Professional Liability Insurance Occurrence Application

1. APPLICANT INFORMATION:

a) Firm Name: _____

b) Owner (s): _____
Please indicate owner's practitioner certification:
_____

c) Contact Person: _____

d) Doing Business as: _____

e) Address: _____
_____
(city) (state) (zip) (county)

f) Are all services provided from this location? . . . . . ☐ Yes ☐ No
If no, please attach separate sheet with addresses for additional locations.

g) Phone: (_____) _____

h) Fax: (_____) _____

i) Email: _____

j) Total Annual Gross Receipts: _____

k) Date Established _____/_____/_____

l) Are you a member of any professional Association? . . ☐ Yes ☐ No
Name: _____

m) Please provide your firm's web address if applicable:
_____

n) Type of Firm:
☐ Staffing/Registry ☐ Rehab Clinic ☐ Counselor
☐ Pharmacy ☐ Nurse Practitioner
☐ Home Health Care Provider
☐ Other _____

o) Is your firm incorporated? . . . . . ☐ Yes ☐ No
(i.e. Inc., P.C., LLC, P.A., Ltd., CORF, etc.)
Please indicate: _____

p) Is your firm a franchise? . . . . . ☐ Yes ☐ No

q) Do you anticipate a change in your operations within the next twelve months? . . . . . ☐ Yes ☐ No
If yes, please explain. _____

r) Are there other entities / subsidiaries? . . . . . ☐ Yes ☐ No
If yes, please explain. _____

s) Description of Operations: *(attach separate sheet if necessary)*
_____
_____

t) Requested Effective Date of Policy _____/_____/_____
(Must be within 60 days following application date.)

2. HIRING/SCREENING AND EMPLOYMENT PROCEDURES:

a) Have the owners and/or employees/contractors ever been the subject of complaints, charges or disciplinary action for any reason, by a court, licensing board or regulatory agency responsible for maintaining the standards of your profession? . . . . . ☐ Yes ☐ No
If yes, please provide detailed documentation on a separate sheet.

b) Do you verify certification and professional licensure status of employees and independent contractors? . . . . . ☐ Yes ☐ No

c) Do you provide job descriptions for all professional and non-professional employees? . . . . . ☐ Yes ☐ No

d) Do you check employees/contractors references before hiring/placing? . . . . . ☐ Yes ☐ No

e) How are references checked?
☐ Written ☐ Verbal ☐ Both

f) Do you question and utilize background checks for prospective employees/contractors regarding any past criminal record? . . . . . ☐ Yes ☐ No

3. RISK MANAGEMENT AND QUALITY ASSURANCE:

a) Are you licensed in all states where you operate? . . . . ☐ Yes ☐ No
List all states of operation: _____

b) Has your license ever been suspended, revoked, or voluntarily surrendered in any state? . . . . . ☐ Yes ☐ No
If yes, please provide details: _____

c) Do you utilize a written Quality Assurance and Risk Management Program? . . . . . ☐ Yes ☐ No
If no, please explain: _____

d) Do you have a Director of Quality Assurance and/or Risk Management? . . . . . ☐ Yes ☐ No

e) Do you place an "informed consent" document in the patient's medical records? . . . . . ☐ Yes ☐ No

f) Are you accredited by any government or other body? ☐ Yes ☐ No
If yes, 1) JCAHO/CHAPS 2) Medicare/Medicaid 3) Other _____
If no, please explain _____
_____

g) Are all employees trained before assignment? . . . . . ☐ Yes ☐ No
If no, please explain. _____
_____

h) Describe your educational training, certification and continuing education programs. *(attach separate sheet if necessary)*
_____
_____
_____

4. CLAIMS HISTORY:

a) Have any claims/suits ever been made against the applicant or employees/contractors? . . . . . ☐ Yes ☐ No
If yes, please provide loss run and details including date, amount paid, and reserve amounts for open claims.

b) Are you or your employees/contractors aware of any circumstances which have occurred and may result in a claim against you? . . . . . ☐ Yes ☐ No

c) Have you or your employees/contractors been declined by any insurance company, cancelled or non-renewed? . . . . ☐ Yes ☐ No
(Not applicable for MO residents)
If yes, please provide detailed documentation, including loss history, on a separate sheet.

