POLICY NUMBER: _____
COMPANY USE ONLY

NATIONAL FIRE & MARINE INSURANCE COMPANY

CLINIC PROFESSIONAL LIABILITY APPLICATION

INSTRUCTIONS

1. PLEASE PRINT LEGIBLY. IF THE APPLICATION IS APPROVED, THE POLICY WILL BE BASED ON THE INFORMATION PROVIDED.
2. PLEASE ANSWER ALL QUESTIONS. IF A QUESTION IS NOT APPLICABLE, PRINT, "N/A".
3. IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SUPPLEMENTAL FORM.

I. ORGANIZATION INFORMATION

A. BROKERAGE FIRM/AGENCY INFORMATION

Professional Liability Solutions Agency
BROKERAGE FIRM/AGENCY NAME

Charlotte, NC 28277
CITY, STATE AND ZIP CODE

BROKER/AGENT NAME

BROKER/AGENT LICENSE NUMBER AND TYPE

800 _ 372 _ 3268
PHONE

704 _ 973 _ 9605
FAX

apply@pls-medmal.com
E-MAIL

B. CONTACT INFORMATION

APPLICANT NAME

MAILING ADDRESS

COUNTY

STREET ADDRESS (IF DIFFERENT)

CONTACT PERSON NAME

TITLE

_____-_____-_____
PHONE

_____-_____-_____
FAX

E-MAIL

WEBSITE ADDRESS

C. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM)**:** _____
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF THE APPLICANT'S CURRENT POLICY.

D. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM)**:** _____
ANNUAL POLICY TERMS WILL BEGIN AND END ON THE SAME MONTH AND DAY.

II. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	OCCURRENCE/CLAIMS-MADE	DEDUCTIBLE
□ **PROFESSIONAL LIABILITY FACILITY**	$_____ PER EVENT/ $_____ AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	□ NONE □ $5,000 □ $25,000 □ $10,000 □ $50,000 □ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: □ INDEMNITY ONLY □ INDEMNITY AND EXPENSE
□ **GENERAL LIABILITY**	$_____ PER EVENT/ $_____ GENERAL AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	□ NONE □ $5,000 □ $25,000 □ $10,000 □ $50,000 □ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: □ INDEMNITY ONLY □ INDEMNITY AND EXPENSE
□ **EXCESS PROFESSIONAL LIABILITY**	$_____ PER EVENT/ $_____ AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	
□ **EXCESS GENERAL LIABILITY**	$_____ PER EVENT/ $_____ GENERAL AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	

(*) IF THERE ARE ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCS, PARTNERSHIPS, ETC.), PLEASE COMPLETE SECTION II (SCHEDULE OF RELATED ENTITIES) OF THE CLINIC SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF THE APPLICANT'S ORGANIZATIONAL CHART INCLUDING THE INFORMATION REQUESTED.

II. COVERAGES, LIMITS AND DEDUCTIBLES (CONTINUED)

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE FOR EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS, ORAL SURGEONS, CRNAS, NURSE MIDWIVES, CRNPS, PODIATRISTS, PHYSICIAN ASSISTANTS OR SURGICAL ASSISTANTS IS BEING REQUESTED, PLEASE COMPLETE SECTION III (COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE) OF THE CLINIC SUPPLEMENTAL APPLICATION.

III. GENERAL INFORMATION

A. TYPE OF LEGAL ENTITY (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

- ☐ PROFESSIONAL CORPORATION
- ☐ PARTNERSHIP OR PROFESSIONAL ASSOCIATION
- ☐ FOR PROFIT
- ☐ NON PROFIT
- ☐ LIMITED LIABILITY CORPORATION (LLC)
- ☐ JOINT VENTURE
- ☐ OTHER (PLEASE EXPLAIN): _____

B. ENTITY OWNERSHIP (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

- ☐ PHYSICIAN OWNED
- ☐ HOSPITAL OWNED
- ☐ INDEPENDENTLY OWNED (PLEASE EXPLAIN): _____
- ☐ OTHER (PLEASE EXPLAIN): _____

C. HOW MANY CLINIC LOCATIONS DOES THE FACILITY HAVE? _____

PLEASE LIST ALL CLINIC LOCATIONS. IF MORE THAN 3 LOCATIONS, PLEASE ATTACH A SEPARATE PIECE OF PAPER SHOWING THE ADDITIONAL LOCATIONS.

