



# Application for CLINICS (Medical, Public Health, Dental, Etc.) PROFESSIONAL LIABILITY INSURANCE (Claims Made Basis)

Please mail or fax this completed application to:

Rockwood Programs, Inc., 4001 Miller Road, Wilmington, DE 19802-1999

Toll-Free: (800) 558-8808 • Fax: (302) 765-6039 • Email: www.rockwoodinsurance.com

### Applicant's Instructions:

- 1 Answer all questions. If the answer requires detail, please attach a separate sheet.
- 2 Application must be signed and dated by owner, partner, or officer.
- 3 Please do not complete application earlier than 45 days before proposed effective date of coverage.
- 4 PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

## 1 Application Information

- a. Full name of Applicant \_\_\_\_\_
- b. Principal business premise address \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
- c. Your practice:  Professional corporation (for profit)  Professional corporation (non-profit)  Partnership  
 Professional Association  Other (please describe) \_\_\_\_\_
- d. Date established \_\_\_\_\_
- e. Number of Employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Total \_\_\_\_\_
- f. Business, corporate or partnership name: \_\_\_\_\_
- g. Name of all partners or members of the firm who provide professional services: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- h. Professional societies or associations in which you are a member: \_\_\_\_\_  
 \_\_\_\_\_
- i. Please attach a copy of letterhead or other business stationery.

## 2 Operations

- a. States Clinics are registered and licensed to practice \_\_\_\_\_  
 If none, please explain. \_\_\_\_\_
- b. Clinic(s) professional specialty \_\_\_\_\_
- c. Do you maintain any beds for overnight occupancy?  Yes  No If **Yes**, complete application form SM 5864 or SM 686.
- d. Total square feet that you occupy (all locations) \_\_\_\_\_
- e. Division of patients or clients:
- |                                       |                              |                                     |                            |
|---------------------------------------|------------------------------|-------------------------------------|----------------------------|
| 1 Alcoholics ..... _____ %            | 6 Drug Addicts .... _____ %  | 11 Pediatric ..... _____ %          | 16 Surgical..... _____ %   |
| 2 Bariatrics ..... _____ %            | 7 Family Planning _____ %    | 12 Physical Rehabilitation _____ %  | 17 Other (specify)         |
| 3 Communicable _____ %                | 8 Hemodialysis .... _____ %  | 13 Psychiatric .. _____ %           | _____                      |
| 4 Dental ..... _____ %                | 9 Holistic Medicine _____ %  | 14 Research or Experimental _____ % | _____ %                    |
| 5 Disability Evaluation ..... _____ % | 10 Obstetrical ..... _____ % | 15 Stress Testing _____ %           | <b>Must Equal.....100%</b> |

**2 Operations, Continued...**

f. Does Clinic use a collection agency? .....  Yes  No  
If **Yes**, name  
of agency \_\_\_\_\_

Does the agency have authority to file a  
collection suit on Clinic's behalf? .....  Yes  No

g. Do owners, partners or directors, (wholly or in part), operate, or  
administer any hospital, nursing home or other institution where  
medical services are customarily rendered? .....  Yes  No  
If **Yes**, give details including name, location, size and no. of beds:  
\_\_\_\_\_  
\_\_\_\_\_

h. Do you own or operate any business other  
than that shown in question 1a.? .....  Yes  No  
If **Yes**, please attach detailed explanations of this activity.

i. Do you advertise your professional services in any manner  
other than a simple listing in a telephone directory?  Yes  No  
If **Yes**, please attach a copy of All of the advertisements.

**3. Professional Services**

a. Do you perform:

1 Acupuncture or acupuncture anesthesia? .....  Yes  No

Explain \_\_\_\_\_

2 Angiography/arteriography/venography? .....  Yes  No

Describe \_\_\_\_\_

3 Catheterization (other than urinary or umbilical)?  Yes  No

Describe \_\_\_\_\_

4 Closed reduction of compound fractures and/or  
normal deliveries and/or dermabrasion? .....  Yes  No

5 Injection of radioisotopes and/or use of  
irradiated substances? .....  Yes  No

Describe \_\_\_\_\_

6 Radiation therapy and/or chemotherapy? .....  Yes  No

Describe \_\_\_\_\_

7 Psychiatric shock therapy? .....  Yes  No

8 Silicone Injections? .....  Yes  No

Describe \_\_\_\_\_

9 Spinal anesthesia (other than saddle blocks or  
caudals)? .....  Yes  No

10 Laser treatment? .....  Yes  No

Describe \_\_\_\_\_

11 Experimental procedures or research testing?  Yes  No  
Describe in detail on separate sheet.

12 Hypnosis? .....  Yes  No

Describe \_\_\_\_\_

b. Do you perform:

1 Norplant insertion/removals? .....  Yes  No

How many yearly \_\_\_\_\_

j. Names and locations of any hospitals or institutions Clinic uses  
in its practice \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

k. Is the Applicant a "Covered Entity" under the Health Insurance  
Portability and Accountability Act of 1996 HIPAA Privacy Rule?

