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

REHABILITATION FACILITY APPLICATION

Important Notice: Claims-made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between claims-made and occurrence coverage or the additional expense associated with an "extension contract" or "tail coverage."

INSTRUCTIONS

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.

I. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	POLICY TYPE	DEDUCTIBLE (PRIMARY COVERAGE)
☐ PROFESSIONAL LIABILITY FACILITY	$__________ PER EVENT $__________ 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	$__________ EACH EVENT $__________ GENERAL 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 EVENT $__________ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS-MADE RETRO DATE: __________	
☐ EXCESS - GENERAL LIABILITY FACILITY	$__________ EACH EVENT $__________ GENERAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS-MADE RETRO DATE: __________	

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 REHABILITATION FACILITY 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 REHABILITATION FACILITY SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF YOUR ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED.

A. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM): ______________________
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF YOUR CURRENT POLICY.

B. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM): ______________________
ANNUAL POLICY TERMS WILL BEGIN AND END ON THE SAME MONTH AND DAY.

II. ORGANIZATION INFORMATION

A. BROKERAGE INFORMATION

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)

II. ORGANIZATION INFORMATION (CONTINUED)

CONTACT PERSON NAME ______________________ TITLE ______________________

BUSINESS PHONE ___ - ___ - ___ BUSINESS FAX ___ - ___ - ___

WEBSITE ADDRESS ______________________

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:

☐ CARF ☐ JCAHO ☐ ISO ☐ OTHER ______________________

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

IF NONE, PLEASE EXPLAIN: ______________________

F. HOW MANY REHAB. FACILITY LOCATIONS DO YOU HAVE? ______________________

IF YOU HAVE MULTIPLE LOCATIONS, ARE ALL LOCATIONS ACCREDITED/CERTIFIED? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS: ______________________

____

G. MEDICAL DIRECTOR:

NAME OF MEDICAL DIRECTOR ______________________

PHONE NUMBER ___ - ___ - ___ EMAIL ______________________

H. ANNUAL PAYROLL

TOTAL ANNUAL PAYROLL: ______________ TOTAL PROJECTED ANNUAL RECEIPTS: ______________

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

IF YES, PLEASE EXPLAIN: ______________________

IV. REHABILITATION FACILITIES OPERATIONS

A. SERVICES

CATEGORIES OF SERVICES (LIST OTHERS IN BLANKS PROVIDED)	**INDICATE NUMBER OF VISITS PROVIDED FOR EACH CATEGORY FOR THE LAST 12 MONTHS.**	**INDICATE NUMBER OF VISITS PROVIDED FOR EACH CATEGORY FOR THE NEXT 12 MONTHS.**
CARDIAC REHABILITATION		
DEVELOPMENTAL DISABILITY		
PHYSICAL/OCCUPATIONAL REHABILITATION		
SPEECH/HEARING THERAPY		
LIST ALL OTHERS:		

IV. REHABILITATION FACILITIES OPERATIONS (CONTINUED)

B. IS THE PATIENT ASSESSED FOR POTENTIAL TO INJURY THAT MIGHT BE INCURRED DURING THERAPY SERVICES EITHER AT THE FACILITY OR IN THEIR LIVING ENVIRONMENT? ☐ YES ☐ NO

ARE THESE POTENTIALS CLEARLY COMMUNICATED TO THE THERAPY TEAM VIA A FORMALIZED PROCESS? ☐ YES ☐ NO

C. DO YOU HAVE ANY BEDS USED FOR OVER-NIGHT OCCUPANCY? ☐ YES ☐ NO IF YES, HOW MANY? ______________

ARE ANY LICENSED AS ACUTE CARE HOSPITAL BEDS? ☐ YES ☐ NO IF YES, HOW MANY? ______________

D. ARE ANY CHANGES PLANNED TO THE SERVICES OR SURGERIES OFFERED IN THE NEXT 12 MONTHS?
(i.e. ARE YOU ADDING OR DISCONTINUING ANY SERVICES?) ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE: ______________

E. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE: ______________

F. IS THERE A SWIMMING/HYDROTHERAPY POOL AT YOUR FACILITY? ☐ YES ☐ NO
IF YES, PLEASE COMPLETE THE SWIMMING POOL/HYDROTHERAPY SUPPLEMENTAL QUESTIONNAIRE (FACILITIES).