LOCATION #1:

_____

STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____

LOCATION #2:

_____

STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____

LOCATION #3:

_____

STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED _____

D. DURING THE NEXT 12 MONTHS, ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS OR DOES THE APPLICANT PLAN ON ADDING ANY ADDITIONAL LOCATIONS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

E. CERTIFICATIONS/ACCREDITATIONS HELD BY THE FACILITY:

☐ AAUCM ☐ JCAHO ☐ AAAHC ☐ NAFAC ☐ UCAOA ☐ AAAASF ☐ OTHER: _____

PLEASE PROVIDE A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

F. ARE ALL LOCATIONS ACCREDITED BY AT LEAST ONE OF THE ORGANIZATIONS LISTED IN QUESTION F, ABOVE? ☐ YES ☐ NO

IF NO, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. DOES THE FACILITY HAVE WRITTEN POLICIES IN PLACE ADDRESSING TELEPHONE ADVICE AND TELEPHONE REQUESTS FOR MEDICATION? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
2. DOES THE FACILITY HAVE WRITTEN POLICIES IN PLACE DESCRIBING THE PRECAUTIONS FOR DEALING WITH PATIENTS WITH INFECTIOUS DISEASES INCLUDING AN ISOLATION POLICY? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
3. IS THE IDENTITY OF PATIENTS RECEIVING TESTS OR MEDICATIONS VERIFIED BY REVIEW OF TWO FORMS ON PATIENT IDENTIFICATION PRIOR TO THE ADMINISTRATION OF THE TEST OR MEDICATION? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
4. DOES THE ORGANIZATION CREATE AND MAINTAIN A MEDICAL RECORD FOR EVERY PATIENT WITH CONTACT INFORMATION AND DATE(S) OF SERVICE? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____
5. DOES THE CLINIC HAVE WRITTEN POLICIES AND PROCEDURES TO PROTECT PATIENT PRIVACY? ☐ YES ☐ NO
   IF NO, PLEASE EXPLAIN: _____

G. MEDICAL DIRECTOR (PLEASE LIST THE MEDICAL DIRECTOR FOR EACH CLINIC AND **ATTACH A DESCRIPTION OF THE MEDICAL DIRECTOR'S DUTIES**)**:**

_____ _____

NAME OF MEDICAL DIRECTOR SPECIALTY OF MEDICAL DIRECTOR

___-___-___ _____

PHONE EMAIL

H. DOES THE MEDICAL DIRECTOR ALSO PROVIDE PROFESSIONAL SERVICES AT THE FACILITY? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

I. ANNUAL PAYROLL:

TOTAL ANNUAL PAYROLL: $_____

J. TOTAL PROJECTED ANNUAL REVENUE: $_____

% MEDICARE: _____%

% Medicaid: _____% Commercial Payors: _____%

% Other: _____ _____%

IV. CLINIC OPERATIONS

A. Is the clinic designated as a federally qualified health center (FQHC)? ☐ Yes ☐ No

A) To qualify for the FTCA discount, please provide the % of the centers overall expenses covered by federal grants (if any) _____%

B) When did the organization first obtain deemed status? ____/____/____ (MM/DD/YYYY)

C) Have there been any changes in the clinic's deemed status since first becoming deemed? ☐ Yes ☐ No

If Yes, please explain: _____

B. Is the facility familiar with any other charitable immunity laws for which the clinic is qualified? ☐ Yes ☐ No

If Yes, please explain: _____

C. Does the clinic have a process in place regarding how to inform patients of the outcome of their diagnostic test(s) when patients are either unable to receive test results during their visit(s) or when the patients results are revised due to further evaluation? ☐ Yes ☐ No

