SPG SPECIALTY PROGRAM GROUP

Urgent Care 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
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 advice is offered to the public?

PRODUCER INFORMATION

Agency Name _____

Mailing Address _____ City/State/Zip _____

Producer Name _____Telephone _____ Email _____

APPLICANT INFORMATION

Named Insured _____ County _____

Primary Location _____ City/State/Zip _____

CEO _____ Risk Manager _____ Website: _____

Email Address for Primary Contact: _____

Medical Director:_____ Direct Patent Care: ☐ Yes (Number of Hours Per Week:_____) ☐ No

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:

_____

_____

Number of locations at which services are provided: _____

Addresses of 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. ☐ Umbrella Liability

Limits $_____/$_____

Retroactive Date _____

4. ☐ Employee Benefits Administration Liability

Total number of employees _____ Retroactive Date: _____

Limits Requested: $_____/$_____

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. 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 %***
Urgent Care			
Family/Preventative Care (Physicals/Immunizations/Wellness/etc.)			
Imaging (X-Ray/CT Scans/EKG/etc.)			
Lab Visits (Blood draws/Diagnostic Tests)			
Pharmacy			
Telehealth Visits			
COVID Related Visits (Testing/Immunization/etc.)			
Other:			

2. 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 Staff unless specifically requested.

Professional License/Status	**Employed Staff Total Hours Per Month**	**IC/1099 Staff Total Hours Per Month**	**Total Number of Staff**	**Include ALL Staff on 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) Nurse – RN/LPN/etc				Y N	Y N
7) Other (describe):					

No coverage is afforded to certain Professional Employees unless specifically requested and approved by underwriting. As such, list all professional staff addressed in 1-2 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**

1. 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? Yes No
2. What are the minimum required limits of insurance for independent contractors? $_____/$_____

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 utilize any non-FDA approved services?	Yes	No
4. Does your facility or any of its subsidiaries have a contract with or provide services to any correctional facilities which includes city or county jails, prisons, juvenile detention and youth correctional facilities?	Yes	No
5. Does your facility or any of its subsidiaries or practitioners provide services to professional athletes or celebrities?	Yes	No
6. If you have a lab with your facility, is it CLIA approved?	Yes	No
7. Is there a transfer agreement in place with a local hospital allowing patients to be directly admitted to the hospital in an emergency situation?	Yes	No
8. What is the distance between this facility and the nearest hospital? _____	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:

California: 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.

Colorado: 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.

District of Columbia and Louisiana: 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.

Florida: 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.

Oklahoma: 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.

Kansas: 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.

Maine, Tennessee, Virginia and Washington: 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.

Maryland: 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.

New Hampshire: 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.

New York : 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.

Ohio: 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.

Oregon: Any person who knowingly and with intent to injure, deceive, defraud any insurer or other person files an application or a claim containing any false, incomplete or misleading information or conceals information concerning any material fact may be guilty of insurance fraud, which may be crime and may subject such person to criminal and civil penalties.

Pennsylvania: 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.

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

HUDSON EXCESS INSURANCE COMPANY
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