.....  Yes  No

If **Yes**, 1 Has the Applicant implemented procedures to comply  
with the HIPAA Privacy Rule? .....  Yes  No

2 Provide the name and title of the Applicant's Privacy Officer  
.....  Yes  No

2 Surgery other than incision of superficial boils  
or suturing superficial fascia? .....  Yes  No

3 Circumcisions and/or dilation and curettage  
and/or insertion of temporary pacemaker? .....  Yes  No

4 Tonsillectomies and/or adenoidectomies  
and/or caesarean sections? .....  Yes  No

5 Cosmetic plastic surgery? .....  Yes  No

Describe \_\_\_\_\_

6 Excision of large cysts and/or I&D of  
deep-seated boils or carbuncles? .....  Yes  No

7 Hysterectomies? .....  Yes  No

8 Open reduction of fractures? .....  Yes  No

Describe \_\_\_\_\_

9 Surgery for weight reduction of patients? .....  Yes  No

10 Abortions and/or menstrual extractions? .....  Yes  No  
Describe (include trimester, method and number of abortions

performed per month) \_\_\_\_\_  
\_\_\_\_\_

11 Cryosurgery (other than use on benign or  
pre-malignant dermatological lesions)? .....  Yes  No

Describe \_\_\_\_\_

12 Silicone implants? .....  Yes  No

Describe \_\_\_\_\_

13 Sterilization procedures? .....  Yes  No

Describe \_\_\_\_\_

14 Biopsies and/or endoscopies? .....  Yes  No

List types performed \_\_\_\_\_  
\_\_\_\_\_

**3. Professional Services, Continued...**

15 Sex change operations? .....  Yes  No

Describe and advise number yearly \_\_\_\_\_

16 Experimental surgery or surgical research? ...  Yes  No

Describe in detail on separate sheet.

17 Other surgery? .....  Yes  No

Describe \_\_\_\_\_

c.1 Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? .  Yes  No  
If **Yes**, answer 2 and 3 below.

2 List All surgical procedures performed (including minor surgery)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3 Do you administer anesthesia (other than topical or local infiltration)? .....  Yes  No

If **Yes**, please attach detailed explanation.

d. Do you perform hospital emergency room care for patients not your own? .....  Yes  No

If **Yes**, please attach explanation and also advise the number of "patient contact" hours Monthly by you:

**4. Staff**

a. Please indicate the number of professional employees, volunteers, and independent contractors. If None, post "0".

<u>Classification</u>	<u>Employees and Volunteers</u>	<u>Independent Contractors</u>
1 Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures.....	_____	_____
2 Physicians: Minor surgery or obstetrical procedures not constituting major surgery .....	_____	_____
3 Proctologists, Ophthalmologists and Urologists .....	_____	_____
4 General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery) .....	_____	_____
5 Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery .....	_____	_____
6 Oral Surgeons .....	_____	_____
7 Nurse Anesthetists .....	_____	_____
8 Optometrists, Opticians .....	_____	_____
9 Pharmacists .....	_____	_____
10 Perfusionists .....	_____	_____
11 Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons .....	_____	_____

1 Emergency Room Physicians \_\_\_\_\_ hrs      3 Nurses \_\_\_\_\_ hrs.

2 Paramedics \_\_\_\_\_ hrs      4 Other \_\_\_\_\_ hrs.

e. Do you use drugs for weight reduction on patients?  Yes  No  
If **Yes**, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.

f. Do you administer methadone treatment? ....  Yes  No  
If **Yes**, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months; Next 12 months.

g. Number of annual x-ray exposures:  
for diagnosis \_\_\_\_\_ for treatment \_\_\_\_\_

h. If x-ray treatment is given, what qualifications are required of the staff? \_\_\_\_\_  
\_\_\_\_\_

i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? .....  Yes  No  
If **Yes**, please attach detailed explanation of this activity.

j. Attach detailed descriptions of any additional activities and/or procedures which you performed.

