



ALLIED HEALTH PROFESSIONAL LIABILITY INSURANCE APPLICATION

Rockwood Programs, Inc.
3001 Philadelphia Pike
Claymont, DE 19703
Tel: 800-365-0816 Fax: 302-764-9125
sales@rockwoodinsurance.com

This is an application for claims-made insurance. It is important that you report any currently known facts, incidents, situations or circumstances that could result in a claim to your current insurer or purchase an extended reporting period endorsement to cover such known facts, incidents, situations or circumstances. Protective Specialty Insurance Company will not provide coverage for known facts, incidents, situations, circumstances or claims of which you are aware prior to the inception date of this coverage.

Instructions for completing this application:

1. Please answer all the questions. This information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
2. If a question is not applicable, state "N/A". If more space is required to answer a question, please attach an exhibit with the question number.
3. The application must be signed and dated by a named insured or authorized person.
4. PLEASE ATTACH THE FOLLOWING:
 - a. Brochures or other descriptive literature about the applicant's services or operations.
 - b. Resume of principals or officers and key professional staff.
 - c. A copy of your letterhead.
 - d. Supplemental application(s) if applicable.
5. Return this and all supplemental applications to:
sales@rockwoodinsurance.com
OR
Rockwood Programs, Inc.
3001 Philadelphia Pike
Claymont, DE 19703

Proposed Effective Date: From _____ to _____

GENERAL INFORMATION

1. Applicant, including all named insureds, DBAs, subsidiaries or professional degree (if an individual):

2. Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Additional locations should be listed on a separate exhibit.

3. Phone: _____ Fax: _____

4. Website: _____ Email Address: _____

5. Applicant is a(n): Individual/solo practitioner Partnership Corporation Association

Employee of (name of corporation): _____ Other: _____

6. Date your entity was established: _____

7. In what state(s) is the applicant/individual licensed/registered to practice? _____

8. During the past five years, has the name changed? Yes No

Has any other business been purchased, merged or consolidated with this applicant? Yes No

If yes to either question, please provide details: _____

9. Is the applicant controlled, owned, affiliated or associated with any other firm, corporation or entity? _____

Yes No

Are any services provided by the applicant to such business enterprises? Yes No

If yes to either question, please provide details: _____

10. Total number of employees, including full-time, part-time, volunteers and independents: _____

EDUCATION/EXPERIENCE

This section to be completed by individuals or solo practitioners only.

Degree/Certification Attained

Years of Training

Institution Name & Location

11. Where have you practiced during the last 10 years?

a. Location: _____ From _____ to _____

b. Location: _____ From _____ to _____

c. Location: _____ From _____ to _____

12. Have you ever failed any professional licensing examination? Yes No

13. Has your license ever been suspended, revoked, renewal refused or voluntarily surrendered?

Yes No

14. Have you ever been investigated for or convicted of a felony? Yes No

15. Have you ever been the subject of any disciplinary action or investigative proceedings or reprimand by any government body, administrative agency or professional association within the last five years?

Yes No

16. Have you ever been treated for alcoholism or drug addiction? Yes No

If yes to 12, 13, 14, 15 or 16, please provide a detailed explanation, including dates and location.

PROFESSIONAL SERVICES

17. Please describe all the services you provide: _____

18. Please state approximate percent of gross revenue derived from the following specialties. The total should equal 100%.

Adoption/foster care services ____%
 Adult day care ____%
 Alcohol & drug abuse services ____%
 Ambulance (air) ____%
 Ambulance (ground) ____%
 Blood bank/blood services* ____%
 Cancer treatment center ____%
 Case management/utilization review ____%
 Chiropractic services ____%
 Clinical trials* ____%
 Cosmetic surgery ____%
 Counseling services ____%
 CRNA (group) ____%
 CRNA (individual) ____%
 Dental services ____%
 Dialysis center/services ____%
 Durable medical equipment ____%
 Emergency call center/crisis hotline ____%
 EMT/paramedic ____%
 Exams/physical assessments ____%
 Eye care services ____%
 Fertility services ____%
 Group homes ____%
 Healthcare center ____%
 College/university ____%
 Community ____%
 Correctional/jail/prison ____%
 Home healthcare services/agency* ____%
 Hospice services ____%
 Hospital ____%
 Hyperbaric services ____%
 Imaging services ____%
 Laboratory services ____%
 Laser treatments ____%
 Lithotripsy ____%
 Medical clinic/urgent care (outpatient)* ____%
 Medical spa/anti-aging services* ____%

Medical student ____%
 Medical training: see "Schools" below
 Mental health clinic/counseling ____%
 Midwife/obstetric services ____%
 Nurse registry ____%
 Nursing home/assisted living ____%
 Organ/tissue services ____%
 Orthotics/prosthetics ____%
 Pain management center ____%
 Pharmacy services ____%
 Plastic surgery ____%
 Psychiatric facilities ____%
 Psychologist ____%
 Referral agency/services ____%
 Rehabilitation center (inpatient) ____%
 Schools ____%
 Dental ____%
 Medical ____%
 Nursing ____%
 Optometry ____%
 Other healthcare providers ____%
 Residential detox facility ____%
 Residential healthcare facility ____%
 Sleep apnea center/services ____%
 Social services ____%
 Staffing services ____%
 Surgical center ____%
 Teleradiology ____%
 Therapy services* ____%
 Physical ____%
 Occupational ____%
 Speech ____%
 Veterinarian ____%
 Visiting nurse association* ____%
 Wound care/hyperbaric services ____%
 Other (specify): _____%
 Other (specify): _____%

