Northland INSURANCE

Master Index

APPLICATION - HEALTH CARE PROVIDER

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
   Street City County State ZIP Code
3. Location of Premises: ❒ Same as mailing address
   ❒ Other _____
4. Telephone ( ) _____ Fax ( ) _____
5. Contact person/phone #: Inspection _____
   Accounting/Records _____
6. Business type: ❒ Individual ❒ Partnership ❒ Corporation ❒ LLC
   ❒ Trust ❒ Other (specify) _____
7. Operating as: ❒ For Profit ❒ Nonprofit ❒ Other _____
8. Interest of Named Insured in premises: ❒ Owner ❒ General Lessee ❒ Tenant ❒ Other _____
9. Part occupied by Named Insured: ❒ Entire ❒ Portion (____ %) ❒ Other (Lessor's Risk Only)
10. Date business established _____

DESIRED TERMS AND CONDITIONS

1. Coverage Desired: ❒ General Liability ❒ Professional Liability
2. Limit of Liability Desired: ❒ $100,000/$300,000 ❒ $300,000/$600,000 ❒ $500,000/$1,000,000
   ❒ $1,000,000/$1,000,000 ❒ Other _____

Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Personal and Advertising Injury	Same as Occurrence Limit
Medical Payments	$5,000

3. ❒ Contractual Liability
4. Effective Date Desired _____ Term Desired _____

TYPE OF FIRM

1. Check your specific professional occupation:
   ❒ Aide/Homemaker
   ❒ Artificial Limb Fitter
   ❒ Audiologist *Do you operate a mobile unit?* ❒ Yes ❒ No
   ❒ Counselor ❒ Psychiatrist ❒ Psychologist ❒ Social Worker

Indicate type of services performed and percentage:

❒ Abortion/Family Planning	____ %	❒ Crisis Intervention	____ %	❒ Occupational	____ %
❒ Alcohol/Drug	____ %	❒ Family/Marital	____ %	❒ School/Youth	____ %
❒ Child Abuse/Sexual Offenders	____ %	❒ General Guidance	____ %	❒ Other	____ %
❒ Criminal	____ %	❒ Hot Line	____ %	_____	____ %

Do you utilize shock and/or drug therapy? ❒ Yes ❒ No

❒ Dental Hygienist
❒ Dietician/Nutritionist *Do you market products under your own label?* ❒ Yes ❒ No
❒ Druggist/Pharmacist *Do you prescribe medications?* ❒ Yes ❒ No
❒ Hearing Aid Specialist
❒ Massage Therapist

❒ Nurse: *Type* _____ *Check if appropriate:* ❒ *X-ray specialist* ❒ *Midwife* ❒ *Nurse anesthetist*

❒ Occupational Therapist
❒ Optician
❒ Optometrist
❒ Physical Therapist
❒ Respiratory Therapist
❒ Speech Therapist
❒ X-Ray Technician
❒ Other _____

2. Description of operations _____

OPERATIONS

1. Do you treat children exclusively? ❒ Yes ❒ No
2. Indicate percentage of time spent in the following work locations:

Administrative Office	____ %	Hospice	____ %	Professional Office	____ %
Classroom	____ %	Outpatient Clinic	____ %	Nursing Home	____ %
Emergency Dept. of Hosp.	____ %	Laboratory	____ %	Other ____	____ %
Hospital Ward (Specify) ____	____ %			Patient's Home	____ %

3. Are you engaged in, associated with, or involved in any other enterprises? ❒ Yes ❒ No
   If yes, explain. _____
4. Are you self-employed? ❒ Yes ❒ No
   If no, provide name of employer. _____

		Yes	No	N/A
5. Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following?	General Liability	❒	❒	❒
	Professional Liability	❒	❒	❒
6. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?		❒	❒	
If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?		❒	❒	
7. Have you entered into any contractual agreements?		❒	❒	
If yes, is legal advice sought to write and approve?		❒	❒	
Does the agreement require you to hold any third party harmless?		❒	❒	

8. Indicate: Receipts _____ Payroll _____ Outpatient Visits _____
   (Number of patient encounters per year)
9. How are funds obtained? (i.e. Medicare, donations, fees, government grants, etc.) _____
10. Do you have recordkeeping procedures? ❒ Yes ❒ No
11. Do you practice: ❒ Full Time (30+ hours/week) ❒ Part Time (30 hours or less/week)
12. Do you have independent contractors working for you? ❒ Yes ❒ No
    Describe, including number of contractors, type, total hours per month worked by all contractors, and in what capacity the independent contractor is working. _____
13. Do you require independent contractors working for you to carry their own professional insurance and provide proof of this coverage? ❒ Yes ❒ No
14. Do you use the services of volunteers or students? ❒ Yes ❒ No
    If yes, describe selection, duties, training, and extent to which they are used. _____

EMPLOYEE PROCEDURES & STAFFING

1. Check the highest level of education you have completed relating to practice in your field:
   - ❒ None required
   - ❒ Associate Degree
   - ❒ Master's Degree
   - ❒ Bachelor's Degree
   - ❒ Doctorate Degree
   - ❒ Post-Doctorate Degree
   - ❒ Other

   School where degree was obtained: _____

   For multiple employees, attach list with names, degree(s), and school(s).
2. Describe any professional training, licensing, or certification needed for this operation. _____
3. Are you certified/licensed? ❒ Yes ❒ No
   If yes, name of board/licensing body. _____

		Yes	No	N/A
4.	Has your license ever been: Restricted?	❒	❒	❒
	Suspended?	❒	❒	❒
	Revoked?	❒	❒	❒
a.	Have you ever been denied a license or board certification?	❒	❒	❒
b.	Have you ever been a patient in any chemical dependency program?	❒	❒	❒
c.	Have your privileges ever been restricted, suspended, or revoked by any heath care facility?	❒	❒	❒
d.	Do you prescribe drugs?	❒	❒	❒
e.	Do you participate in any peer review or utilization review activities?	❒	❒	❒

Explain all YES answers. _____

5. Years practicing current professional occupation _____
6. Years in business under the above name _____
7. List any professional association or organization of which you are a member. Show complete name.
   ❒ None _____

		Yes	No
8.	Do you have employees?	❒	❒
9.	Do you conduct criminal background checks of employees?	❒	❒
	If yes, are copies kept on file?	❒	❒

10. Check all procedures you use when hiring professional, paraprofessional, or any other employee providing patient care services at your facility:

		None	Written	Verbal
a.	Educational background or residency program check, when applicable.	❒	❒	❒
b.	Previous employers check.	❒	❒	❒
c.	Personal references check.	❒	❒	❒
d.	Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals?	❒	❒	❒

PREVIOUS EXPERIENCE

1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities? ❒ Yes ❒ No
   If yes, explain. _____

2. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years?
❒ Yes ❒ No *If yes, give name of company, date and reason.*

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	**Carrier**	**Policy Number**	**Coverage**	**Check if Claims-Made**	**Premium**
				❒	
				❒	
				❒	

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years.
Attach separate sheet if necessary.

Dates (Month/Year)	**Allegations**	**Amount**	**Paid**	**Reserve**
			❒	
			❒	
			❒	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address