G. DO YOU HAVE WRITTEN POLICIES AND PROCEDURES THAT ADDRESS:

1. SCOPE OF PRACTICE ☐ YES ☐ NO
2. PATIENT ASSESSMENTS AND TREATMENT PLANNING ☐ YES ☐ NO
3. DOCUMENTATION GUIDELINES ☐ YES ☐ NO
4. PATIENTS RIGHTS AND RESPONSIBILITIES ☐ YES ☐ NO
5. PATIENT DISCHARGE ☐ YES ☐ NO

IF ANY OF THESE RESPONSES ARE NO, PLEASE EXPLAIN: ______________

H. DO YOU HAVE A WRITTEN EMERGENCY TRANSPORT POLICY AND AN AGREEMENT WITH A LOCAL HOSPITAL TO PROVIDE EMERGENCY CARE? ☐ YES ☐ NO

HOSPITAL PROVIDING EMERGENCY CARE:

____
NAME

____
ADDRESS

I. ARE APPLICABLE PROFESSIONAL ORGANIZATION GUIDELINES IN PLACE TO GOVERN ALL TREATMENT? ☐ YES ☐ NO

J. ARE ALL TREATMENTS PERFORMED ACCORDING TO PRESCRIBED TREATMENT PLANS ORDERED BY PHYSICIAN(S) AND THE RECOMMENDATIONS OF LICENSED THERAPIST(S)? ☐ YES ☐ NO

K. IS THERE A PROCESS IN PLACE FOR RECOGNITION AND TREATMENT/REFERRAL OF CO-MORBIDITIES? ☐ YES ☐ NO

L. IS THERE A FORMALIZED PROTOCOL FOR COMMUNICATING PROGRESS TO THE ORDERING PHYSICIAN(S) AS WELL AS THE REPORTING OF ANY CHANGES IN THE PATIENTS HEALTHCARE STATUS? ☐ YES ☐ NO

M. IF PHASE II CARDIAC REHAB IS PROVIDED, DO YOU FOLLOW THE AACUPR GUIDELINES? ☐ YES ☐ NO

V. MEDICAL STAFF

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN, IF ANY, 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 REHABILITATION FACILITY SUPPLEMENTAL APPLICATION. ALSO, COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR EACH PHYSICIAN.

PHYSICIAN'S 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

V. MEDICAL STAFF (CONTINUED)

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

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 REHABILITATION FACILITY 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
AIDES			
CRNA'S			
DENTISTS			
LABORATORY TECHNICIANS			
LPN'S / RN'S			
MEDICAL TECHNICIANS			
NURSE MIDWIVES			
NURSE PRACTITIONER			
OCCUPATIONAL THERAPISTS			
OPTOMETRISTS / OPTICIANS			
ORAL SURGEONS			
PERFUSIONISTS			
PHYSICAL THERAPISTS			
PHARMACISTS			
PHYSICIAN ASSISTANTS			
PODIATRISTS			
RESPIRATORY THERAPISTS			
PSYCHOLOGISTS			
RADIOLOGY / X-RAY TECHNICIANS			
SURGICAL ASSISTANTS			
OTHERS (DESCRIBE)			

C. 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/PERFORMANCE IMPROVEMENT PROGRAM THAT:

1. IDENTIFIES/RECOGNIZES PATTERNS OF OCCURRENCES OR POTENTIALS FOR OCCURRENCES? ☐ YES ☐ NO
2. IMPLEMENTS AND MONITORS CORRECTIVE ACTION PLANS? ☐ YES ☐ NO
3. DEVELOPS AND IMPLEMENTS ACTION PLANS FOR CONTINUOUS PROCESS IMPROVEMENTS? ☐ YES ☐ NO
4. MONITORS, ANALYZES AND SETS IN ACTION QUALITY INDICATORS? ☐ YES ☐ NO
5. EMPLOYS A SYSTEM FOR ASSESSING AND RESPONDING TO PATIENT AND EMPLOYEE SATISFACTION? ☐ YES ☐ NO
6. PROVIDES FOCUSED INTERVENTIONS AND EDUCATION TO IMPROVE PATIENT SAFETY? ☐ YES ☐ NO