*Supplemental information may be needed

19. Please indicate sources of gross revenue.

Source	Revenues last year	Projected this year
Fees for services	\$ _____	\$ _____
Government funding	\$ _____	\$ _____
Charitable contributions	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____
Total Gross Revenues	\$ _____	\$ _____
Estimate of total projected revenue for next year: \$ _____		

20. Indicate the total number of all professional employees, including volunteers and independent contractors.

	Full-time/Part-time		Full-time/Part-time
Athletic trainer	____ / ____	Optometrist	____ / ____
Chiropractor	____ / ____	Orthotist	____ / ____
Clerical/administration	____ / ____	Perfusionist	____ / ____
Counselor	____ / ____	Pharmacist	____ / ____
CRNA	____ / ____	Phlebotomist	____ / ____
Dental hygienist	____ / ____	Physician assistant	____ / ____
EKG/EEG tech	____ / ____	Physicians, surgeons, dentists	____ / ____
Home health aides	____ / ____	Physiotherapist	____ / ____
Imaging technician	____ / ____	Psychologist/psychotherapist	____ / ____
Lab tech	____ / ____	Social workers	____ / ____
Medical assistant	____ / ____	Therapist: Occupational	____ / ____
Medical tech	____ / ____	Therapist: Physical	____ / ____
Naprapath	____ / ____	Therapist: Inhalation	____ / ____
Nurses aides	____ / ____	Therapist: Radiation	____ / ____
Nurses, LPN	____ / ____	Therapist: Rehab	____ / ____
Nurses, RN	____ / ____	Therapist: Speech	____ / ____
Nurse practitioner	____ / ____	Therapist: Sports Medicine	____ / ____
Optician	____ / ____	Other: _____	____ / ____

- a. Are all individuals listed above licensed in accordance with all applicable local, state and federal regulations?
 - Yes No If no, please explain: _____
- b. Do you require any above individuals to maintain their own professional liability coverage?
 - Yes No If yes, please explain: _____
- c. Do all individuals listed above maintain professional liability coverage equal to or greater than the applicant?
 - Yes No If no, please explain: _____

21. Please provide the annual number of patient encounters.

Type of visit	Last year	Projected this year
Clinic (# of visits)	_____	_____
Laboratory (# of procedures)	_____	_____
Other (specify)	_____	_____

22. Is the applicant a “covered entity” under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No

If yes:

a. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No

If no, please explain: _____

b. Please provide the name and title of the applicant’s Privacy Officer: _____

23. Please list any professional associations or societies of which you are a member:

24. Are you associated with or do you work for a physician or surgeon? (Individuals/solo practitioners only) Yes No

If yes, please provide the name and specialty of the physician:

PROCEDURES

If yes to any of the below, please attach an exhibit.

25. Do you perform any:

- a. Surgery, other than incision of superficial boils or suturing of superficial fascia? Yes No
- b. Circumcision, dilation and curettage, or insertion of temporary pacemakers? Yes No
- c. Radiation or chemo therapy? Yes No
- d. Psychiatric shock therapy? Yes No
- e. Invasive medical procedures or surgery? Yes No
- f. Plastic surgery? Yes No
- g. Open reduction of fractures? Yes No
- h. Surgery for weight loss? Yes No
- i. Abortions, sterilization procedures or sex change operations? Yes No
- j. Silicone implants? Yes No
- k. Endoscopies? Yes No
- l. Hospital room emergency care? Yes No
- m. Methadone treatment? Yes No
- n. Anesthesia other than topical? Yes No
- o. Injection of radioisotopes or use of any irradiated substances? Yes No

26. Do you:
- a. Maintain any beds for overnight occupancy? Yes No
 - b. Own, operate or administer a hospital or nursing home? Yes No
 - c. Own or operate any business other than shown in this application? Yes No
 - d. Advertise your professional services in any manner other than a telephone directory? Yes No
 - e. Compound in bulk, manufacture or wholesale medicines, including pharmaceuticals? Yes No
27. Are you under contract to any individual other than the named insured? Yes No
If your contract contains a hold harmless agreement, please attach a copy of the contract.
28. Are you:
- a. Employed by any individual or entity other than that shown in this application? Yes No
 - b. Under contract to any individual or entity other than that shown in this application? Yes No
 - c. Employed by or under contract to any governmental entity? Yes No
 - d. Associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? Yes No
29. If the applicant has a training school, complete the following:
- a. Professions for which students are being trained: _____
 - b. Maximum number of students per session: _____
 - c. Number of sessions per year: _____
 - d. Percent of time in clinical setting: _____
 - e. Qualifications of faculty (MD, RN, PhD): _____

PRIOR INSURANCE INFORMATION

Check here if no prior insurance.