D. Are patients who present with conditions requiring follow-up care provided referrals to appropriate primary care or specialty phsyicians? ☐ Yes ☐ No

E. Does the clinic maintain in-house medications? ☐ Yes ☐ No

If Yes, please explain how these are stored, inventoried, and dispensed: _____

_____

F. In the next 12 months, does the clinic plan to change any of the services it offers? (i.e. adding or discontinuing any services) ☐ Yes ☐ No

If Yes, please describe: _____

G. Have any services been discontinued during the last 24 months? ☐ Yes ☐ No

If Yes, please describe: _____

H. Most recent year, number of annual visits to this facility: _____

I. Upcoming year, estimated number of annual visits to this facility: _____

J. Are there specific criteria patients need to meet in order to qualify for services at your clinic? ☐ Yes ☐ No

If Yes, please explain: _____

K. How are non-volunteer providers compensated? _____

L. Please check any of the following procedures that will be performed at the facility:

☐ Abortions
☐ Alcohol/Drug Testing
☐ Allergy Shots
☐ Alternative/Integrative/Complimentary Medicine
☐ Anesthesia
  ☐ Topical
  ☐ Nerve Blocks (Please list types): _____
  _____
  ☐ General
☐ Behavioral Health
☐ Chiropractic
☐ Cosmetic Procedures (Please list types): _____
  _____
☐ Dental
☐ Diagnostic Radiology, If applicable, are all films overread by a radiologist? ☐ Yes ☐ No
☐ Dialysis
☐ ECG, If applicable, are all test results overread by a cardiologist? ☐ Yes ☐ No
☐ Fractures, If applicable, please describe the level of treatment: _____
☐ Home Health Care
☐ Immunizations
☐ Laboratory (Pathology)
☐ Obstetrics, If applicable, please describe types of services provided:
  _____
☐ Occupational Medicine, If applicable, please list the companies with which the clinic contracts to provide services and explain the services provided:
  _____
  _____
☐ Occupational/Physical therapy, If applicable, number of visits: _____
☐ Osteopathic Manipulation Therapy
☐ Pharmacy
☐ Physicals
☐ Research/Experimental, If applicable, please explain: _____
☐ Social Services
☐ Substance Abuse Treatment
  ☐ Methadone
☐ Treatment for Chronic Pain, If applicable, number of visits: _____
☐ Urgent Care
☐ Other: _____
  _____
  _____
  _____

If additional space is needed, please attach a separate sheet of paper.

V. MEDICAL STAFF

A. Please provide the information requested below for each physician, if any, that practices at the facility.
(If more room is needed, please attach a separate roster of medical staff).

IMPORTANT NOTE: If coverage is desired for physicians, please so state on Section III (Coverages, Limits and Deductible Schedule)**, and Section IV** (Schedule of Medical Professionals) **of the Clinic Supplemental Application. Also, complete a separate Physician Individual Professional Liability Insurance Application for each physician.**

PHYSICIAN'S NAME	INDICATE IF THE PERSON IS A: MEMBER (M) PARTNER (P) SHAREHOLDER (S) EMPLOYEE (E) CONTRACTED PHYSICIAN (C) OR ALL OTHER (AO)	PRIMARY LICENSE NUMBER	INDICATE PRIMARY SPECIALTY	INDICATE THE NUMBER OF HOURS PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT THE FACILITY	VOLUNTEER?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

B. Are all of the physicians practicing at the facility board certified? ☐ Yes ☐ No

If No, how many are not board certified? _____

C. Does the facility have any physicians on staff that do not maintain staff privileges at a hospital? ☐ Yes ☐ No

D. Indicate the number of health professionals, other than physicians, who work at the facility: _____

IMPORTANT NOTICE: If coverage is desired for health professionals other than physicians, please so state on Section III (Coverages, Limits and Deductibles Schedule) **and list these health care providers on Section V** (Schedule of Medical Professionals) **of the Clinic Supplemental Application. If separate limits of coverage are desired, also submit an application for each individual for whom separate limits coverage is requested.**

