1-877-245-5887
Return application by fax or email
fax: (310) 796-9054
email: info@cbmalagains.com

CBMALAGA
Insurance Services LLC

POLICY NUMBER _____
COMPANY USE ONLY

CANCER TREATMENT CENTER LIABILITY APPLICATION

I. ORGANIZATION INFORMATION

PLEASE PRINT LEGIBLY. IF THE APPLICATION IS APPROVED, THE POLICY WILL BE BASED ON THE INFORMATION PROVIDED. PLEASE ANSWER ALL QUESTIONS. IF A QUESTION IS NOT APPLICABLE, STATE "N/A". IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SUPPLEMENTAL FORM.

A. CB Malaga Insurance Services LLC - www.cbmalagains.com
BROKERAGE FIRM/AGENCY NAME

CITY, STATE, AND ZIP CODE

BROKER/AGENT NAME

877 - 245 - 5887 ____ - ____ - ____ _____
PHONE **FAX** **E-MAIL**

B. CONTACT INFORMATION

APPLICANT NAME (LEGAL CORPORATION NAME)

MAILING ADDRESS **COUNTY**

STREET ADDRESS (IF DIFFERENT)

CONTACT PERSON NAME **TITLE**

____ - ____ - ____ ____ - ____ - ____ ____ - ____ - ____
BUSINESS PHONE **BUSINESS FAX** **RESIDENCE PHONE**

WEBSITE ADDRESS

C. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM): _____
This date cannot be earlier than the expiration date of your current policy.

D. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM): _____
Annual policy terms will begin and end on the same month and day.

II. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	POLICY TYPE	DEDUCTIBLE (PRIMARY COVERAGE)
☐ PROFESSIONAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ GENERAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ EXCESS PROFESSIONAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	
☐ EXCESS - GENERAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	

II. COVERAGES, LIMITS AND DEDUCTIBLES (CONTINUED)

If you are requesting shared limit or separate limit coverage for employed or contracted Physicians, Surgeons, Residents, Interns, Fellows, Dentists, Oral Surgeons, CRNAs, Nurse Midwives, CRNPs, Podiatrists, Physician Assistants Or Surgical Assistants, please complete Section III (Coverages, Limits And Deductibles Schedule) of the Cancer Treatment Center Supplemental Application.

(*) IF YOU HAVE ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.), PLEASE COMPLETE SECTION II (SCHEDULE OF RELATED ENTITIES) OF THE CANCER TREATMENT CENTER SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF YOUR ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED.

III. GENERAL INFORMATION

A. TYPE OF LEGAL ENTITY (Please put an "X" in the applicable spaces):

☐ Professional Corporation

☐ Partnership or Professional Association

☐ Joint Venture

☐ Limited Liability Corporation (LLC)

☐ Other (Please Explain): _____

B. ENTITY OWNERSHIP (Please put an "X" in the applicable spaces):

☐ Physician Owned

☐ Hospital Owned

☐ Independently Owned

☐ Other (Please Explain): _____

C. TAX STATUS (Please put an "X" in the applicable spaces):

☐ For Profit

☐ Not For Profit

☐ Other (Please Explain): _____

D. LICENSES HELD BY YOUR FACILITY: _____

E. CERTIFICATIONS/ACCREDITATIONS HELD BY YOUR FACILITY:

☐ CMS ☐ JCAHO ☐ AAAHC ☐ ACRO ☐ ACR ☐ IMQ ☐ OTHER: _____

PLEASE PROVIDE A COPY OF YOUR CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

F. HOW MANY CANCER TREATMENT CENTER LOCATIONS DO YOU HAVE? _____

1. IF YOU HAVE MULTIPLE LOCATIONS, ARE ALL LOCATIONS ACCREDITED? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS: _____

G. DO YOU PLAN TO ADD ANY LOCATIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

_____

H. ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

I. MEDICAL DIRECTOR:

_____
NAME OF MEDICAL DIRECTOR

_____ - _____ - _____ _____
PHONE NUMBER **EMAIL**

J. ANNUAL PAYROLL

TOTAL ANNUAL PAYROLL: _____ TOTAL PROJECTED ANNUAL RECEIPTS: _____

IV. CANCER TREATMENT CENTER OPERATIONS

A. PLEASE PROVIDE PATIENT/VISIT INFORMATION FOR THE FOLLOWING GENERAL CATEGORY OF PROCEDURES:

UTILIZATION	CURRENT (LAST 12 MONTHS) PATIENTS/VISITS	PROJECTED (NEXT 12 MONTHS) PATIENTS/VISITS
RADIATION ONCOLOGY/THERAPY		
NON-RADIOLOGICAL ONCOLOGY		
SURGICAL ONCOLOGY		
ALL OTHER		

