SPG SPECIALTY PROGRAM GROUP

Miscellaneous Medical Professional Facility Application

Please include the following documents or underwriting supplements:

1. **Loss History** (supply the following):
   a. Minimum of Five (5) years of currently valued carrier loss runs
   b. Full details of allegation on all losses paid or outstanding in excess of $50,000
2. Most recent accrediting **agency and state licensure report** with recommendations and the response to any contingencies.
3. **Schedule of Physicians** to be covered: ☐ N/A, No physicians to be covered.
   a. Active physicians (see Roster attached).
   b. Departed physicians (separately attached).
4. Copy of **Risk and Quality Plans**. (e.g. Risk Manager, CEO, CFO)
5. Current Audited Financials
6. Attach a copy of brochure and marketing materials. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., in which professional advise is offered to the public?

PRODUCER INFORMATION

Agency Name _____

Mailing Address _____ City/State/Zip _____

Producer Name _____Telephone _____ Fax _____

APPLICANT INFORMATION

Named Insured _____ County _____

Primary Location _____ City/State/Zip _____

CEO _____ Risk Manager _____ Website: _____

Email Address for Primary Contact: _____

LEGAL ENTITIES

Named Insured: Provide names and descriptions of all legal entities that are intended for coverage under the policy being applied for. If more space is required, provide by attachment. Please fill in all sections.

Name	Description	Hours of Operation	Date Acquired	Retroactive Date

List all owned (50% or more) entities to be considered as a Named Insured, or attach a separate list:

How many locations do you provide services at:

Additional Locations:

FACILITY INFORMATION

1. How many years has the facility been in operation? _____

2. How many years has the facility been under present ownership? _____

3. **Ownership and Control** **Tax Status**

☐ Governmental ☐ For Profit

☐ Individual ☐ Not for Profit

☐ Partnership ☐ Medicare Approved

☐ Corporation ☐ Charitable

☐ Other (explain)_____

4. Provide a list of all owners including their percentage of ownership:

Name	% of Ownership	Name	% of Ownership

INSURANCE COVERAGE REQUEST

1. Requested Effective Date _____

2. Requested Limits

Professional Liability $_____ /$_____ ☐Claims Made Retroactive Date_____
per claim aggregate

General Liability $_____ /$_____ ☐Claims Made Retroactive Date_____
Per occurrence aggregate ☐Occurrence Coverage

Deductible ☐ None

Professional Liability $_____ /$_____ General Liability $_____ /$_____
per claim aggregate per claim aggregate

3. Self Insured Retention $_____ /$_____
per claim aggregate

a) What coverage does the SIR contemplate? ☐ Professional Liability ☐ General Liability ☐ Other _____

b) Is there an Insurance Trust? Yes No

c) Is there an Insurance Captive? Yes No

d) What organization handles claims for the SIR? _____

e) What legal firm is responsible for defending claims against the insured? _____

_____

4. ☐ Straight Excess Liability ☐ Umbrella Liability

Limits $_____/$_____

Retroactive Date _____

5. ☐ Employee Benefits Administration Liability

Total number of employees _____ Retroactive Date: _____

Limits Requested: $_____/$_____

6. Does the Hospital participate in the Virginia-Birth Neurology Injury Compensation Program? Yes No

INSURANCE HISTORY
Complete the following professional liability insurance history:

***Current Carrier** _____

☐ Claims Made ☐ Occurrence

Effective Date _____ Expiration Date_____

Retroactive Date _____

Limits $_____/$_____

☐ Deductible/SIR $ _____

Expiring premium(s) $ _____

(**attach copy of current policy)*

1st Prior Carrier _____

☐ Claims Made ☐ Occurrence

Effective Date _____ Expiration Date_____
Retroactive Date _____

2nd Prior Carrier _____

☐ Claims Made ☐ Occurrence

Effective Date _____ Expiration Date_____
Retroactive Date _____

SERVICES

1. Does your organization maintain beds for overnight occupancy? ☐ Yes ☐ No. If yes, please complete below.

BEDS
Occupancy: The daily average number of occupied beds shall be the sum of the annual occupancy divided by 365. Acute Care Beds are defined as: All beds licensed by the state, including but not limited to, all beds designated for burn, coronary, intensive care, medical, surgical, pediatrics, or other acute care patients.

