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Allied Health Care Professional and General Liability Application

This is an application for a Professional and General Liability Insurance policy. Please read your policy carefully. Defense costs shall be applied against the deductible.

SECTION I. PROFESSIONAL LIABILITY UNDERWRITING INFORMATION

Applicant's name (include DBA name): ____________________

Location address: ____________________ ❑ Same as mailing address

City: ____________________ State: ____________________ Zip code: ____________________

Web address: ____________________ E-mail address of primary contact: ____________________

Number of locations ____________ Percent of services rendered outside the U.S., if any ____________ % Annual revenue

Type of professional (i.e. massage therapist, mental health counselor, physical therapist, etc.)	Employees/Owners/ Partners/Self Employed		Independent Contractors (even if coverage is not desired for them)	
	Full Time	Part Time	Full Time	Part Time
1.				
2.				
3.				
4.				
5.				

Independent contractor *means an individual who performs professional services for others and receives an IRS Form 1099 for compensation paid.*
Part time *means less than 1,000 hours worked per year.*

1. Provide a detailed description of the nature of applicant's operation and services provided:
   ____
   ____
2. Is the applicant seeking coverage for independent contractors? ❑ Yes ❑ No
   a. Does the applicant verify that all independent contractors working on their behalf maintain professional liability? ❑ Yes ❑ No
3. Has any professional(s) seeking coverage been providing their services less than three years? ❑ Yes ❑ No
   If "Yes," detail experience and qualifications: ____________________
   ____
4. Do all professionals listed above, for whom coverage is sought, have a current, unrestricted professional license or its equivalent as required under federal or state law and/or the rules and regulations of the profession? ❑ N/A ❑ Yes ❑ No
5. List professional license(s) and degree(s) or equivalents held by each professional listed above:
   ____
   ____
6. Is the applicant controlled, owned, affiliated or associated with any firm, corporation or company not identified in this application? ❑ Yes ❑ No
   If "Yes," please provide details: ____________________
7. Does the applicant have any subsidiaries for which coverage is sought? ❑ Yes ❑ No
   If "Yes," please provide the name, percentage owned and professional classification of each subsidiary and include them in the list of professions above: ____________________
8. Percentage of services provided to minors ____________ %
   a. Are the parents or guardian present for these services? ❑ Yes ❑ No
9. Do any clients receive overnight or 24-hour care? (This would not include shift work involving service by more than one caregiver over that period of time) ❑ Yes ❑ No
10. Do any clients receive live-in care where the caregiver lives with the client? ❑ Yes ❑ No
11. What percent of the applicant's total operations involve 24-hour or overnight services through shift work (more than one caregiver over that period of time)? ____________ %

12. Do any professionals for whom coverage is sought provide, practice, perform, administer or assist in any of the following now or expect to in the next 12 months:
   a. Surgery or surgical procedures including pre-operative and post operative procedures? ❑ Yes ❑ No
   b. Injections of any kind? ❑ Yes ❑ No
   c. Diagnosing conditions, disorders or diseases in patients? ❑ Yes ❑ No
   d. Services as a physician, surgeon, nurse, anesthetist, anesthesiologist, psychiatrist, chiropractor, acupuncturist, pharmacist or dentist? ❑ Yes ❑ No
   e. Designing, testing, selling, distributing or manufacturing products of any kind including vitamins, minerals, herbal, medicinal or nutritional supplements? ❑ Yes ❑ No
   f. More than 25% of services involving the transportation of clients/patients? ❑ Yes ❑ No
   g. Prescribing, monitoring or dispensing medication, equipment, or devices? ❑ Yes ❑ No
   h. Provide professional services within any prison/correctional facility or for any probation or prison release program? ❑ Yes ❑ No
   i. Hospice care? ❑ Yes ❑ No
   j. Medical health care services (including but not limited to monitoring blood pressure, changing dressings, monitoring respiration rates)? ❑ Yes ❑ No
   k. Provide more than 10% of services within a nursing home(s), or hospital? ❑ Yes ❑ No
   l. Does the applicant provide any bathing and/or hygiene services? ❑ Yes ❑ No

   If “Yes” to any of the above, describe service(s) provided and percentage of patients/clients receiving each service(s):

   ____

   ____

13. Are criminal background checks and license verifications conducted for all professionals? ❑ Yes ❑ No
14. Does the applicant obtain a written informed consent from parents/guardians of minors receiving services? ❑ In all cases ❑ Sometimes ❑ Never
15. List additional insured(s) required by contract to be included for professional liability coverage:

Name	Address	Relationship to Applicant

Attach a statement of details for all “Yes” answers to the following questions:

16. a. Has the applicant or any professional listed above had a professional license or its equivalent denied, revoked, restricted, suspended; been fined or disciplined in any way or been the subject of any investigation by any authority for any reason, including but not limited to allegations of sexual abuse? ❑ Yes ❑ No
   b. Are any such actions pending as of the date of this application? ❑ Yes ❑ No
17. Has the applicant initiated litigation against any patients or clients in the past five years? ❑ Yes ❑ No
   (if “Yes,” provide names, dates, status of litigation and demand amount)
18. In the past five years, has any claim been made or suit brought against the applicant, its predecessor(s) in business or any of its present or former owners, partners, officers, directors, employees or independent contractors? ❑ Yes ❑ No
19. Is the applicant or any person proposed for this insurance aware of any circumstance, allegation, contention or incident which may result in a claim being made against the applicant or any person proposed for this insurance? ❑ Yes ❑ No
20. Has any policy of professional liability insurance ever been cancelled or non-renewed by an insurance carrier? ❑ Yes ❑ No
   (Not applicable in MO.) If “Yes,” provide details ______________________________
21. a. Does the applicant currently have professional liability insurance in force? ❑ Yes ❑ No
   b. Does the applicant currently have general liability insurance in force? ❑ Yes ❑ No
   If “Yes,” specify:

Name of Professional Carrier	Limit	Retroactive Date (if any)	Deductible	Annual Premium	Policy Period	Claims Made (C) or Occurrence (O)
Name of General Liability Carrier	**Limit**	**Retroactive Date (if any)**	**Deductible**	**Annual Premium**	**Policy Period**	**Claims Made (C) or Occurrence (O)**

   c. Number of years continuous, uninterrupted insurance coverage? Professional liability: ____________ General liability: ____________
22. Does applicant agree to maintain commercial general liability insurance? ❑ N/A ❑ Yes ❑ No
   If “No,” explain: ______________________________

SECTION II. GENERAL LIABILITY UNDERWRITING INFORMATION (complete only if seeking this coverage)

1. Any general liability claims against applicant (paid, reserved or pending) in the past five years? ❑ Yes ❑ No

   If "Yes," please provide details: ____________________

2. Additional insured(s) to be included for general liability coverage:

Name	Address	Relationship to Applicant

3. Has any general liability policy been cancelled or non-renewed by an insurance carrier? *(Not applicable in MO.)* ❑ Yes ❑ No

   If "Yes," provide details: ____________________

4. Is the applicant the owner of the insured location? ❑ Yes ❑ No

   If "Yes," list all tenants of the building and the area of the portion occupied (if there are apartments, please indicate number of units)

Tenant	Building area or number of apartment units

This is an application for a claims made Professional Liability policy. General Liability may be provided on either a claims made or occurrence basis. Except as otherwise provided, the policy will cover only claims first made against the applicant and reported to the insurer during the policy period. Please note that in most policies the limit of liability available to pay damages shall be reduced and may be completely exhausted by payment of claims expenses. Damages and claims expenses shall be applied against the deductible.

I/we hereby declare that the above statements and declarations are true and that I/we have not suppressed or misstated any material facts. I/we agree that any misrepresentation or misstatement of material facts may void coverage under the proposed insurance. I/we agree that this application shall be the basis of the contract with the insurer and that coverage, if written, will be provided on a claims made basis. It is understood and agreed that completion of this application neither binds the insurer to provide coverage nor the applicant to purchase the insurance. I/we agree that if the information supplied on this application changes between the date the application is executed and the time the proposed insurance policy is bound or coverage commences, the applicant will immediately notify the carrier in writing of such changes. The carrier reserves its rights to modify or withdraw its proposal following such changes.

If your state requires that we have information regarding you Authorized Retail Agent or Broker, please provide below.

Retail agency name ____________________ License No. ____________

Agent's signature ____________________ Phone No. (____) ____________
(Required in New Hampshire)

Email Address ____________________

Agency mailing address ____________________

City ____________________ State ________ Zip ____________

Applicant's Signature ____________________ Title ____________________

President, Chairperson of the Board, Managing Member or Executive Director

Date ____________________

Retail agency name ____________________ License No. ____________

Agent's signature ____________________ Phone No. (____________)
(Required in New Hampshire)

Email Address ____________________

Agency mailing address ____________________

City ____________________ State ________ Zip ____________