B. PLEASE INDICATE WHICH OF THE SERVICES BELOW ARE BEING PROVIDED BY YOUR FACILITY:

- ☐ RADIATION THERAPY
- ☐ INTERNAL RADIOTHERAPY (BRACHYTHERAPY) - RADIOACTIVE IMPLANTS
- ☐ EXTERNAL RADIOTHERAPY (TELETHERAPY) - EXTERNAL BEAM THERAPY, GAMMA KNIFE
- ☐ STEREOTACTIC RADIOSURGERY (SRS)
- ☐ STEREOTACTIC RADIOTHERAPY (SRT)
- ☐ INTENSITY-MODULATED RADIATION THERAPY (IMRT)
- ☐ THREE-DIMENSIONAL IMAGING
- ☐ CHEMOTHERAPY
- ☐ PAIN MANAGEMENT
- ☐ MIND-BODY MEDICINE
- ☐ NATUROPATHIC MEDICINE
- ☐ NUTRITIONAL
- ☐ UREA THERAPY
- ☐ CRYOTHERAPY

C. ARE ANY CHANGES PLANNED TO SERVICES YOU OFFER IN THE NEXT 12 MONTHS? ☐ YES ☐ NO

(i.e. ARE YOU ADDING OR DISCONTINUING ANY SERVICES?)

IF YES, PLEASE DESCRIBE: _____

_____

D. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

_____

E. DO YOU HAVE THE FOLLOWING EQUIPMENT AT YOUR FACILITY?

1. CRASH CART WITH FULL CARDIAC LIFE SUPPORT CAPABILITIES AND NECESSARY IV FLUIDS? ☐ YES ☐ NO
2. DEFIBRILLATOR? ☐ YES ☐ NO
3. EKG? ☐ YES ☐ NO
4. OXYGEN? ☐ YES ☐ NO

F. WHAT PROVISIONS HAVE BEEN MADE FOR EMERGENCY CARE/TRANSFER PROTOCOL? PLEASE DESCRIBE:

_____

G. HOSPITAL PROVIDING EMERGENCY CARE:

_____

NAME

_____

ADDRESS

H. DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY, PHARMACY ETC.)? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: _____

_____

I. HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE.

IV. CANCER TREATMENT CENTER OPERATIONS (CONTINUED)

J. DO YOU HAVE WRITTEN POLICY AND PROCEDURES THAT ADDRESS:

1. WRITTEN PROTOCOLS REGARDING RADIATION OVERDOSE/UNDERDOSE? ☐ YES ☐ NO
2. PROCEDURES RELATING TO WRONG SITE AND/OR GEOGRAPHIC MISS? ☐ YES ☐ NO
3. GUIDELINES IN THE EVENT OF RADIATION BURN AND/OR RADIATION NECROSIS? ☐ YES ☐ NO
4. EMERGENCY TRANSFER PROTOCOLS? ☐ YES ☐ NO
5. WRITTEN AGREEMENT WITH A HOSPITAL TO PROVIDE EMERGENT HIGHER LEVEL OF CARE? ☐ YES ☐ NO
6. EQUIPMENT SAFETY PROTOCOLS SUCH AS CALIBRATION, IDENTIFYING OPERATING IRREGULARITIES, ETC.? ☐ YES ☐ NO
7. PERIODIC TRAINING AND IN-SERVICE EDUCATION? ☐ YES ☐ NO

IF "NO" FOR ITEMS 1-7 ABOVE, PLEASE EXPLAIN: _____

_____

K. DO YOU PERFORM ANY PROCEDURES WHICH REQUIRE ANESTHESIA SERVICES? ☐ YES ☐ NO

IF YES, WHAT PERCENT? _____ %

V. MEDICAL STAFF

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN THAT PRACTICES AT YOUR FACILITY.
(If more room is needed, please attach a separate roster of Medical Staff)

IMPORTANT NOTE: IF COVERAGE IS DESIRED FOR PHYSICIANS, PLEASE INDICATE THAT ON SECTION III (COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE) AND SECTION IV (THE SCHEDULE OF MEDICAL PROFESSIONALS) OF THE CANCER TREATMENT CENTER SUPPLEMENTAL APPLICATION. ALSO COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR EACH PHYSICIAN.

