



Application for ALLIED HEALTHCARE

(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 (include professional degree if applicant is an individual): _____

b. Principal business premise address: _____

City _____ County _____ State _____ Zip _____

c. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____

d. Business Phone: (_____) _____ Home Phone: (_____) _____

e. Date of Birth: _____ Place of Birth: _____

Are you a U.S. citizen? Yes No If **No**, your status: _____ date of entry into USA: _____

f. Square feet of total office space (all locations): _____

g. Your practice:

- Solo practitioner (unincorporated) Solo practitioner (incorporated) Partnership
 Professional corporation (for profit) Professional corporation (non-profit) Professional Association
 Employee of (Give Name of Employer) _____
 Other (please describe) _____

h. Formal business, corporate or partnership name: _____

i. Please list the names of all partners or members of your professional association/corporation who provide professional services:

j. Please attach a copy of your letterhead.

k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1995 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: _____

2 Education/Experience (Individual Applicant Only)

a. Education	Institution and Address	Years of Training From/To	Degree or Certification Attained
		/	
		/	
		/	

2 Education/Experience (Individual Applicant Only) Continued...

b. Where have you practiced your profession during the last ten years?

	From/To
In	/
In	/
In	/

c. Have you ever failed any professional licensing or specialty organization examination? Yes No If **Yes**, please attach a detailed explanation including the dates and location.

3 Applicant Practice

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation.

b. Please indicate your professional specialty (Check One):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Optician | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Counselor (describe) | <input type="checkbox"/> Medical Personnel Pool | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Naprapath | <input type="checkbox"/> Orthotist | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Hearing Aid Fitter | <input type="checkbox"/> Nurse, Licensed Practical | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Visiting Nurse Assoc. |
| <input type="checkbox"/> Home Healthcare Agency | <input type="checkbox"/> Nurse, Registered | <input type="checkbox"/> Pharmacist | <input type="checkbox"/> X-ray Technician |
| <input type="checkbox"/> Inhalation Therapist | <input type="checkbox"/> Nurses Registry | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other (specify) |
| | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Psychologist | |

c. Please indicate the sources and amounts of actual and projected revenue:

Source	Amount This Fiscal Year	Amount Next Fiscal Year
1. Charitable Contributions	\$	\$
2. Government Funding	\$	\$
3. Fee for Services:	\$	\$
4. Other:	\$	\$
Total Gross Revenue:	\$	\$

d. Please provide the number of patient or client visits:

Type of Visit	Number of Visits	Number of Visits
	Last 12 Months	Next 12 Months
Clinic		
Laboratory		
Other (specify)		
Total Number of Visits		

e. Please specify any professional societies or associations in which you are a member:

f. Are you associated with or do you work for a physician or surgeon? Yes No If **Yes**, please give the name and the specialty of the physician: _____

g. Please give the approximate percentage of time spent in the following work locations:

Administrative Office % Nursing Home % Hospital Ward (specify) _____ %
 Classroom % Operating Room .. _____ % _____ %
 Emergency Dept. of Hospital _____ % Outpatient Clinic _____ % Professional Office (specify profession) _____ %
 Laboratory % Patient's Home _____ % _____ %

h. Please indicate the approximate division of your patients or clients among:

Alcoholics % Drug Addicts % Obstetrical % Surgical %
 Bariatrics % Family Planning... _____ % Pediatric % Disability Evaluation %
 Communicable _____ % Hemodialysis % Psychiatric _____ % Physical Rehabilitation %
 Dental % Holistic Medicine _____ % Stress Testing _____ % Research or Experimental _____ %
 Other: _____ % Other: _____ %

i. Please indicate the number and type of your employees and/or volunteers. If NONE, post "0".

Type of Profession	Number	Type of Profession	Number	Type of Profession	Number
Inhalation Therapists	_____	Nurses, Registered ...	_____	Physiotherapists	_____
Laboratory Technicians	_____	Opticians	_____	Social Workers	_____
Nurse Anesthetists	_____	Optometrists	_____	Speech Therapists	_____
Nurses, Licensed Practical ..	_____	Perfusionists	_____	Other (specify):	_____
Nurses Practitioner	_____	Pharmacists	_____		_____

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

4 Applicant Procedures

a. Do you render professional services directly to patients? Yes No If "Yes", please describe **in detail** and indicate the extent of supervision by others:

Description of Professional Services	Percent of Time Supervised	Qualifications of Supervisor
_____	_____%	_____
_____	_____%	_____
_____	_____%	_____

b. Do you render professional services that do not involve contact with a patient? Yes No If **Yes**, please describe these services **in detail**. _____

c. 1. Do you perform or assist in any surgical procedures? Yes No

2. Please list All surgical procedures performed (including minor surgery): _____

3. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others?
 Yes No If **Yes**, please attach a detailed explanation.

4. Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility?
 Yes No If **Yes**, please attach a detailed explanation.

d. Do you perform radiation therapy? Yes No

e. Do you perform psychiatric shock therapy? Yes No

f. Do you compound in bulk, manufacture or wholesale medicine? Yes No
If **Yes**, please provide a detailed explanation.

g. Do you perform veterinary services? Yes No
If **Yes**, please indicate the approximate division of your work among the following categories:

Greyhounds _____% Thoroughbreds _____%

Animals valued over \$5,000 _____%

Please attach an explanation including the frequency and the type(s) of animals treated.

h. Do you administer artificial insemination? Yes No
If **Yes**, please answer the following questions:

1. What type(s) of animals are involved: _____

2. Are you responsible for the storage of the semen?

Yes No If **Yes**, please explain: _____

3. What percent of your practice is involved with artificial insemination? %

i. Are you ever responsible for indentifying contagious diseases in your locality and/or for recommending remedial action? Yes No
If **Yes**, please attach a detailed explanation.

5 Personnel

a. Please list the number and type of independent contractors who provide professional services on your behalf. If None, post "0".

Type of Profession	No.	Type of Profession	No.	Type of Profession	No.	Type of Profession	No.
Inhalation Therapists	_____	Nurse Practitioner	_____	Perfusionists	_____	Speech Therapists ..	_____
Laboratory Technicians	_____	Nurse, Registered	_____	Pharmacists	_____	Social Workers	_____
Nurse Anesthetists	_____	Opticians	_____	Physiotherapists	_____		
Nurses, Licensed Practical	_____	Optometrists	_____	Other (specify):	_____		

b. Do you supervise any individuals who are not your own employees? Yes No If **Yes**, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals on a separate sheet.

c. Please indicate by profession the number of individuals you supervise: Number of Physicians _____
 Laboratory technicians _____ X-ray technicians _____ Other (specify): _____

6 Applicant Affiliations

a. Do you own or operate any business other than that shown in Question 1(a) above? Yes No
 If **Yes**, please give details on a separate sheet.

b. Are you employed by any individual or entity other than that shown in Question 1(a) above? Yes No
 If **Yes**, please attach an explanation describing details of your responsibilities.

c. Are you under contract to any individual or entity other than that shown in Question 1(a) above? Yes No
 If **Yes**, please attach an explanation describing details of your responsibilities. If your contract contains a hold-harmless agreement, a copy of the contract must be attached.

d. Are you employed by or under contract to any government entity? Yes No If **Yes**, please attach an explanation including the details of your responsibilities.

e. 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 your advertisements.

f. 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 a detailed explanation and a copy of All of your advertisements.

g. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered? Yes No
 If **Yes**, please give details including the name, location, size and number of beds.

i. i) Do you use a collection agency? Yes No
 If **Yes**, please state the name of the agency.

ii) Does the agency have the authority to file a collection suit at its discretion? Yes No

h. If you have a training school, please complete the following. Attach a separate sheet 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.)
			%		
			%		
			%		

7 Applicant History/Claims (Attach detailed explanations for all **Yes** answers in this section.)

a. Have you or any of your employees:

- Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes No
- Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? .. Yes No
- Ever been treated for alcoholism or drug addition? Yes No
- 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

7 Applicant History/Claims, Continued: (Attach detailed explanations for all **Yes** answers in this section.)

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

b. Please list prior professional liability insurance carried for each of the past four years. If None, post "0".

	Present Year	2nd Year	3rd Year	4th Year
Policy Insurance Carrier				
Policy Number				
Limits of Liability	\$	\$	\$	\$
Deductible (if any)	\$	\$	\$	\$
Premium Amount	\$	\$	\$	\$
Inception (Mo/Day/Yr)	/ /	/ /	/ /	/ /
Expiration (Mo/Day/Yr)	/ /	/ /	/ /	/ /
Was this a Claims Made Policy Form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Retro Date (Mo/Day/Yr)	/ /	/ /	/ /	/ /

c. 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.

d. 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 a separate sheet.

* **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.