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HEALTHCARE FACILITY APPLICATION (NON-HOSPITAL)

NEW BUSINESS

CBMALAGA
Insurance Services LLC

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

SECTION I – INTRODUCTORY INFORMATION

Applicant Name: _____ No. of Years in Operation: _____

Address: _____ Telephone No.: ( ) _____

_____ Fax No.: ( ) _____

County: _____ Fiscal Year Begins: _____

Contact: _____ Tax ID No.: _____

Contact Email: _____ NPI No.: _____

Website Address: _____ Desired Effective Date: _____

NOTE: If more than one named insured, list name, location and tax identification number of each and explain the ownership and/or operational interest of each on a separate sheet.

SECTION II – FACILITY / CORPORATE ORGANIZATION

Type of Entity: ☐ Government ☐ Non-Profit ☐ Profit ☐ Other_____
☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture

Attach a list of all stockholders and their percent of ownership and identify any medical designations held by any stockholder. **Attach latest year-end audited financial statement.**

Is your facility accredited? By whom:_____ ☐ Yes ☐ No
If yes, attach copy of report.

Attach a narrative detail of the nature of your operations at each of your locations (if more than one) including the types of procedures or services rendered and all other activities conducted. Diagnostic Centers should also attach a list of diagnostic equipment.

Who is Medical Director of the facility?_____
Please provide details of background and job duties and responsibilities.

Are there any affiliated business entities, i.e., any land or equipment partnerships, from which land or equipment is leased? If so, list on a separate sheet. ☐ Yes ☐ No

List all properties owned, controlled or occupied:

Address:_____ Sq.Ft._____ Owned_____ Leased_____

Address:_____ Sq.Ft._____ Owned_____ Leased_____
Please attach additional sheets if necessary.

Is general liability coverage desired? ☐ Yes ☐ No

General Liability Limits: Each Occurrence_____ Aggregate_____

Effective date of coverage:_____ Retroactive Date: (if applicable)_____

Professional Liability Limits: Per Medical Incident_____ Aggregate_____

Effective date of coverage:_____ Retroactive Date: (if applicable)_____

Excess Liability Limits: Per Medical Incident_____ Aggregate_____

SECTION III – GENERAL EXPOSURE DATA

For requested visit classifications, complete number of visits and <u>not</u> number of procedures. For example, if someone came in and had more than one type lab work done, or maybe lab work and then x-ray, that would be just one visit and <u>not</u> the total number of procedures. For requested procedure classifications, provide the actual number of procedures.

Description	Number	Description	Number
Abortion Clinic	_____ Occupied Beds _____ Visits	Mental Health Counseling	_____ Occupied Beds _____ Visits
Ambulance Service	_____ Staff	Ocular Lab	_____ Ann.Receipts
Bariatric Surgery	_____ Procedures	Optical Establishment	_____ Ann.Receipts
Birthing Center	_____ Occupied Beds _____ Visits	Organ Bank-Direct Processing	_____ Ann.Receipts
Blood or Plasma Bank	_____ Donations	Organ Bank-No Direct Processing	_____ Ann.Receipts
Cardiac Rehab.	_____ Occupied Beds _____ Visits	Other Outpatient Services	_____ Visits
College/University Health Center	_____ Occupied Beds _____ Visits	Pathology Lab	_____ Ann.Receipts
Community Health/Outpatient Clinic	_____ Occupied Beds _____ Visits	Pharmacy (retail only)	_____ Ann.Receipts
Crises Stabilization Center	_____ Occupied Beds _____ Visits	Physical/Occupational Rehab.	_____ Occupied Beds _____ Visits
Dental Lab	_____ Ann.Receipts	Quality Control/Reference Lab	_____ Ann.Receipts
Developmental Disability Rehab.	_____ Occupied Beds _____ Visits	Radiation/Oncology Center	_____ Occupied Beds _____ Procedures
Dialysis Center	_____ Visits	Substance Abuse-Counseling	_____ Occupied Beds _____ Visits
Emergicenter	_____ Occupied Beds _____ Visits	Substance Abuse-Skilled Medical	_____ Occupied Beds _____ Visits
Home Care-Durable Equipment	_____ Ann.Receipts	Surgicenter	_____ Occupied Beds _____ Procedures
Home Care-Intravenous Therapy	_____ Visits	Trauma Rehab.-Skilled Medical	_____ Occupied Beds _____ Visits
Home Care-Personal Care	_____ Visits	Trauma Rehab.-Therapy	_____ Occupied Beds _____ Visits
Home Care-Rehabilitation	_____ Visits	Trauma Rehab.-Transitional Living	_____ Occupied Beds _____ Visits
Home Care-Respiratory Therapy	_____ Visits	Urgicenter	_____ Occupied Beds _____ Visits
Home Care-Skilled Care	_____ Visits	Weight Loss Center	_____ Occupied Beds _____ Visits
Hospice Care	_____ Occupied Beds _____ Visits	X-ray/Imaging Center	_____ Ann.Receipts
Medical Lab	_____ Ann.Receipts		
Municipal Health Department	_____ Visits		