<u>Classification</u>	<u>Employees and Volunteers</u>	<u>Independent Contractors</u>
12 Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet) .....	_____	_____
13 Unlicensed Interns .....	_____	_____
14 Dentists (no oral surgery) .....	_____	_____
15 Orthodontists .....	_____	_____
16 Podiatrists .....	_____	_____
17 Chiropractors .....	_____	_____
18 RN, LPNs .....	_____	_____
19 Other .....	_____	_____
20 Other .....	_____	_____

**Note:** if you require any of the above to be Named Insureds, please submit separate application for each such individual.

b. Are all of the above individuals licensed in accordance with applicable state and federal regulations? .....  Yes  No  
If **No**, please attach explanation.

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY **YES** ANSWERS TO THE FOLLOWING:

1 Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association? .....  Yes  No

**4. Staff, Continued...**

- 2 Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No
  - 3 Ever been treated for alcoholism or drug addiction?  Yes  No
  - 4 Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  Yes  No
  - 5 Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?  Yes  No
  - d. Do you supervise any individual other than your own employees?  Yes  No
- If **Yes**, please provide explanation of responsibilities and

relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

Type of Profession	Number
Physicians .....	_____
X-ray Technicians .....	_____
Laboratory Technician .....	_____
Other .....	_____
Other .....	_____
Other .....	_____
Other .....	_____

**5 Revenues**

a. Please state sources and amounts of total revenue:

Source	This Fiscal Year	Next Fiscal Year
1 Charitable Contributions \$	_____	\$ _____
2 Government Funding .....	\$ _____	\$ _____
3 Fee for Service .....	\$ _____	\$ _____
4 Other	_____	_____
_____ \$	_____	\$ _____
<b>Total Gross Revenue .....</b>	<b>\$ _____</b>	<b>\$ _____</b>

b. Please provide number of outpatient visits:

Type of Visit	Last 12 Months	Next 12 Months
Clinics .....	_____	_____
Laboratory .....	_____	_____
Emergency .....	_____	_____
_____	_____	_____
_____	_____	_____
<b>TOTAL VISITS .....</b>	<b>_____</b>	<b>_____</b>

c. If you have a training school, please complete the following. Attach separate schedule if needed.

Specify Profession for which Students are being Trained	Max. No. of Students Per Session	No. of Sessions Per Year	% of Time Involved in Clinical Setting	Number of Faculty	Qualifications of Faculty (e.g MD, RN, PhD, etc.)
_____	_____	_____	_____%	_____	_____
_____	_____	_____	_____%	_____	_____
_____	_____	_____	_____%	_____	_____

**6 Affiliations**

- a. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients?  Yes  No  
If **Yes**, please attach detailed explanation and a copy of All of the advertisements.
- b. Are you employed by any individual or entity other than that shown in Question 1(a)?  Yes  No  
If **Yes**, please attach explanation.
- c. Are you under contract to any individual or entity other than that shown in Question 1(a)?  Yes  No  
If this contract contains a hold-harmless agreement, copy of contract must be attached.
- d. Are you in the employ of or under contract to any federal governmental entity?  Yes  No

**7 History/Claims**

- a. Has any claim or suit been brought against you and/or any of your employees?  Yes  No  
If **Yes**, a supplemental claim information form must be completed for each claim or suit.

**7 History/Claims, Continued...**

b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? .....  Yes  No  
 If **Yes**, please give details on separate sheet.

c. Please list general liability insurance carried for each of the past three years. If None, post "0".

	Present Year	2nd Year	3rd Year
<b>Insurance Carrier</b>			
<b>Policy Number</b>			
<b>Limits of Liability</b>	\$	\$	\$
<b>Deductible (if any)</b>	\$	\$	\$
<b>Premium</b>	\$	\$	\$
<b>Inception (Mo/Day/Yr)</b>	/ /	/ /	/ /
<b>Expiration (Mo/Day/Yr)</b>	/ /	/ /	/ /
<b>Was this a Claims Made Policy Form?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Retro Date (Mo/Day/Yr)</b>	/ /	/ /	/ /

\* **Notice to Applicant:** The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting option is exercised in accordance with the terms of the policy.

**Warranty:** I/We warrant to the insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by Issuance of a policy. **I/We authorize the release of claim information from any prior insurer to Rockwood Programs, Inc.**

Name of Applicant \_\_\_\_\_ Title (Officer, partner, etc.) \_\_\_\_\_

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signing this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.