POSITIVE PHYSICIANS
Insurance Company
Price. Protection. Peace of Mind.

Healthcare Facility Professional Liability Application

☐ Issue ☐ Quote

1. Name and mailing address of applicant

_____
_____
_____
_____

Contact person _____
Phone (____) _____
Fax (____) _____
E-mail _____

Website Address _____

2. Name and mailing address of agent

_____
_____
_____
_____

Phone (____) _____
Fax (____) _____
E-mail _____
Agent's Website Address _____

3. Tax ID # _____ License # _____

4. Type of coverage requested
☐ Claims-Made ☐ Occurrence

5. Requested effective date _____

6. Requested retroactive date: _____
(*If requesting prior acts coverage, the supplemental prior acts application must be completed and a copy of your current policy must be provided.)*

7. Professional liability - limits of liability requested
_____

8. This organization operates as: (Check each box that applies)

☐ Chiropractic Clinic
☐ Emergency (free standing ER)
☐ Health Center - All Other
☐ Laboratory:
  ☐ Dental
  ☐ Medical
  ☐ Pathology
  ☐ X-Ray
  ☐ All Other
☐ Rehab Facility
  ☐ Cardiac
  ☐ Development/Disability
  ☐ Occupational
  ☐ Substance
  ☐ Trauma
☐ Surgicenter: Number of Procedures
  ____ General
  ____ Oral
  ____ OB/GYN
  ____ Infertility
  ____ Gastroenterology
  ____ Ophthalmology
  ____ Plastic
☐ Dialysis Center
☐ Health Center
☐ Hospice
☐ Medical Registry
☐ Visiting Nurse Association
☐ Urgicenter
☐ Other, describe: _____
  ____ Podiatry
  ____ Bariatric
  ____ Orthopaedic
  ____ Other: _____

9. Number of locations: _____
Addresses: _____
_____

	past 12 months	projected next 12 months
10. Patient Visits (each encounter):	_____	_____
11. Gross receipts:	_____	_____
12. Payroll: *Financial Statements may be necessary.*	_____	_____

Name: _____

13. Are overnight facilities available? ☐ Yes ☐ No

14. Hours of operation: _____

15. Please describe the nature of the services performed. Attach a copy of advertising material, stationery, telephone directory yellow pages, handouts, or other advertisements.

_____

_____

_____

16. Describe the type of organization and ownership: (check all that apply)

☐ Professional Association ☐ Partnership, General ☐ Corporation
☐ Community Clinic (non-profit) ☐ Joint Venture ☐ Partnership, Limited
☐ For Profit ☐ Not For Profit
☐ Other, describe: _____

17. Are there subsidiaries that are to be included in this coverage? ☐ Yes ☐ No
If yes, please list the name of each subsidiary, and provide a current organizational chart.

_____

_____

Complete Appendix B - Organization Application for each organization.

18. List all members, partners, or stockholders. Indicate which ones work at the organization and their positions. (If available, provide an organizational chart that illustrates all relevant personnel and the structure of your organization, including any relationships with other organizations.)

_____

_____

_____

19. Is coverage desired for staff of this organization? ☐ Yes ☐ No
If yes, *complete Appendix A - Staff Schedule of this application.*
If no, are employees required to maintain their own insurance? ☐ Yes ☐ No
If employees maintain their own insurance, at what limits? $_____
Do you require proof of insurance? ☐ Yes ☐ No

20. How long has the organization been in business? _____ Years _____ Months

21. Has the organization ever been sued or have any claims been made against it? ☐ Yes ☐ No
If yes, *attach a copy of insurance company's loss run(s).*

22. Name of current professional liability insurance carrier: _____
Attach a copy of the declarations page showing: retroactive date, limits of liability, policy period, and any restrictive endorsements.

23. Has your professional liability insurance ever been cancelled, refused or non-renewed? ☐ Yes ☐ No
If yes, for what reason and when? _____

24. List the state or municipal licensing requirements with which the facility complies.
☐ None required.

_____

25. Are radiation or shock therapy, nitrous oxide (or any other anesthetics) administered on site? ☐ Yes ☐ No

26. If anesthesia machines are used, are they all equipped with fail-safe devices? ☐ Yes ☐ No

27. Are abortions performed on site? ☐ Yes ☐ No
If yes, how many within the past 12 months? _____

28. Are procedures in place for patient transfers to another facility in the event of an emergency? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

29. Are medications administered? ☐ Yes ☐ No
If yes, by whom? _____

30. Do you provide any services over the internet? ☐ Yes ☐ No

31. Do you treat patients at a correctional facility? ☐ Yes ☐ No

32. Do you perform any bariatric procedures *(weight loss procedures)*? ☐ Yes ☐ No
If yes, what percentage of your practice is spent on bariatrics? _____ %

33. Are physicians' services rendered? ☐ Yes ☐ No
If yes, are the physicians: ☐ private physicians
☐ contracted physicians
☐ employed physicians

34. Are you accredited by any nationally-recognized accrediting agency? ☐ Yes ☐ No
If yes, please list the agency: _____.
If no, explain why the organization has not applied or why the organization is not eligible.

_____

_____

_____

35. Are you licensed by Department of Health & Human Resources? ☐ Yes ☐ No

36. List names of employed personnel who are certified in CPR or ALCS.

_____

_____

37. Does the organization have a written Quality Assurance/Risk Management Program? ☐ Yes ☐ No

38. Name of designated Risk Manager: _____
Phone number: (_____) _____

39. Does the facility have any non-expendable medical, dental or surgical machines or services that are used for diagnostic or treatment procedures by individuals other than members of your organization? ☐ Yes ☐ No

40. Do you sell or lease any medical equipment or other product in connection with your operation? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

41. If you lease equipment to others, do you provide maintenance on the equipment? ☐ Yes ☐ No
If yes, please describe: _____

_____

_____

42. Do you participate as a principal investigator for any clinical trials? ☐ Yes ☐ No
If yes, do you follow FDA-approved protocols? ☐ Yes ☐ No
If yes, please explain on a separate sheet of paper.

Signature

This section must be completed by all applicants.

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind Positive Physicians Insurance Company to complete the insurance, but it is agreed that this application shall be the basis of a contract should a policy be issued. I authorize release and exchange of any underwriting or claims information between all prior carriers and the Positive Physicians Insurance Company. I understand that Positive Physicians Insurance Company reserves the right to reject any applicant that does not meet its underwriting standards.

Signature of Applicant _____ Date _____
Officer of Organization

Positive Physicians Insurance Company reserves the right to reject any applicant that does not meet its underwriting standards.

NOTICE

ANY PERSON WHO KNOWINGLY AND WITH 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 PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Appendix A - Staff Schedule

Policy Number: _____

Corporation Name: _____

Do you anticipate any changes in staff or services provided by this entity in the next year? ☐ Yes ☐ No

If yes, please describe: _____

_____

List all professional staff including members, partners and shareholders (Physicians, Chiropractors, Dentists, etc.)

Name	Policy # if Positve insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all Allied Professionals (RN, LPN, CRNA, Nurse Midwife, Techs, Social Worker, Occupational or Physical Therapist, Licensed Counselor, Physician Assist Non-Surg. or Surg., etc.)

Name	Policy # if Positive insured	License number	Specialty or position	Date of hire	Status		Avg. # hrs. per wk
					Employee	Independent Contactor	

List all other clerical staff

Name	Position	Date of hire	Avg. # hrs. per wk.

For all professional staff not insured with Positive*, attach certificates of insurance or a copy of their professional liability policy and claims history for each individual.*

Signature: _____ Date: _____