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED
NURSE PRACTITIONERS			
PHYSICIAN ASSISTANTS			
LPNs/RNs			
LABORATORY TECHNICIANS			
SOCIAL WORKERS			
OTHER (PLEASE SPECIFY):			

E. Does the applicant supervise anyone other than its own employees? ☐ Yes ☐ No

If Yes, describe the responsibility of both the supervisory and supervised individuals, and the relationships between the individuals:

_____

Also indicate, by type of medical professional, the number of individuals the facility supervises:

_____

VI. RISK MANAGEMENT

A. Is there a formal risk management program? ☐ Yes ☐ No

B. Is there a full-time risk manager? ☐ Yes ☐ No

If No, what are their other responsibilities and how much time is devoted to risk management? _____

_____

C. Is there a written incident reporting procedure? ☐ Yes ☐ No

1. If Yes, does this procedure require review and appropriate corrective action be taken? ☐ Yes ☐ No
2. Is there a follow-up to assure compliance? ☐ Yes ☐ No

D. Is there an ongoing quality assurance (QA) committee in place? ☐ Yes ☐ No

1. If Yes, is the person responsible for risk management a member of this committee? ☐ Yes ☐ No
2. To whom is the quality assurance committee accountable?

Name _____ Title _____

3. What quality indicators are monitored (please list)? _____

4. Does the facility monitor its infection rates? ☐ Yes ☐ No

E. Is there an active peer review process for physicians that is part of the quality mangement program? ☐ Yes ☐ No

If No, please explain: _____

F. Is there an ongoing continuing education program for: Nursing Staff? ☐ Yes ☐ No

Other Allied Health Professionals? ☐ Yes ☐ No

G. Name of the person our risk management consultant may contact for an on-site visit:

Name _____ Title _____

VII. CREDENTIALING

A. When hiring professionals and support staff, does the applicant:

1. Verify educational background? ☐ Yes ☐ No
2. Check all references including past employers? ☐ Yes ☐ No
3. Check for pending license suspensions, revocations or disciplinary actions by other facilities? ☐ Yes ☐ No
4. Check criminal history? ☐ Yes ☐ No
5. Require prior medical professional claim history? ☐ Yes ☐ No

B. Are the credentials of each physician reviewed by a medical staff committee and approved by the governing body prior to granting privileges? ☐ Yes ☐ No

C. Is an ongoing quality assurance review maintained on all staff members' clinical work? ☐ Yes ☐ No

D. Do medical staff bylaws require each physician working at the applicant's facility to maintain professional liability insurance? ☐ Yes ☐ No

1. If Yes, what are the required minimum limits of liability? $ _____ / $_____
2. If retired physicians are working at the facility, where is their professional liability coverage provided? _____
3. Are certificates of insurance obtained at least annually from each individual to verify coverage is in place? ☐ Yes ☐ No

E. What are the minimum limits of liability required for non-physician medical professionals working at the applicant's facility to carry? $ _____ / $_____

Are certificates of insurance obtained at least annually from each individual to verify coverage is in place? ☐ Yes ☐ No

F. Has the license of any physician been restricted, revoked or suspended in the last five years? ☐ Yes ☐ No

If Yes, please explain: _____

G. Are you aware if any current or former employees or contractors: (please attach an explanation of any "yes" answers)

1) Have ever been the subject of disciplinary or investigative proceedings, or a reprimand by a Governmental License Board or administrative agency, hospital or professional association? ☐ Yes ☐ No

2) Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinace, other than traffic offenses, or had hospital privileges, DEA license, or Medicare/Medicaid privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

VIII. PHYSICAL PLANT

A. Please furnish the following information for all owned or leased property operated or occupied by the applicant.
A separate summary of locations/exposures that provides the information requested below is acceptable.