B. IS THERE AN ORIENTATION PROGRAM FOR ALL NEW EMPLOYEES? ☐ YES ☐ NO

C. IS THERE ON-GOING TRAINING FOR COMPLIANCE, SAFETY AND EQUIPMENT USAGE? ☐ YES ☐ NO

D. IS THERE A FORMALIZED INFECTION CONTROL PLAN, PARTICULARLY FOR THE CLEANING OF EQUIPMENT? ☐ YES ☐ NO

E. IS THERE A FALL PREVENTION PROGRAM WHICH INCLUDES A RISK ASSESSMENT FOR FALLS ON THE FIRST VISITS? ☐ YES ☐ NO

F. ARE STAFF TRAINED AND TESTED ON EMERGENCY PROCEDURES ON A REGULAR BASIS AND ARE DIRECTIONS FOR SUMMONING HELP AND/OR TRANSFER CLEARLY POSTED? ☐ YES ☐ NO

G. IS THERE A PROCESS TO RECEIVE, DISSEMINATE, AND ACT UPON VENDOR INFORMATION, WARNINGS OR RECALLS OF EQUIPMENT, SUPPLIES, AND MEDICATIONS? ☐ YES ☐ NO

H. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR THESE ACTIVITIES:

______________________________ ______________________________
NAME TITLE

ARE RESPONSIBILITIES CLEARLY DEFINED IN THE JOB DESCRIPTION FOR THE POSITION? ☐ YES ☐ NO

VII. CREDENTIALING

A. DOES THE FACILITY OR ORGANIZATION HAVE BYLAWS? ☐ YES ☐ NO

B. DOES THE FACILITY OR ORGANIZATION HAVE FORMAL HIRING AND DISMISSAL POLICIES? ☐ YES ☐ NO

C. IS THERE VERIFICATION OF EDUCATION, LICENSURE AND CERTIFICATION IF APPLICABLE TO THE JOB FUNCTION? ☐ YES ☐ NO

D. HAS AN APPLICANT'S LICENSE OR CERTIFICATION EVER BEEN INVESTIGATED, LIMITED, REVOKED, SUSPENDED, REFUSED, CANCELLED, OR VOLUNTARILY SURRENDERED BY OR TO ANY STATE OR FEDERAL LICENSING BOARD OR REGULATORY AGENCY? ☐ YES ☐ NO

THIS INCLUDES, BUT IS NOT LIMITED TO MEDICARE, MEDICAID, OR REIMBURSEMENT PROGRAMS.

IF YES, PLEASE EXPLAIN: ______________________________

____

E. DOES THE CREDENTIALING PROCESS INCLUDE THE FOLLOWING:

1. PROOF OF MALPRACTICE INSURANCE (IF NOT OBTAINED THROUGH THIS POLICY)? ☐ YES ☐ NO
2. ARE CERTIFICATES OF INSURANCE OBTAINED? ☐ YES ☐ NO
3. REFERENCES FOR PROVIDERS AND EMPLOYEES? ☐ YES ☐ NO
4. ARE BACKGROUND CHECKS DONE (INCLUDING CRIMINAL HISTORY)? ☐ YES ☐ NO

F. IS COMPETENCY VALIDATION MONITORED AND DOCUMENTED ANNUALLY? ☐ YES ☐ NO

G. ARE SCOPE OF PRACTICE AND CLINICAL LIMITATIONS DEFINED IN JOB DESCRIPTIONS, PRIVILEGES, ETC.? ☐ YES ☐ NO

H. WHO REVIEWS AND/OR APPROVES PHYSICIAN APPLICANTS (IF ANY)? ______________________________

I. WHO REVIEWS AND/OR APPROVES ALL OTHER STAFF APPLICANTS? ______________________________

J. DO YOU HAVE FORMAL POLICIES FOR EXPECTED BEHAVIOR AND MECHANISMS FOR ENFORCING THE BEHAVIOR FOR THE FOLLOWING:

1. SEXUAL ABUSE AND/OR HARASSMENT ☐ YES ☐ NO
2. DISCRIMINATION AND/OR VIOLENCE ☐ YES ☐ NO
3. SUBSTANCE ABUSE ☐ YES ☐ NO

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 EQUIPMENT AND MACHINES OR DEVICES AT THE FACILITY? ☐ YES ☐ NO

1. HOW OFTEN ARE EQUIPMENT/MACHINES OR DEVICES INSPECTED AND MAINTAINED? ______________________________

   ____
2. WHO PERFORMS THE MAINTENANCE ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS
3. IF INDEPENDENT CONTRACTOR, WHAT IS THE MINIMUM GENERAL LIABILITY LIMIT THAT YOU REQUIRE THEM TO CARRY?