Type of Bed	**No. Licensed Beds**			**Average Annual Occupied Beds**		
	Current Year	1st Prior	2nd Prior	Current Year	1st Prior	2nd Prior
Other Specify: _____						
Other Specify: _____						

2. Complete this section with information regarding the types of services performed at your facility:
OUTPATIENT VISITS
Hours of operation: _____

	***Current* annual visits**	***Projected* annual visits**	***Revenue %***
Alcohol/Drug Rehabilitation			
Ambulance Service (number of runs) circle ground or air			
Blood Banks (number of donors annually)			
Dental			
Drug and Alcohol			
Emergency Medicine			
Urgent Care Center			
Home Health Care			
Hospice			
Imaging Center			
Kidney Dialysis Visits			
Laser Vision Correction Center			
Endoscopy Center			
Community Clinic			
Social Services			

	Current annual visits	***Projected*** annual visits	***Revenue %***
Lab Visits			
Mental Health Services			
Nursing Home/Assisted Living/ Residential Care Visits			
Outpatient Cancer Treatment			
Physical Rehabilitation/Therapy			
Organ Tissue Bank (see supplemental application)			
Pharmacy			
Research Facility/Clinical Trials			
Weight Loss Center			
Sleep Center			
Cosmetic Aesthetics Medical Clinic (see supplemental application)			
Surgery Center (see supplemental application)			
Do you compound, manufacture or repackage anything that is sold to your patients/clients?			
Other exposures (specify)			

3. Annual gross receipts for last twelve months and projected revenue for coming year:

Current: _____ Projected receipts: _____

PERSONNEL

NOTE: No individual coverage is afforded to the following Professional Employees unless specifically requested

1. a) Complete the following table for Employed or Independent Contractor (**IC**) staff working in your Clinic/Spa:

Professional License/Status * Must be scheduled on policy to be covered.	**Number Employed Staff**	**Number IC/1099 Staff**	**Exclude Any Employed Staff from this Policy?**	**Do You Confirm Excluded Employees & ICs Have Own Policy?**
1) Physician/Surgeon (MD/DO)*****			☐ **Y**** ☐ **N**	☐ **Y** ☐ **N**
2) Doctor - D.D.S./D.C./D.P.M./etc.*****			☐ **Y**** ☐ **N**	☐ **Y** ☐ **N**
3) Nurse Anesthetist (CRNA)*****			☐ **Y**** ☐ **N**	☐ **Y** ☐ **N**
4) Nurse Practitioner (NP)*****			☐ **Y**** ☐ **N**	☐ **Y** ☐ **N**
5) Physician Assistant (PA)*****			☐ **Y**** ☐ **N**	☐ **Y** ☐ **N**
6) Medical Director, With Patient Care*			☐ **Y**** ☐ **N**	☐ **Y** ☐ **N**
7) Medical Director, No Patient Care			****List all employees and their specialty that are to be excluded from this policy:**	
8) Nurse – RN/LPN/etc.				
9) Other (describe):				

b) No coverage is afforded to certain Professional Employees unless specifically requested. As such, list all professional "employed staff" addressed in 1. a) 1-6 above that should be covered/scheduled on your policy. Answer all subsequent columns for their work performed only on behalf of the clinic

Name	Medical License	Clinic Hours Per Week	Retro Date / Hire Date Please note if they are not the same date	Specialty	If Prior Column is not 100%, list other Specialty & Percentage

2. Do you periodically and consistently confirm the licensing requirements needed by you and any employed or independent staff to ensure each person can perform the procedures or treatments they offer through your clinic/spa? Yes No
3. What are the minimum required limits of insurance for independent contractor?

GENERAL INFORMATION

1. Does your facility or any of its subsidiaries participate in any experimental, investigational or other unconventional therapies including any alternative medicine activities? Yes No
2. Does your facility or any of its subsidiaries participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No
3. Does your facility or any of its subsidiaries provide services to any federal or non-federal prisons? Yes No
4. If you have a lab with your facility, is it CLIA approved? Yes No

UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, provide an explanation in the Comments section.

1. Within the past 10 years, has any insurance carrier declined, cancelled, refused to renew, restricted, or surcharged any professional liability insurance policy issued to your clinic or any owner/officer? Yes No
2. Within the past 10 years, have you, your clinic or any health care professional rendering services on your behalf been notified of an involvement in a malpractice claim, suit, or incident, either directly or indirectly? If **Yes**, how many claims, suits or incidents have been brought to your attention? _____ Yes No
3. Within the past 10 years, have you, your clinic or any health care professional rendering services on your behalf been investigated or audited by a governmental or regulatory agency? Yes No
4. Within the past 10 years, has any healthcare practitioner, patient, or insurance plan filed a complaint of any kind against you or your clinic with a medical society, foundation or state/federal agency? Yes No
5. Within the past 10 years, has any healthcare professional working in your clinic had their admitting privileges to any hospital or other healthcare facility restricted, revoked or placed on probation? Yes No
6. Are you or any health care professional rendering services on your clinic's behalf aware of any conduct, circumstance, occurrence, incident or accident that is likely to or reasonably could be expected to give rise to a claim **that has not yet been reported** to the your current and/or prior insurance carrier? Yes No
7. Does any healthcare professional working in your clinic currently have or in the past had a probationary, restricted or suspended license? Yes No
8. Do the principal owners of your clinic own, operate, or control any specialized, medically related business, such as a pharmacy, laboratory, physical therapy center, free-standing surgery center, etc. that has not been previously named and described in this application? Yes No

COMMENTS / EXPLANATIONS:

NOTICE

To All Prospective Insureds: 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia and 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 Florida Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Oklahoma Applicants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Notice to Kansas Applicants: An act committed by 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.