Are any procedures performed on persons rendered unconscious through anesthesia? If yes, give detailed description on a separate sheet of how anesthesia is provided, including minimum patient age and number of overnight beds on premises or affiliated. ☐ Yes ☐ No

SECTION IV – PERSONNEL

Physicians providing health care services at this entity:

Name	Specialty	Board Certified	Board Eligible	C=Contracted E=Employed P=Private	Current Insurance Carrier

Please attach additional sheets if necessary.

Do you require certification of Professional Liability Coverage? If so, how much? ☐ Yes ☐ No

_____

Non-Physician Personnel	# Employed	# Contracted
Aids or Orderlies		
Audiologists		
Chiropractors		
Dental Hygienists / Technicians		
*Dentists		
Dietitians / Nutritionists		
EEG or EKG Operators		
Electrologists		
Inhalation / Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
Nurse Anesthetists - Are they supervised by an anesthesiologist? ☐ Yes ☐ No		
Nurse Midwives (Coverage Cannot be Provided)		
Nurse Practitioners		
Occupational / Physical Therapists		
Opticians		
Optometrists		
Oral Surgeons		
Paramedics or EMT's		
Perfusionists		
Pharmacists		
Pharmacy Technicians		
Physician Assistants		
Physiotherapists		
Podiatrists		
Psychologists / Psychotherapists		
RNs		
Social Workers		
Speech Therapists		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe)		

**Separate Application Required – Refer to Company*

SECTION V – INSURANCE / CLAIM INFORMATION

Have any claims ever been made or suits brought against you or any of your employees in the last five years because of any alleged malpractice, error or mistake, or from any premise accident arising in any manner out of your operations? If yes, attach a separate sheet listing date of occurrence, circumstances of claim and amount paid or amount reserved. ☐ Yes ☐ No

Do you have knowledge of any pending claims or activities that might give rise to a claim in the future? If yes, give details. ☐ Yes ☐ No

Current Insurer:_____

If claims-made, state retroactive date: GL - _____ PL - _____

IMPORTANT: PLEASE READ CAREFULLY

GENERAL FRAUD WARNING – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

COLORADO FRAUD WARNING – It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA FRAUD NOTICE – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY FRAUD WARNING – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NEW JERSEY FRAUD WARNING – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK FRAUD WARNING – 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO FRAUD WARNING – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA FRAUD WARNING – Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA FRAUD WARNING – 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.

VIRGINIA FRAUD WARNING – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WISCONSIN EXCEPTION – If the company agrees to be bound under the terms of this application, your policy will be cancelled if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application.

Name: _____ Signature: _____

Date: _____ Title: _____

Insurance Agent/Broker (if applicable):			
Agent:		Phone:	( )
Agency:		Fax:	( )
Address:		Email:	
		License No.:	
Signature:			