Address of Property to be Insured	Use/Occupancy	Square Footage	Age	Type of Construction	Number of Stories	Fire Protection*
Patient Care Buildings:						
Other Buildings:						

*For each building, indicate if there is a: Sprinkler System—Full, Partial or No sprinkler system; Smoke Detector, Heat Detector; Fire Alarm—Central Station or Local Alarm

B. **DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

IX. GENERAL LIABILITY

DO YOU DESIRE GENERAL LIABILITY COVERAGE? ☐ YES ☐ NO

IF NO, SKIP TO SECTION X.

A. **IS THERE A PREVENTATIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR MEDICAL EQUIPMENT AT THE FACILITY?** ☐ YES ☐ NO

1. HOW OFTEN ARE NON-EXPENDABLE MACHINES OR DEVICES INSPECTED AND MAINTAINED? _____
2. WHO PERFORMS THE MAINTENANCE ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS
3. IF INDEPENDENT CONTRACTORS, WHAT IS THE MINIMUM GENERAL LIABILITY LIMIT THAT IS REQUIRED BY THE FACILITY?

   $_____ / $_____
4. DOES THE APPLICANT OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THAT COVERAGE IS IN PLACE? ☐ YES ☐ NO

B. **IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT THE FACILITY OWNED BY PHYSICIANS?** ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE PREVENTATIVE MAINTENANCE, INSPECTION AND REPAIR OF THE EQUIPMENT? _____

C. **IS THE APPLICANT'S BIO-MEDICAL EQUIPMENT EVER LOANED OR DONATED TO OTHERS FOR USE?** ☐ YES ☐ NO

IF YES, DESCRIBE: _____

D. **DOES THE APPLICANT RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS?** ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? _____

E. **DOES THE APPLICANT USE AN ADVERTISING AGENCY?** ☐ YES ☐ NO

1. IF YES, WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS REQUIRED? $_____ / $_____
2. IS THE APPLICANT INCLUDED AS AN ADDITIONAL INSURED ON THE ADVERTISING AGENCY'S POLICY? ☐ YES ☐ NO
3. IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF THE APPLICANT? ☐ YES ☐ NO

F. **ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS?** ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE CHANGES PLANNED, INCLUDING THE TIME FRAME AND ESTIMATED COST: _____

G. **PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJECTIONS FOR THE NEXT 12 MONTHS:**

1. HABITATIONAL RISK: ☐ APARTMENT ☐ DWELLING ☐ HOTEL ☐ NONE ☐ OTHER, PLEASE DESCRIBE: _____
   A) NUMBER OF UNITS: _____ UNITS YEAR BUILT: _____
   B) ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER? ☐ YES ☐ NO
   C) FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? ☐ YES ☐ NO
2. PAID PARKING: RECEIPTS/YEAR: $_____
3. SPECIAL ATHLETIC OR FUND RAISING EVENTS: RECEIPTS/YEAR: $_____
   DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED: _____

H. **DOES THE APPLICANT LEASE SPACE TO OTHERS?** ☐ YES ☐ NO

_____
CITY, STATE AND ZIP CODE

_____ _____
SQUARE FOOTAGE OCCUPANCY/USE OF SPACE

1. DOES THE LEASE REQUIRE THE TENANT TO CARRY A GENERAL LIABILITY (GL) INSURANCE POLICY WITH A LIMIT OF AT LEAST $1,000,000 PER OCCURRENCE? ☐ YES ☐ NO
2. IS A CERTIFICATE OF INSURANCE OBTAINED ANNUALLY TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO
3. IS THE TENANT REQUIRED TO LIST THE APPLICANT AS AN ADDITIONAL INSURED ON THE TENANT'S GL POLICY? ☐ YES ☐ NO

X. EXCESS LIABILITY

DOES THE APPLICANT DESIRE EXCESS LIABILITY COVERAGE? ☐ YES ☐ NO

IF NO, SKIP TO SECTION XI.

A. **HAS THE APPLICANT'S EXCESS PROFESSIONAL OR COMMERCIAL GENERAL LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS?** ☐ YES ☐ NO

IF YES, WHAT WAS THE PRIOR LIMIT AND WHEN WAS IT INCREASED?

$ _____ / $ _____ _____ / _____
MM YYYY

XI. COVERAGE HISTORY AND INFORMATION

NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATES OF MISSOURI AND CALIFORNIA.

A. HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER INSURANCE COVERAGE TO THE APPLICANT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

_____

B. PLEASE CHECK WHICH TYPE OF NOTICE THE APPLICANT'S PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE IT WILL FORMALLY RECOGNIZE A CLAIM UNDER ITS POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

☐ WRITTEN NOTICE FROM THE APPLICANT THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

C. HAS THE APPLICANT CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS, AS WELL AS INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS, AND HAVE THESE BEEN FORWARDED TO THE CURRENT INSURER? ☐ YES ☐ NO

IF YES, PROVIDE THE DATE OF THE REVIEW AND THE NAME AND TITLE OF THE PERSON CONDUCTING THE REVIEW:

_____ _____ _____

MM YYYY NAME AND TITLE

D. PLEASE PROVIDE THE APPLICANT'S INSURANCE HISTORY FOR THE LAST FIVE YEARS.

POLICY PERIOD	MOST RECENT YEAR	1 YEAR PRIOR	2 YEARS PRIOR	3 YEARS PRIOR	4 YEARS PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
GENERAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
EXCESS LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					

XII. LOSS INFORMATION (IMPORTANT! FULLY COMPLETE)

FOR EACH CLAIM, POTENTIAL CLAIM OR SUIT MENTIONED BELOW, PLEASE COMPLETE SECTION I (LOSS HISTORY) OF THE CLINIC SUPPLEMENTAL APPLICATION.

A. HAS THE APPLICANT (INDEPENDENTLY OR THROUGH A NAMED INSURED) BEEN INVOLVED NOW OR IN THE PAST, DIRECTLY OR INDIRECTLY, IN A CLAIM, POTENTIAL CLAIM, OR SUIT ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION OR ANY FORMER OR PRESENT EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE CORPORATION, PARTNERSHIP OR ORGANIZATION? ☐ YES ☐ NO

IF YES, HOW MANY? _____

IF YES, HAVE THESE BEEN REPORTED TO THE APPLICANT'S INSURER? ☐ YES ☐ NO

B. DOES THE APPLICANT OR ANY OF ITS EMPLOYEES/CONTRACTORS HAVE KNOWLEDGE OF ANY INCIDENT, OR UNEXPECTED ADVERSE OUTCOME RESULTING IN INJURY OR DEATH, CLAIM, POTENTIAL CLAIM, OR SUIT IN WHICH THE APPLICANT MAY BECOME INVOLVED, INCLUDING WITHOUT LIMITATION, KNOWLEDGE OF ANY INJURY ARISING OUT OF THE RENDERING OR FAILING TO RENDER PROFESSIONAL SERVICES WHICH MAY GIVE RISE TO A CLAIM INVOLVING FORMER OR PRESENT PARTNERS, MEMBERS OF THE CORPORATION, OR ANY FORMER OR PRESENT EMPLOYEE OR INDEPENDENT CONTRACTOR OF THE CORPORATION, PARTNERSHIP OR ORGANIZATION WHICH MAY GIVE RISE TO A CLAIM? ☐ YES ☐ NO

IF YES, HOW MANY? _____

IF YES, HAVE THESE BEEN REPORTED TO THE APPLICANT'S INSURER? ☐ YES ☐ NO

XIII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION. IF NOT AVAILABLE, PLEASE EXPLAIN.

A. A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

B. FINANCIAL INFORMATION. THE MOST RECENT THREE (3) YEARS OF FINANCIAL STATEMENTS INCLUDING THE AUDITOR'S OPINION, IF APPLICABLE.

C. FTCA DEEMING APPLICATION (IF APPLICABLE)

D. **List of operations or activities performed that are not otherwise described in the application.**
E. **Loss information.** Recently valued loss runs from the applicant's insurance carriers covering the last (10) full years. The loss information should include paid and reserved amounts.
F. **Annual report** (if one is published).
G. All current **advertising materials.**
H. Organizational chart including the **names of all entities and a brief description of operations.**
I. **Copy of the applicant's current insurance policy.**

XIV. IMPORTANT NOTICE

This insurance may contain claims-made coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made and reported during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date. Please read and review the policy carefully.

