants licensed in all states in which they are operating? Yes No
If No, explain: _____
- List all memberships in professional organizations: _____

SECTION I. RISK MANAGEMENT

- Are patient records protected in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996)? Yes No
If No, explain: _____
- Has any Applicant ever had an incident that resulted in an allegation of sexual abuse? Yes No
If Yes, explain: _____
- Is an informed consent process in place? Yes No



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4. Are copies of informed consent forms maintained in patient files? Yes No
5. Does any 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:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Acceptance of Verbal Physician Orders:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chain of Command:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Administration Procedures:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Training:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Management:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food Preparation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Handling of Complaints:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incident Reporting:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lifting Requirements:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Equipment Training:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Record Documentation:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Acceptance:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Discharge Procedures:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Rights:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reporting Suspected Abuse:	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. Is compliance with these policies and procedures enforced and monitored? Yes No
9. Do all contracts for clinical services include the following provisions:
- a. Mutual hold harmless and indemnification agreements? Yes No
- b. Require third parties to carry Professional and General Liability insurance with limits of at least \$1,000,000/\$3,000,000? Yes No
- c. Require the third party to provide the Applicant(s) with a Certificate of Insurance? Yes No
- d. Require the third party to be named as an Additional Insured on the Applicants' Professional and/or General Liability policy? Yes No
- If Yes:
- i. Please provide the name and details of the third party and their relationship to the Applicant(s): _____
- ii. Does the Applicant(s) require third parties to carry their own Professional Liability and General Liability insurance with limits of at least \$1,000,000/\$3,000,000? Yes No
10. Does the Applicant(s) require Certificates of Insurance from all Independent Contractors: Yes No

SECTION J. EMPLOYMENT PRACTICES



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Does the Applicant(s) perform criminal background checks on:

- prospective employees independent contractors leased workers volunteers?

If Yes, what level of background check is performed (select all that apply):

- County
 State
 Federal

1. Are job descriptions provided for all professional and nonprofessional employees? Yes No
2. Do employees actively participate in continuing educational programs? Yes No
3. Does the Applicant(s) verify employment related references? Yes No
5. Does the Applicant(s) verify certification and/or professional licensure status of employees, Independent Contractors and Leased Workers? Yes No
6. Does the Applicant(s) confirm in writing any of the following related to prospective employees:
 - a. Whether their medical Professional Liability insurance has been denied or canceled? Yes No
 (Missouri Applicants: You do not need to answer this question and the answer to this question will not be considered in quotation decisions.)
 - b. Whether they have been involved in any Professional Liability claims or litigation? Yes No
 - c. Whether any action has ever been taken on their clinical privileges? Yes No
 - d. Does the Applicant(s) screen employees for drug and alcohol abuse? Yes No
 - e. Does the Applicant(s) screen employees for any previous allegations against them involving sexual abuse or molestation? Yes No
 - f. Does the Applicant(s) 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(s).

Location	Square Footage	Year Built	Construction	Number of Floors	Type of Fire Protection(5)

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

2. Has the Applicant(s) 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: _____



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4. Does any Applicant own, operate or control a day care facility? Yes No
If Yes:
a. Are day care services open to the public? Yes No
b. Number of Children: _____
c. Number of Adults: _____
d. Days and hours of operation: _____
5. Does any Applicant sell, rent or lease medical supplies and/or equipment to others? Yes No
If Yes, describe: _____
6. Does any Applicant perform maintenance or repairs on equipment sold or leased? Yes No
If Yes, describe: _____
7. Is all equipment checked and documented as to its condition prior to release? Yes No
 Not Applicable
8. Do all Applicants perform preventive maintenance on all equipment according to a written schedule?
 Yes No
 Not Applicable
9. Does any Applicant modify products in any way from their original use/form?
If Yes, describe: _____ Yes No
10. Does any Applicant repackage or re-label any items obtained from suppliers?
If Yes, describe: _____ Yes No
11. Is any equipment sold under the Applicants' name?
If Yes, describe: _____ Yes No
12. Does any Applicant have a sales staff? Yes No
If Yes, is the sales staff trained by the manufacturer? Yes No
13. Does any Applicant repair or sell used equipment to others?
If Yes, describe: _____ Yes No
14. Does any Applicant distribute oxygen cylinders? Yes No
If Yes:
a. Are the oxygen cylinders pre-filled? Yes No
b. Does any Applicant fill oxygen cylinders at the Applicants' premises? Yes No
15. Do all Applicants follow FDA and DOT regulations for the sterilization and transportation of oxygen?
 Yes No
16. Product Categories: Complete for all products sold/leased by the Applicant(s): Not Applicable
- Category I EXPENDABLE ITEMS – Intended for one-time usage and disposed of (i.e., adhesive tape, bandages, hypodermic needles, etc.):
Sales Receipts: \$_____



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Category II NON-EXPENDABLE ITEMS (DME) - Durable Medical Equipment, excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids, walkers, strollers, canes, crutches, wheelchairs, prosthetic devices and IV stands.

Sales Receipts: \$_____ Lease Receipts: \$_____

Category III DIAGNOSTIC OR TREATMENT DEVICES – This category includes treatment devices or equipment not used to sustain life or perform critical life monitoring functions. This category includes items such as blood pressure gauges, IV pumps, portable EKG machines or sensing devices.

Sales Receipts: \$_____ Lease Receipts: \$_____

Category IV LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES. This category includes oxygen and other medical gases used in conjunction with respiratory therapy, dialysis or heart/lung machines, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction. Failure or improper function of which, could result in the death or serious deterioration of the patients' health condition.

Sales Receipts: \$_____ Lease Receipts: \$_____

SECTION L. 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 Each Claim/ Aggregate	Retention/Deductible Each claim/aggregate	Premium	Claims-Made/Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence

2. General Liability Insurance Coverage Information: (Complete only if GL coverage is requested.) Provide the following information for each of the last 3 years starting with the current or expiring year.

Company	Policy Period	Limits of Liability Each Claim/ Aggregate	Retention/Deductible Each Claim/ Aggregate	Premium	Claims-Made/Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____ <input type="checkbox"/> Occurrence
_____	_____	\$_____/_____ \$_____	\$_____/_____ \$_____	\$_____	<input type="checkbox"/> Claims-Made Retro Date: _____



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Company	Policy Period	Limits of Liability Each Claim/ Aggregate	Retention/Deductible Each Claim/ Aggregate	Premium	Claims-Made/Occurrence
					<input type="checkbox"/> Occurrence

3. MISSOURI APPLICANTS SKIP THIS QUESTION

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 M. PRIOR ACTS

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(s) 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 N. FRAUD WARNING, DECLARATION & CERTIFICATION, AND SIGNATURE

NOTICE TO ARKANSAS, LOUISIANA, RHODE ISLAND & WEST VIRGINIA 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 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.



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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 containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

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 MAINE 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 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 MINNESOTA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE 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.

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 INFORMATION IN AN APPLICATION 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 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.



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NOTICE TO OREGON APPLICANTS: WARNING: 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 for the purpose of misleading information concerning any fact material thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the 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 & 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 VERMONT APPLICANTS: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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 REPRESENTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS AND ATTACHMENTS 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 MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, 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 COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH



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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)