APHA Lloyds of London
Professional Liability Application

Submit to:
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Professional Liability Application for Health Care Services

(TO BE COMPLETED ONLY IF A MORE SPECIFIC APPLICATION IS NOT APPLICABLE)
INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

Tax ID: _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____)_____ Fax (_____)_____

Email: _____

Website: _____

1.6 Person to contact for Survey: Name: _____Title: _____

Email: _____Telephone Number: (_____)_____

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) or B) below:

☐ A. The **APPLICANT** is an: ☐ INDIVIDUAL ☐ Employee ☐ Student ☐ Sole Practitioner

☐ B. The **APPLICANT** is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability

☐ Other –Please Describe _____

1.9 Entity is: ☐ For Profit ☐ Non-Profit

Please describe source of funds: _____

_____

1.10 **Proposed Effective Date:** _____

1.11 Requested Limits of Liability (if ava ilable) : $_____/$_____

1.12 Annual Gross Receipts: Estimated next twelve months - $_____

Last twelve months - $_____ Estimated

1.13 Annual Re muneration: next twelve months - $_____ Last

twelve months - $_____

1.14 Total Premises Square Footage Occupied By Applicant:_____

PART II. EXPOSURES

2.1 Service is licensed as_____

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted :

_____

_____

2.3 List all memberships in professional organizations. _____

_____

2.4 Total number of all staff_____

2.5 Number of Professional Staff:

E = Employed
C = Contracted

__Aides/Orderlies
__Acupuncturists
__Audiologists
__Chiropractors
__Dentists
__Dental Hyg /Tech.
__Dental Assistants
__Dietitians/Nutritionists
__EEG/ EKG Operator
__Electrologists
__Hearing Aid Fitters
__Inhalat//RespTherap . -
__Lab Technicians
__LPN's
__Optometrists
__Opticians
__Paramed/EMT
__Pharmacists
__Pharmacy Tech
__Physicians/Surgeons*
__Physician Assistants
__Physiotherapists/Phys/Therap
__Podiatrists
__Prosthetic Device Fitters
__Psychologists/Psychotherap
__RN's
__Social Workers
__SpeechTherap

__MassageTherapist

Medical

__Technicians Nurse

__Midwives Nurse

__Practitioners

__OccupationTherapist

__Veterinarian

__X-Ray Technician

__Radiologist

__X-Ray Radiologist Therapist

Other, describe_____

* Attach list and indicate specialty

2.6 If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors and annual estimated Out Patient Visits by professional category._____

_____

2.7 Do you require:

A) Contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?_____

B) Employed or contracted physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? _____

2.8 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? __Yes __No

2.9 What minimum limits of Professional Liability are required?_____

2.10 What was your total number of patient/client visits last year?_____

Estimated next year? _____

2.11 **Adult Day Care** __Yes __No

If YES, please provide average occupancy:_____

2.12 Breakdown of patient services:

_% Pediatric

_% Dental

_% Obstetric

_% Psychiatric

_% Rehabilitative Therapy

_% Minor Surgery

_ % Major Surgery

_% Orthopedic

_% Gynecological

_% Emergency Medical

_% General Exams

_% Occupational Medical

_% Optometry/Ophthalmology

_% Nutrition (Diet)

_% Other(describe)_____

_____

2.13 Are any of the following performed?

Administer anesthesia (general or local)? __Yes __No

Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)? __Yes __No

Cardiac Catheterization	__Yes __No
Diagnostic tests	__Yes __No
Chemotherapy	__Yes __No
X-Rays	__Yes __No
Radiation Therapy	__Yes __No
Reduction of Fracture	__Yes __No
Shock Therapy	__Yes __No
Prescribe medication	__Yes __No
Obstetric procedures	__Yes __No

For all "yes" answers, please give detailed description on separate page or back of application.

PART III. RISK MANAGEMENT

3.1 Give name of Administrator/Supervisor and describe his/her training and experience._____

_____

_____

3.2 Do you enter into contractual agreements?__Yes __No
IF **YES,** please enclose copies of all such contracts.

3.3 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? __Yes__No

If **NOT,** are you agreeable to instituting this procedure? __Yes __No

3.4 Enclose a copy of all brochures or advertising materials distributed by you.

3.5 Describe any "fund raising" or other special events activities conducted._____

_____

3.6 Describe any swimming pool, playground or amusement exposure._____

_____

3.7 Do you rent, sell, or otherwise provide any equipment or products to others? __Yes__No
IF **YES,** complete our Products Supplement.

3.8 Do you provide 24 hour bed and board care for any patients, or do you (wholly or in part) own, operate or administer any facility which does provide such services? __Yes__No
IF **YES,** complete our Residential Facilities Application.

3.9 Do you provide any of the following services?

A) Blood Bank/Plasma Centers __Yes __No

B) Cemeteries/Funeral Homes/Morticians __Yes __No

C) Medical Arts Schools and Colleges __Yes __No

D) Pharmacies __Yes __No

E) Nursing Homes __Yes __No

IF **YES,** please complete the appropriate supplement application.

3.10 Do you have any other premises or operations exposures not stated in this application? __Yes__No
IF **YES,** enclose complete description and underwriting/rating information.

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date?_____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						
2.						
3.						
4						
5.						

If claims-made, what is the most recent retroactive date?_____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? __Yes__No

IF **YES,** please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary).

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? __Yes __No

IF **YES,** describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

Date	Applicant	Title