PHYSICIAN'S NAME AFTER EACH NAME, INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)	**PRIMARY LICENSE NUMBER**	**INDICATE PRIMARY SPECIALTY**	**INDICATE THE NUMBER OF HOURS PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT YOUR FACILITY**

B. ARE EACH OF THE PHYSICIANS PRACTICING AT YOUR FACILITY BOARD CERTIFIED? ☐ YES ☐ NO

IF NO, HOW MANY ARE NOT BOARD CERTIFIED? _____

C. DO YOU HAVE ANY PHYSICIANS ON STAFF THAT DO NOT MAINTAIN STAFF PRIVILEGES AT A HOSPITAL? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

D. PLEASE INDICATE THE NUMBER OF HEALTH PROFESSIONALS, OTHER THAN PHYSICIANS, WHO WORK AT YOUR FACILITY: _____

V. MEDICAL STAFF (CONTINUED)

IMPORTANT NOTE: IF COVERAGE IS DESIRED FOR HEALTH PROFESSIONALS, OTHER THAN PHYSICIANS, PLEASE INDICATE THAT ON SECTION III (COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE) AND SECTION V (THE SCHEDULE OF MEDICAL PROFESSIONALS) OF THE CANCER TREATMENT CENTER SUPPLEMENTAL APPLICATION. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED.

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED
NURSE PRACTITIONERS			
PHYSICIAN ASSISTANTS			
LPN'S/RN'S			
RADIATION PHYSICISTS			
RADIATION THERAPISTS			
RADIATION THERAPY TECHNOLOGISTS			
NUCLEAR MEDICINE THERAPISTS			
DOSIMETRISTS			
DIETICIANS			
SIMULATION TECHNOLOGISTS			
SOCIAL WORKERS			
OTHERS (DESCRIBE)			

E. DO YOU SUPERVISE ANYONE OTHER THAN YOUR OWN EMPLOYEES? ☐ YES ☐ NO

IF YES, DESCRIBE THE RESPONSIBILITY OF THE INDIVIDUALS AND WHAT YOUR RELATIONSHIPS ARE TO THESE INDIVIDUALS:

_____

ALSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL, THE NUMBER OF INDIVIDUALS YOU SUPERVISE:

_____

VI. RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT PROGRAM? ☐ YES ☐ NO

B. IS THERE A FULL-TIME RISK MANAGER? ☐ YES ☐ NO

IF NO, WHAT ARE THEIR OTHER RESPONSIBILITIES AND HOW MUCH TIME IS DEVOTED TO RISK MANAGEMENT?

_____

C. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR RISK MANAGEMENT:

_____ _____

NAME TITLE

D. IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS? ☐ YES ☐ NO

E. IS THERE A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ YES ☐ NO

1. IF YES, DOES THIS PROCEDURE REQUIRE REVIEW AND APPROPRIATE CORRECTIVE ACTION BE TAKEN? ☐ YES ☐ NO
2. IS FOLLOW-UP MADE TO ASSURE COMPLIANCE? ☐ YES ☐ NO

F. IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE? ☐ YES ☐ NO

1. IF YES, IS THE PERSON RESPONSIBLE FOR RISK MANAGEMENT A MEMBER OF THIS COMMITTEE? ☐ YES ☐ NO
2. TO WHOM IS THE QUALITY ASSURANCE COMMITTEE ACCOUNTABLE?

_____ _____

NAME TITLE

3. WHAT QUALITY INDICATORS ARE MONITORED (PLEASE LIST)? _____

_____

4. DO YOU MONITOR INFECTION RATES AT YOUR FACILITIES? ☐ YES ☐ NO

G. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS WHICH IS PART OF THE QUALITY MANAGEMENT PROGRAM? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

_____

H. IS THERE AN ON-GOING CONTINUING EDUCATION PROGRAM FOR: NURSING STAFF? ☐ YES ☐ NO

OTHER ALLIED HEALTH PROFESSIONALS? ☐ YES ☐ NO

I. NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:

_____ _____

NAME TITLE

VII. CREDENTIALING

A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF DO YOU:

1. VERIFY EDUCATIONAL BACKGROUND? ☐ YES ☐ NO
2. CHECK ALL REFERENCES INCLUDING PAST EMPLOYERS? ☐ YES ☐ NO
3. CHECK FOR PENDING LICENSE SUSPENSIONS, REVOCATIONS, OR DISCIPLINARY ACTIONS BY OTHER FACILITIES? ☐ YES ☐ NO
4. CHECK CRIMINAL HISTORY? ☐ YES ☐ NO
5. REQUIRE PRIOR MEDICAL PROFESSIONAL CLAIM HISTORY? ☐ YES ☐ NO

B. ARE CREDENTIALS OF EACH PHYSICIAN REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES? ☐ YES ☐ NO

C. IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK? ☐ YES ☐ NO

D. DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN, PODIATRIST AND DENTIST WORKING AT YOUR FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

1. IF YES, WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED? $ _____ / $ _____
2. ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

E. WHAT ARE THE MINIMUM LIMITS OF LIABILITY YOU REQUIRE NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT YOUR FACILITY TO CARRY? $ _____ / $ _____

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

F. HAS THE LICENSE OF ANY PHYSICIAN, PODIATRIST OR DENTIST BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

G. HAVE YOU MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK OF ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF DURING THE LAST 5 YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

_____

VIII. PHYSICAL PLANT

A. PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY YOU. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE, PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.

ADDRESS OF PROPERTY TO BE INSURED	USE/OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	FIRE PROTECTION*
PATIENT CARE BUILDINGS:						
OTHER BUILDINGS:						

*FOR EACH BUILDING INDICATE IF THERE IS A: SPRINKLER SYSTEM - FULL, PARTIAL OR NO SPRINKLER SYSTEM
SMOKE DETECTOR, HEAT DETECTOR
FIRE ALARM - CENTRAL STATION OR LOCAL ALARM

B. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

IX. GENERAL LIABILITY

DO YOU DESIRE GENERAL LIABILITY COVERAGE? ☐ YES ☐ NO
If yes, complete this section. If no, skip to Section X.

A. IS THERE A PREVENTIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR THE BIO-MEDICAL EQUIPMENT AND SURGICAL MACHINES OR DEVICES AT THE FACILITY? ☐ YES ☐ NO

1. HOW OFTEN ARE NON-EXPENDABLE MEDICAL OR SURGICAL MACHINES OR DEVICES INSPECTED AND MAINTAINED?

_____

IX. GENERAL LIABILITY (CONTINUED)

2. WHO PERFORMS THE MAINTENANCE ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS

3. IF INDEPENDENT CONTRACTORS, WHAT ARE THE MINIMUM GENERAL LIABILITY LIMITS THAT YOU REQUIRE THEM TO CARRY?

$ _____ / $ _____

4. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

B. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE PREVENTIVE MAINTENANCE, INSPECTION AND REPAIR OF THE EQUIPMENT?

_____

IX. GENERAL LIABILITY (CONTINUED)

C. DO YOU LEND OR DONATE YOUR BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE? ☐ YES ☐ NO

IF YES, DESCRIBE: _____

_____

D. DO YOU RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? _____

_____

E. DO YOU USE AN ADVERTISING AGENCY? ☐ YES ☐ NO

1. IF YES, WHAT IS THE MINIMUM PROFESSIONAL LIABILITY LIMIT THAT YOU REQUIRE THEM TO CARRY?

$ _____ / $ _____

2. ARE YOU INCLUDED AS AN ADDITIONAL INSURED ON THE ADVERTISING AGENCY'S POLICY? ☐ YES ☐ NO

3. IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF YOUR FACILITY? ☐ YES ☐ NO

F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE CHANGES PLANNED INCLUDING THE TIME FRAME AND THE ESTIMATED COST: _____

_____

G. PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJECTED NUMBER OR AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS:

HABITATIONAL RISK: INDICATE IF AN: ☐ APARTMENT ☐ DWELLING ☐ HOTEL

1. NUMBER OF UNITS: _____ YEAR BUILT: _____

a. ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER? ☐ YES ☐ NO

b. FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? ☐ YES ☐ NO

☐ PAY PARKING RECEIPTS PER YEAR: _____

☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS RECEIPTS PER YEAR: _____

2. DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED: _____

_____

H. DO YOU LEASE OR RENT SPACE TO OTHERS? ☐ YES ☐ NO

IF YES, INDICATE THE FOLLOWING:

_____

CITY, STATE, AND ZIP CODE

_____ _____

SQUARE FOOTAGE OCCUPANCY/USE OF SPACE

1. DOES YOUR LEASE REQUIRE THE TENANT TO CARRY GENERAL LIABILITY INSURANCE WITH AT LEAST A $1,000,000 LIMIT? ☐ YES ☐ NO

2. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

3. IS THE TENANT REQUIRED TO LIST YOU AS AN ADDITIONAL INSURED ON THEIR GENERAL LIABILITY POLICY? ☐ YES ☐ NO

X. EXCESS LIABILITY

DO YOU DESIRE EXCESS LIABILITY COVERAGE? ☐ YES ☐ NO
If yes, complete this section. If no, skip to Section XI.

A. HAVE YOUR EXCESS PROFESSIONAL OR COMMERCIAL GENERAL LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, WHAT WAS THE PRIOR LIMIT AND WHEN WAS IT INCREASED?

_____

XI. COVERAGE HISTORY AND INFORMATION

**** NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATE OF MISSOURI.**

A. HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

_____

B. PLEASE CHECK WHICH TYPE OF NOTICE YOUR PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE THEY WILL FORMALLY RECOGNIZE A CLAIM UNDER THEIR POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

☐ WRITTEN NOTICE FROM YOU THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

C. HAVE YOU CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS AND HAVE YOU FORWARDED THEM TO YOUR CURRENT INSURER? ☐ YES ☐ NO

IF YES, PROVIDE THE DATE OF THE REVIEW AND THE NAME AND TITLE OF THE PERSON CONDUCTING THE REVIEW:

____ ____ _____

MM YYYY NAME AND TITLE

D. PLEASE PROVIDE YOUR INSURANCE HISTORY FOR THE LAST FIVE YEARS:

POLICY PERIOD	MOST RECENT YEAR	YEAR 1 PRIOR	YEAR 2 PRIOR	YEAR 3 PRIOR	YEAR 4 PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
GENERAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
EXCESS LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					

XII. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)

For <u>EACH</u> claim, potential claim or suit mentioned below, please complete Section I (Loss History) of the Cancer Treatment Center Supplemental Application.

A. Has your organization (independently or through a named insured) been involved now or in the past, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization? ☐ YES ☐ NO

If yes, how many? _____

If yes, have these been reported to your insurer? ☐ YES ☐ NO

B. Does your organization or any of your employees/contractors have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization which may give rise to a claim? ☐ YES ☐ NO

If yes, how many? _____

If yes, have these been reported to your insurer? ☐ YES ☐ NO

XIII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION:

A. A COPY OF YOUR CERTIFICATE / ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

B. FINANCIAL INFORMATION. THE MOST RECENT THREE (3) YEARS OF FINANCIAL STATEMENTS INCLUDING THE AUDITOR'S OPINION, IF APPLICABLE.

C. MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.

D. COPY OF YOUR LETTERHEAD.

E. LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.

F. LOSS INFORMATION. RECENTLY VALUED LOSS RUNS FROM INSURANCE CARRIERS COVERING THE LAST TEN (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS.

G. ANNUAL REPORT (IF ONE IS PUBLISHED).

H. ALL CURRENT **ADVERTISING MATERIALS.**

I. ORGANIZATIONAL CHART INCLUDING THE **NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.**

J. COPY OF YOUR CURRENT INSURANCE POLICY.

XIV. IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES

IMPORTANT NOTICE:

THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE.

PLEASE READ AND REVIEW THE POLICY CAREFULLY.

FRAUD NOTICE:

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

A FRAUDULENT INSURANCE ACT IS COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

INITIAL HERE

PLEASE READ AND SIGN

ON BEHALF OF THE ENTITY APPLYING FOR COVERAGE HEREIN:

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO MATERIAL FACT HAS BEEN KNOWINGLY SUPPRESSED OR MISSTATED.

I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY.

I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY PHYSICIAN, DENTIST, FIRM, OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND COVERAGE.

BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT THERE IS NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED A COMPLETED APPLICATION; (2) OFFERED A PREMIUM QUOTE; AND (3) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND THAT IF THE PREMIUM OR FIRST INSTALLMENT IS PAID BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF THESE TERMS ARE NOT COMPLIED WITH, THERE WILL BE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER INDIVIDUALS OR ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND, IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REQUESTED, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

SIGNATURE OF AUTHORIZED INDIVIDUAL | TITLE | DATE