XV. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

Any person who knowingly and with intent to injure, deceive, or defraud any insurance company or other person files an application for insurance containing any materially false information or fails to provide complete 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 prosecuted under state law and may be guilty of a felony and subject to criminal and civil penalties, fines, denial of insurance or confinement in prison.

Initial Here

XVI. PLEASE READ AND SIGN

On behalf of the entity applying for coverage herein:
I hereby declare that the above statements and particulars are true and that no material fact has been knowingly suppressed or misstated.

I agree that this application shall be the basis of the contract with the Company.

I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in professional specialty, affiliation, or working arrangement with any physician, dentist, firm or professional association.

I understand that any material misrepresentation or omission made on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind coverage.

By making this application, I am not relying upon any oral or written representation that coverage has or will be extended or that a policy of insurance will be issued.

I further understand and agree that there is no right to demand or expect coverage until the Company has: (1) received a completed application; (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if the premium or first installment is paid by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if these terms are not complied with, there will be no coverage for any claim under any policy of insurance for which this application is being submitted. I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other individuals or entities to verify and/or ascertain information regarding credentials and background both prior to and, if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information requested, which the Company, in good faith, believes to be applicable and pertinent to this application, and if issued, the contract of insurance issued hereunder.

Signature of Officer or Authorized Representative	Title	Date

XVII. SUPPLEMENTAL INFORMATION

NATIONAL FIRE & MARINE INSURANCE COMPANY
CLINIC SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF YOU HAVE BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE INSURANCE COMPANY FOR LESS THAN TEN YEARS OR IF YOUR FACILITY PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE INSURANCE COMPANY.

THE LOSS INFORMATION SHOULD ADDRESS BOTH YOUR PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION.

CLAIM NUMBER _____

A. CLAIMANT NAME: _____ AGE: _____

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU. _____ _____
MM YYYY

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. _____ _____
MM YYYY

D. NAME OF DOCTOR(S), HEALTH CARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLVED IN THE CLAIM OR SUIT:

_____

E. DEFENDING INSURANCE CARRIER NAME:

_____

F. WAS A CLAIM MADE OR A SUIT FILED? ☐ YES ☐ NO

G. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT: ☐ OPEN ☐ CLOSED

IF CLOSED, DATE OF CLOSING/SETTLEMENT OR AWARD: _____ _____
MM YYYY

IF CLOSED, WAS PAYMENT MADE? ☐ YES ☐ NO

IF NO, WAS CLAIM OR SUIT WTIHDRAWN? ☐ YES ☐ NO

AMOUNT PAID ON APPLICANT'S BEHALF: $ _____

TOTAL AMOUNT OF SETTLEMENT OR AWARD: $ _____

WAS THIS MATTER CLOSED WITH APPLICANT'S CONSENT? ☐ YES ☐ NO

IF OPEN, HAS SETTLEMENT BEEN OFFERED? ☐ YES ☐ NO

IF OPEN, HAS TRIAL DATE BEEN SET? ☐ YES ☐ NO

TRIAL DATE: _____ _____
MM YYYY

H. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: _____

TREATMENT PROVIDED: _____

ALLEGED NEGLIGENCE: _____

ALLEGED INJURY: _____

I. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY INCLUDING APPLICANT'S LEVEL OF INVOLVEMENT).

_____

_____

II. SCHEDULE OF RELATED ENTITIES

LIST OF ENTITIES RELATED TO THE APPLICANT'S (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.)

NAME OF ENTITY	DESCRIPTION OF OPERATIONS	DATE ACQUIRED, CREATED OR MERGED	INDICATE APPLICANT'S OWNERSHIP PERCENTAGE IN THIS ENTITY	COVERAGE DESIRED? IF YES, INDICATE SHARED OR SEPARATE LIMITS.

