Northland Insurance Companies

An Associates Company

APPLICATION - HEALTH CARE PROVIDER

BUSINESS INFORMATION

1. Named Insured ______________________________
2. Mailing Address ______________________________
   Street City County State ZIP Code
3. Location of Premises: ❑ Same as mailing address
   ❑ Other ______________________________
4. Telephone (______) ____________________ Fax (______) ____________________
5. Contact person/phone #: Inspection ______________________________
   Accounting/Records ______________________________
6. Business type: ❑ Individual ❑ Partnership ❑ Corporation ❑ LLC ❑ Other __________
7. Operating as: ❑ For Profit ❑ Nonprofit ❑ Other ______________________________
8. Interest of Named Insured in premises: ❑ Owner ❑ General Lessee ❑ Tenant ❑ Other__________
9. Part occupied by Named Insured: ❑ Entire ❑ Portion (______%) ❑ Other (Lessor's Risk Only)
10. Date business established ____________________

DESIRED TERMS AND CONDITIONS

1. Coverage Desired: ❑ General Liability ❑ Professional Liability
2. Limit of Liability Desired: ❑ $100,000/$300,000 ❑ $300,000/$600,000 ❑ $500,000/$1,000,000
   ❑ $1,000,000/$2,000,000 ❑ Other ____________________

Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Personal and Advertising Injury	Same as Occurrence Limit
Medical Payments	$5,000

3. ❑ Contractual Liability
4. Effective Date Desired ____________________ Term Desired ____________________

TYPE OF FIRM

1. Check your specific professional occupation:
   - ❑ Aide/Homemaker
   - ❑ Artificial Limb Fitter
   - ❑ Audiologist *Do you operate a mobile unit?* ❑ Yes ❑ No
   - ❑ Counselor ❑ Psychiatrist ❑ Psychologist ❑ Social Worker

   Indicate type of services performed and percentage:

❑ Abortion/Family Planning	____%	❑ Crisis Intervention	____%	❑ Occupational	____%
❑ Alcohol/Drug	____%	❑ Family/Marital	____%	❑ School/Youth	____%
❑ Child Abuse/Sexual Offenders	____%	❑ General Guidance	____%	❑ Other	____%
❑ Criminal	____%	❑ Hot Line	____%	______________	____%

   Do you utilize shock and/or drug therapy? ❑ Yes ❑ No
   - ❑ Dental Hygienist
   - ❑ Dietician/Nutritionist *Do you market products under your own label?* ❑ Yes ❑ No
   - ❑ Druggist/Pharmacist *Do you prescribe medications?* ❑ Yes ❑ No
   - ❑ Hearing Aid Specialist
   - ❑ Massage Therapist

❑ Nurse: *Type*______________________ *Check if appropriate:* ❑ *X-ray specialist* ❑ *Midwife* ❑ *Nurse anesthetist*

❑ Occupational Therapist
❑ Optician
❑ Optometrist
❑ Physical Therapist
❑ Respiratory Therapist
❑ Speech Therapist
❑ X-Ray Technician
❑ Other____

2. Description of operations____

____

____

____

____

OPERATIONS

1. Do you treat children exclusively? ❑ Yes ❑ No
2. Indicate percentage of time spent in the following work locations:

Administrative Office	_____%	Hospice	_____%	Professional Office	_____%
Classroom	_____%	Outpatient Clinic	_____%	Nursing Home	_____%
Emergency Dept. of Hosp.	_____%	Laboratory	_____%	Other_______________	_____%
Hospital Ward (Specify)	______________________________		_____%	Patient's Home	_____%

3. Are you engaged in, associated with, or involved in any other enterprises? ❑ Yes ❑ No
   If yes, explain.____
4. Are you self-employed? ❑ Yes ❑ No
   If no, provide name of employer.____

	Yes	No	N/A
5. Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following? General Liability	❑	❑	❑
Professional Liability	❑	❑	❑
6. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?	❑	❑	
If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?	❑	❑	
7. Have you entered into any contractual agreements?	❑	❑	
If yes, is legal advice sought to write and approve?	❑	❑	
Does the agreement require you to hold any third party harmless?	❑	❑	

8. Indicate: Receipts________ Payroll________ Outpatient Visits________
   (Number of patient encounters per year)
9. How are funds obtained? (i.e. Medicare, donations, fees, government grants, etc.)____________________________
10. Do you have recordkeeping procedures? ❑ Yes ❑ No
11. Do you practice: ❑ Full Time (30+ hours/week) ❑ Part Time (30 hours or less/week)
12. Do you have independent contractors working for you? ❑ Yes ❑ No
    Describe, including number of contractors, type, total hours per month worked by all contractors, and in what capacity the independent contractor is working.____

    ____
13. Do you require independent contractors working for you to carry their own professional insurance and provide proof of this coverage? ❑ Yes ❑ No
14. Do you use the services of volunteers or students? ❑ Yes ❑ No
    If yes, describe selection, duties, training, and extent to which they are used. ____________________________

    ____

EMPLOYEE PROCEDURES & STAFFING

1. Check the highest level of education you have completed relating to practice in your field:

❑ None required
❑ Associate Degree
❑ Master's Degree
❑ Bachelor's Degree
❑ Doctorate Degree
❑ Post-Doctorate Degree
❑ Other
School where degree was obtained:
____

For multiple employees, attach list with names, degree(s), and school(s).

2. Describe any professional training, licensing, or certification needed for this operation.___________________________

____

3. Are you certified/licensed? ❑ Yes ❑ No
If yes, name of board/licensing body.____

		Yes	No	N/A
4. Has your license ever been:	Restricted?	❑	❑	❑
	Suspended?	❑	❑	❑
	Revoked?	❑	❑	❑
a. Have you ever been denied a license or board certification?		❑	❑	❑
b. Have you ever been a patient in any chemical dependency program?		❑	❑	❑
c. Have your privileges ever been restricted, suspended, or revoked by any heath care facility?		❑	❑	❑
d. Do you prescribe drugs?		❑	❑	❑
e. Do you participate in any peer review or utilization review activities?		❑	❑	❑

Explain all YES answers. ____

____

5. Years practicing current professional occupation_________
6. Years in business under the above name_________
7. List any professional association or organization of which you are a member. Show complete name.
❑ None____

	Yes	No
8. Do you have employees?	❑	❑
9. Do you conduct criminal background checks of employees?	❑	❑
If yes, are copies kept on file?	❑	❑

10. Check all procedures you use when hiring professional, paraprofessional, or any other employee providing patient care services at your facility:

	None	Written	Verbal
a. Educational background or residency program check, when applicable.	❑	❑	❑
b. Previous employers check.	❑	❑	❑
c. Personal references check.	❑	❑	❑
d. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals?	❑	❑	❑

PREVIOUS EXPERIENCE

	Yes	No
1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities?	❑	❑

If yes, explain. ____

____

2. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? *If yes, give name of company, date and reason.* ❑ ❑

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS

Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				❑	
				❑	
				❑	

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. *Attach separate sheet if necessary.*

Dates (Month/Year)	Allegations	Amount	Paid	Reserve
			❑	
			❑	
			❑	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant	Title	Date

Signature of Producing Agent	Date

Agent Name and Address