5. PROFESSIONAL LIABILITY SECTION

a. EMPLOYEES/INDEPENDENT CONTRACTORS

Profession	# Full-Time	# Part-Time	Annual Hrs.	Payroll	Profession	# Full-Time	# Part-Time	Annual Hrs.	Payroll
Art Therapist					Medical Records Administrator				
Athletic Trainer					Medical Records Tech.				
Audiologist					Mental Retardation Worker				
Bio-Med Tech.					Music Therapist				
Blood Bank Tech.					Nuclear Medical Tech.				
Cardiology Tech.					Nurses:				
Case Manager					RN				
Certified Lab Tech.					Home Health Aide				
Chiropractic Assistant					LPN/LVN				
Circulation Tech.					Nurses Aide				
Clinical Lab Tech.					Nursing Asst.				
Community Health Assistant					Geriatric Nursing Asst.				
Community Health Tech.					Nurse Practitioners:				
Corrective Therapist					Geriatric/Adult/NP/Family Planning NP				
Counseling Professionals:					Psychiatric NP				
Psychotherapist/ Psychologist					Pediatric/Family Practice/Neonatal				
Clinical Counselor					OB/GYN/Acute Care NP				
Alcohol/Drug Counselor					Nutritionist				
Marriage/Family Counselor					OT:				
School Counselor					Occupational Therapist				
Pastoral Counselor					Occupational Therapist Assistant				
Bodywork Counselor					Certified Occupational				
Genetic Counselor					Therapist Assistant				
Life Coach Counselor					Optometry Tech / Asst.				
Psychological Counselor					Orthopedic Assistant				
Licensed Prof. Counselor					Pedorthist				
Vocational Counselor					Personal Trainer				
Counselor Educator					Pharmacist				
Forensics Counselor					Pharmacist Tech.				
Rehabilitation Counselor					Phlebotomist				
Mental Health Counselor					Physical Therapist				
Dance Therapist					Physical Therapist Assistant				
Diagnostic Medical Sonographer					Podiatric Assistant				
Dialysis Tech.					Radiation Therapist				
Dietitian					Radiologic Tech.				
EEG Tech.					Recreation Therapist				
EKG Tech.					Rehabilitation Assistant				
Electrologist					Rehabilitation Therapist				
EMS:					Respiratory Care Provider				
Paramedic / Instructor					Respiratory Therapist				
Basic / Intermediate					Respiratory Therapist Tech.				
Emergency Medical Tech.					Social Worker, Clinical				
Volunteer Emergency					Speech Hearing Therapist				
Medical Tech.					Speech Language Pathologist				
Enterostomal Therapist					Sports Medicine Instructor				
Exercise Physiologist					Sports Medicine Therapist				
Health Educator					Surgical Tech.				
Histologic Tech.					X-Ray Machine Operator				
Kinesiologist / Kinesiotherapist					Other Healthcare Aide				
Laboratory Aide					Other Professions (List Professions/Job Titles)				
Massage Therapist									
Medical Assistant					Other				
Medical Lab Tech.					Total				
Medical Tech.									
Medical Tech. Assistant									

Coverage is not available for Certified Nurse Anesthetist or Midwives. If you are a RN and NP, you must list your area of practice as a NP.
For additional professions not listed, please attach a separate sheet.

b. What percentage of the above are independent contractors? _____

Name of Firm: _____

c. LOCATION WHERE SERVICES ARE PROVIDED (Total must equal 100%).

- ☐ Patient Home _____%
- ☐ Hospitals _____%
- ☐ Nursing Homes _____%
- ☐ Clinics (No M.D./D.O.) _____%
- ☐ Doctor's Offices _____%
- ☐ Surgi/Emergi Center _____%
- ☐ Hospice/Assisted Living Center _____%
- ☐ Your Own Home _____%
- ☐ Prison _____%
- ☐ School _____%
- ☐ Rehabilitation Facility _____%
- ☐ Other (specify) _____ _____%

Total _____%

d. TYPE OF SERVICES PROVIDED (Total must equal 100%).