III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (IF SHARED OR SEPARATE PHYSICIAN OR ALLIED COVERAGE IS BEING REQUESTED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW

COVERAGE	REQUESTED LIMITS	OCCURRENCE / CLAIMS MADE	DEDUCTIBLE / SIR
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE CLINIC PROFESSIONAL LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE CLINIC PROFESSIONAL LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE CLINIC PROFESSIONAL LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE CLINIC PROFESSIONAL LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY- EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS-SEPARATE LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE CLINIC.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ **PROFESSIONAL LIABILITY EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS- SEPARATE LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE CLINIC.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE

IMPORTANT NOTE:

UNLESS OTHERWISE INDICATED BELOW, REQUESTED COVERAGE WILL BE LIMITED TO PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED, WHILE EMPLOYED OR UNDER CONTRACT WITH THE APPLICANT OR RELATED ENTITY (SERVICES LIMITED TO DUTY AND SCOPE OF SERVICES).

CHECK ONE:

☐ LIMITED TO DUTY AND SCOPE OF APPLICANT AS INDICATED ABOVE

☐ REQUESTING 24-HOUR COVERAGE

IV. SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND / OR ORAL SURGEONS, PLEASE PROVIDE THE INFORMATION BELOW. ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL FOR WHOM COVERAGE IS REQUESTED (SHARED LIMIT OR SEPARATE LIMIT COVERAGE). CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

NAME OF MEDICAL PROFESSIONAL	EMPLOYMENT STAUS: (C)ONTRACT (E)MPLOYED (F)ACULTY (R)ESIDENT	NUMBER OF PROCEDURES/ HOURS WORKED AT THE CLINIC	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOYMENT WITH APPLICANT	RESTRICTED (RE) TO APPLICANT'S OPERATION OR 24-HOUR (24)	LIMITS: SHARED (SH), SEPARATE (SE)

V. SCHEDULE OF MEDICAL PROFESSIONALS - CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR CRNAS, NURSE MIDWIVES, CRNPS, PODIATRISTS, PHYSICIAN ASSISTANTS AND / OR SURGICAL ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION BELOW. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL FOR WHOM COVERAGE IS REQUESTED. CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF CLAIMS MADE COVERAGE IS BEING REQUESTED, COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE DATE OF EMPLOYMENT WITH THE APPLICANT ENTITY. (*) IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE DATE OF THE EMPLOYMENT WITH THE APPLICANT, PRIOR ACTS COVERAGE WILL BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE APPLICANT.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICAION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

INSTRUCTIONS FOR COMPLETING EACH COLUMN

#1) EMPLOYMENT STATUS: (C) CONTRACT, (E) EMPLOYED OR (F) FACULTY
#2) SPECIALTY: CRNA, CRNP, NURSE MIDWIFE, PA, PODIATRIST, SURGICAL ASSISTANT
#3) IF CRNP OR PA, DOES INDIVIDUAL PRESCRIBE MEDICATION? INDICATE YES OR NO.
#4) IF CLAIMS MADE COVERAGE TYPE, INDICATE RETRO DATE.
#5) DATE OF EMPLOYMENT WITH APPLICANT/FIRST NAMED INSURED (FNI).
#6) FULL TIME EQUIVALENCY (FTE) - CALCULATE FTE BY DIVIDING THE TOTAL NUMBER OF HOURS OF PROFESSIONAL SERVICE PER WEEK BY 40 HOURS.
#7) LICENSE NUMBER.
#8) COVERAGE SCOPE: (RE) RESTRICTED TO NAMED INSURED'S OPERATION, *OR* (24) 24-HOUR COVERAGE.
#9) LIMITS: (SH) SHARED OR (SE) SEPARATE.

COLUMN #:	1	2	3	4	5	6	7	8	9
NAME OF MEDICAL PROFESSIONAL	(C) (E) OR (F)	SPECIALTY	PRESCR.? YES/NO	IF CM, RET-RO DATE	DATE OF EMPLOYMENT WITH FNI	FTE	LICENSE #	(RE) OR (24)	(SH) OR (SE)