Professional Liability

30. List the professional liability insurance carried for each of the past five (5) years, including periods of no coverage.

Insurance Carrier	Policy Period	Limit of Liability per Claim/Aggregate	Coverage Type	Deductible (if any)	Policy Premium
	From: To:		<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence		
	From: To:		<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence		
	From: To:		<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence		
	From: To:		<input type="checkbox"/> Claims-made <input type="checkbox"/> Occurrence		

31. Does your current policy contain a prior acts limitation or a retroactive date? Yes No

If yes, indicate the date: _____

Please attach a copy of your current policy's prior acts endorsement and/or declarations retroactive date.

32. Has any application for similar insurance made on behalf of the applicant or any of its predecessors in business been declined or has any such insurance ever been rescinded, canceled or has renewal been refused? Yes No

If yes, please provide details: _____

General Liability

Please indicate the expiring information, if coverage is requested.

33. Current carrier: _____

34. Policy period: From _____ to _____

35. Limit per occurrence/claim: _____ Products/completed ops aggregate: _____

36. General aggregate: _____ Deductible: _____

37. Claims-made Occurrence If claims-made, please indicate the retroactive date: _____

38. Please provide a schedule of locations including square footage.

39. Please provide a fully completed ISO general liability application, if coverage is requested.

CLAIM ACTIVITY

IMPORTANT NOTICE: All KNOWN FACTS, INCIDENTS, CIRCUMSTANCES OR SITUATIONS that could result in a professional liability claim are specifically excluded from this coverage. Report all such KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATIONS OR CLAIMS to your current insurer. If any KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATION OR CLAIMS omission exists that could result in a professional liability claim, then such claim and/or any claim arising from such KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATIONS OR CLAIMS is excluded from coverage that may be provided under this proposed insurance. Further, failure to disclose such KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATIONS OR CLAIM may result in the proposed insurance being void or subject to rescission.

40. Has any proposed named insured ever been investigated or convicted of a felony? Yes No

If yes, please provide complete details on a separate sheet, including the present status of any individuals.

41. Has the applicant or any employee, principal, partner, officer or director, past or present, ever been the subject of any disciplinary action or investigative proceedings or reprimand by any government body, administrative agency, or professional association within the last five years? Yes No

If yes, please provide complete details on a separate sheet, including the present status.

42. Has any claim or suit been made against the applicant or its predecessor or any current or former member, principal, partner, officer, director or employee? Yes No
If yes, please provide claim details and a currently valued loss run for a minimum of five years. Please describe procedures or training the applicant uses to avoid similar situations in the future:

43. Does the applicant know of any fact, incident, circumstance or situation that could result in a professional liability claim or suit against any current or former member, principal, partner, officer, director or employee or its predecessor entity(ies)? Yes No
If yes, has this been reported to your current carrier? Yes No

44. Has any local, state or federal professional license or license to prescribe or dispense narcotics been refused, suspended, revoked, renewal refused or accepted on special terms or ever voluntarily surrendered?
 Yes No If yes, please provide details on a separate sheet.

COVERAGE REQUESTED

45. Please indicate the limit of liability desired.
Per Claim/Annual Aggregate: \$500,000/\$1,000,000 \$1,000,000/\$3,000,000
 \$2,000,000/\$4,000,000 Other: _____

46. Please indicate the deductible desired. In selecting the deductible, please remember that claim expenses, including legal fees and costs of defense, are chargeable to the deductible.
Per Claim Deductible: \$5,000 \$10,000 \$25,000 Other: \$ _____

Please provide additional comments that would further clarify the information above or address characteristics of your practice not specifically addressed herein.

SIGNATURE

By signing this application, you represent and agree to each of the following four (4) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your company is aware of any actual or alleged fact, circumstance, situation, incident, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in the Claim Activity section of this application; and

2. Each of the statements and answers given in this application, and any supplemental applications, are:
 - a. Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
 - b. Representations you are making on behalf of all persons and entities proposed to be insured;
 - c. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
3. This application, along with any supplemental applications, are hereby deemed to be attached to the policy and incorporated into the policy, whether or not any of the supplemental applications are physically attached to a particular copy of the policy, and regardless of whether any of the supplemental applications are signed or dated.
4. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this application, or in any supplemental application, that may occur or be discovered after the completion date of said application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

FRAUD WARNING: Any person who knowingly and with the 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 purposes of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

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 MARYLAND AND LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY 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 MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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 DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE 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 CIVIL FINES AND PENALTIES.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage. Please see IMPORTANT NOTICE in the Claim Activity section above.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

An authorized representative who is an active owner, officer or partner of your firm must sign this application within thirty (30) days prior to the policy inception date.

If additional space is needed, please provide details on a separate attachment.

I understand the information submitted herein becomes a part of my professional liability insurance application and is subject to the same warranties and conditions.

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.

Signature of Owner, Officer or Partner Date

Printed or Typed Name and Title