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., 3001 Philadelphia Pike, Claymont, DE 19703
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 occupance? ☐ 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 ____ %	**Must Equal**.....100%

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 thatshown in question **1**a.? ..... ☐ 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.

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

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 _____

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:

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.

4. Staff

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

Classification	Employees and Volunteers	Independent Contractors
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		
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		
	$	$
Total Gross Revenue	$	$

b. Please provide number of outpatient visits:

Type of Visit	Last 12 Months	Next 12 Months
Clinics		
Laboratory		
Emergency		
TOTAL VISITS		

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
Insurance Carrier			
Policy Number			
Limits of Liability	$	$	$
Deductible (if any)	$	$	$
Premium	$	$	$
Inception (Mo/Day/Yr)	/ /	/ /	/ /
Expiration (Mo/Day/Yr)	/ /	/ /	/ /
Was this a Claims Made Policy Form?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Retro Date (Mo/Day/Yr)	/ /	/ /	/ /

*** 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.