Notice to Maine, Tennessee, Virginia and Washington Applications: 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 and/or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or 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 Hampshire Applicants: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

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 $5,000 and the stated value of the claim for each such violation.

Notice to New York Applicants (Fire insurance applications): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Notice to New York Applicants (Automobile): Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation."

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 purposes 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 Pennsylvania Applicants (Automobile): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information, shall, upon conviction, be subject to imprisonment for up to seven (7) years and the payment of a fine of up to $15,000.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

This application is for insurance to be placed on a surplus lines basis with Hudson Excess Insurance Company.

_____ _____

Signature **Date**

_____

Print Name/Title

Supplemental Claim Information Form

1. Full name of applicant: _____

2. Full name of claimant: _____

3. Indicate whether: ☐ Claim ☐ Suit ☐ Incident Report

4. Date of incident: _____ 5. Date claim was reported to Carrier: _____

6. Additional defendants: _____

7. If closed:
   Total loss paid including deductible: $ _____ Defense costs: $ _____

   Check One: ☐ Court judgment ☐ Out of court settlement
   Date closed: _____

8. If pending:
   Claimant's settlement demand: $ _____

   Defendant's offer for settlement: $ _____

   Insurer's loss reserve: $ _____

   Deductible amount: $ _____

   Is claim in suit? Yes No
   If **Yes**, amount asked in summons: $ _____

9. Insurance carrier:_____

10. Description: (Provide enough information to allow evaluation. Use reverse side or additional sheet if required.)

A. Alleged act, error or omission upon which Claimant bases claim:

B. Description of case and events:

C. Description of the type and extent of injury or damage allegedly sustained:

_____ _____
Signature of applicant Date

FEDERAL TORT CLAIMS ACT ("FTCA")
GAP COVERAGE SUPPLEMENTAL APPLICATION

(Note: This supplemental application is to be completed in conjunction with the Healthcare Facility Application)

(Please print or type and be sure to sign and date page 3)

GENERAL INFORMATION

Named Insured:_____ County:_____

Primary Location:_____ City/State/Zip:_____

Tribal Affiliation:_____

FTCA ELIGIBILITY INFORMATION

1. Does the organization currently have FTCA coverage through Section 330 of the Public Health Services Act ("PHSA")?
   Yes No

2. Is this facility operated under a 638 contract or Self-Governance agreement? Yes No

If the answers to Question 1 and/or 2 above are "yes", please complete the following:

3. Please explain and identify those services and/or procedures for which the organization does not have FTCA protection:

4. Provide the total percentage and description of the healthcare services and healthcare provider exposure that falls outside the scope of the applicable agreement:

   Percentage of Non-FTCA Exposure: _____%

   Describe the services and provider exposure not covered under the FTCA immunity if not already addressed under Question 1-4 above:

GENERAL PRACTICE INFORMATION

1. Are students, interns, externs, residents and/or fellows training in the Health Center? Yes No

2. Do any of the students, interns, externs, residents and/or fellows have any direct patient contact? Yes No

   If the answers to Questions 1 and/or 2 above are "yes", how many and what services are they providing? Please describe below:

3. Do any of your employed or contracted healthcare providers supervise the care provided by students, interns, externs, residents and/or fellows to non-Health Center patients? Yes No

   If so, how many students, interns, externs, residents and/or fellows are supervised that provide care to non-Health Center patients? How often and what type of services are being provided?

4. Are the patients described in Question 3 above a part of your provider's required on-call scope of employment? Yes No

   If not, please explain:

5. Are any employed or contracted healthcare provider(s) providing healthcare services outside of the United States? Yes No

   If so, specify the name, medical specialty, retroactive date and activities being performed outside of the United States, and the percentage of the overall total services being provided by the healthcare provider(s).

6. Are any healthcare providers employed or contracted by the Health Center supervising non-Health Center employees and staff – such as serving as Medical Director(s) for a Health Center contracted nursing home or as Medical Director for the local emergency medical system? Yes No

   If so, please list the healthcare provider('s/s') name(s), medical specialt(y/ies) and the organization(s) the healthcare provider(s) is/are supervising non-Health Center employees and staff and serving as Medical Director.

7. Does your healthcare provider(s) employment or contractor agreement allow the healthcare provider(s) to moonlight or practice any other activities outside of their scope of employment or outside of the Scope of Project of your deemed Health Center?
   Yes No

   If so, provide the name of the healthcare provider(s) and describe the activities being performed.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS SUPPLEMENTAL APPLICATION CHANGES BETWEEN THE DATE OF THIS SUPPLEMENTAL APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

Notice to California Applicants: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For FL, KY, MN, NJ, OH and PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person who 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. For NY residents only: And shall also be subject to a civil penalty not to exceed five thousand ($5,000) dollars and the stated value of the claim for each such violation.

This supplemental application is for insurance to be placed on a surplus lines basis with Hudson Excess Insurance Company.

Signature **Date**

Print Name/Title