- ☐ Skilled Nursing Care _____%
- ☐ Home Care _____%
- ☐ Personal Care/Companion _____%
- ☐ Physical Therapy _____%
- ☐ Respiratory Therapy _____%
- ☐ Ventilator Care _____%
- ☐ Infusion Therapy _____%
- ☐ Chemotherapy _____%
- ☐ Trach Care _____%
- ☐ High Tech/Critical Care _____%
- ☐ Wellness/Fitness _____%
- ☐ Other (specify) _____ _____%

Total _____%

e. STAFFING (To Other Facilities for a Fee). (Total must equal 100%).

- ☐ Nursing Home _____%
- ☐ Hospital _____%
- ☐ Clinics _____%
- ☐ Doctor's Offices _____%
- ☐ Other (specify) _____ _____%

Total _____%

f. Limits of Liability Requested: ☐ $1,000,000 per claim/$3,000,000 aggregate ☐ Other (specify)_____
(May be subject to state specific guidelines)

g. Does this firm provide any bed, board or overnight services? . . . . . ☐ Yes ☐ No

6. PREVIOUS PROFESSIONAL LIABILITY INSURANCE COVERAGE (PAST FIVE YEARS):

Insurance Company	Limits	Effective Date	Annual Premium	Claims Made* or Occurrence	Retro-Active Date

*If you checked claims-made, please check the appropriate box below:

☐ I have purchased the extended reporting period endorsement on my prior policy.

Name of carrier: _____

☐ I wish to be considered for Prior Acts Coverage and have attached a copy of my certificate of insurance listing my current coverage limits, current carrier and retroactive date. I understand that approval for prior acts coverage is subject to approval by the Underwriter. I realize that unless I purchase Prior Acts Coverage which coincides with the retroactive date of my previous claims-made policy and have no extended reporting period endorsement that I will have a gap in coverage.

☐ I understand that I elected not to purchase the Extended Reporting Period Endorsement on my previous claims-made policy, and I also have elected not to purchase Prior Acts Coverage on my new claims-made policy. I understand that I will be uninsured for the period in which my prior claims-made policies existed. Furthermore, I understand that because of this there will be a gap in my insurance coverage.

Name of Firm: _____

7. GENERAL LIABILITY SECTION

Would you like to include the optional General Liability Coverage? . . . . . ☐ **Yes** ☐ **No**

(There is an additional charge for this coverage pending underwriter approval. Rate may vary due to additional location or higher limit request.)

If yes, complete the section below and attach a separate sheet if necessary.

a. Owned or leased premises:

Address	Own or Lease?
1.	
2.	
3.	

PREVIOUS GENERAL LIABILITY INSURANCE COVERAGE (PAST FIVE YEARS):

Insurance Company	Limits	Effective Date	Annual Premium	Claims Made or Occurrence	Retro-Active Date

8. CONTRACTUAL AGREEMENTS

Do you have written agreements with third parties? . . . . . ☐ Yes ☐ No

If yes, does each agreement include the following:

A mutual indemnification/hold harmless agreement? . . . . . ☐ Yes ☐ No

A requirement that the other party carry liability insurance with liability limits equal to or exceeding yours? . . . . . ☐ Yes ☐ No

A statement for any service providers and independent contractors? . . . . . ☐ Yes ☐ No

A requirement for currently licensed/ appropriately qualified staff? . . . . . ☐ Yes ☐ No

I have answered these questions to the best of my knowledge. I have not withheld any information that would influence the judgment of the Insurance Company. My signing of this application does not bind the Company to complete the insurance. This application will be the basis of the contract should a Certificate of Insurance be issued.

Name of Principal or Officer: (please print) _____

Signature of Principal or Officer: _____ Date: _____

Agent/Broker Information:

Agency Name: _____ Contact Name: _____

Address: _____
(street) (city) (state) (zip)

Telephone: (____) _____ Fax: (____) _____ Email: _____