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

IX. GENERAL LIABILITY (CONTINUED)

B. IS ANY OF THE 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? ________

____

C. DO YOU LEND OR DONATE YOUR 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:

☐ PAY PARKING RECEIPTS PER YEAR: __________

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

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 XII.

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?

$ ____________ / $ ____________ ________ ________

MM YYYY

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.

XI. COVERAGE HISTORY AND INFORMATION (CONTINUED)

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 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 EACH CLAIM, POTENTIAL CLAIM OR SUIT MENTIONED BELOW, PLEASE COMPLETE SECTION I (LOSS HISTORY) OF THE REHABILITATION FACILITY 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. COPY OF YOUR LETTERHEAD.

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

E. 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.

F. ALL CURRENT **ADVERTISING MATERIALS.**

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

H. COPY OF YOUR CURRENT INSURANCE POLICY.

XIV. FRAUD NOTICE

MANDATORY: ALL OKLAHOMA APPLICANTS MUST READ AND INITAL THE FOLLOWING:
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.

INITIAL HERE

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

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

REHABILITATION FACILITY SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF YOU HAVE BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE FOR LESS THAN TEN YEARS OR IF YOUR FACILITY PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE INSURANCE COMPANY.

THE LOSS INFORMATION SHOULD ADDRESS BOTH YOUR PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: ____________________

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION.

CLAIM NUMBER: ____________________

A. CLAIMANT NAME: ____________________ AGE: ____

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU. ____ MM ____ YYYY

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. ____ MM ____ YYYY

D. NAME OF DOCTOR(S), HEALTHCARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLVED IN THE CLAIM OR SUIT:

____

E. DEFENDING INSURANCE CARRIER NAME:

____

F. WAS A CLAIM MADE OR A SUIT FILED? ☐ YES ☐ NO

G. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT: ☐ OPEN ☐ CLOSED

IF CLOSED, DATE OF CLOSING /SETTLEMENT OR AWARD: ____ MM ____ YYYY

IF CLOSED, WAS PAYMENT MADE? ☐ YES ☐ NO

IF NO, WAS CLAIM OR SUIT WITHDRAWN? ☐ YES ☐ NO

AMOUNT PAID ON YOUR BEHALF: $ ____________

TOTAL AMOUNT OF SETTLEMENT OR AWARD: $ ____________

WAS THIS MATTER CLOSED WITH YOUR CONSENT? ☐ YES ☐ NO

IF OPEN, HAS SETTLEMENT BEEN OFFERED? ☐ YES ☐ NO

IF OPEN, HAS TRIAL DATE BEEN SET? ☐ YES ☐ NO

TRIAL DATE: ____ MM ____ YYYY

H. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: ____________________

TREATMENT PROVIDED: ____________________

ALLEGED NEGLIGENCE: ____________________

ALLEGED INJURY: ____________________

I. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY INCLUDING YOUR LEVEL OF INVOLVEMENT).

____

____

____

____

II. SCHEDULE OF RELATED ENTITIES

LIST OF ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.)

NAME OF ENTITY	DESCRIPTION OF OPERATIONS	DATE ACQUIRED, CREATED OR MERGED	INDICATE YOUR OWNERSHIP PERCENTAGE IN THIS ENTITY	COVERAGE DESIRED? IF YES, INDICATE SHARED OR SEPARATE

III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (IF SHARED OR SEPARATE PHYSICIAN OR ALLIED COVERAGE IS BEING REQUESTED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW

COVERAGE	REQUESTED LIMITS	OCCURRENCE / CLAIMS-MADE	DEDUCTIBLE / SIR
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE REHABILITATION CENTER LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE SURGERY CENTER LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE REHABILITATION CENTER LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE SURGERY CENTER LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SEPARATE LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: ________ **NOTE: THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE SURGERY CENTER.**	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ ___________ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SEPARATE LIMIT COVERAGE.**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: ________ **NOTE: THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE SURGERY CENTER.**	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ ___________ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE

IMPORTANT NOTE:

UNLESS OTHERWISE INDICATED BELOW, REQUESTED COVERAGE WILL BE LIMITED TO PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED, WHILE EMPLOYED OR UNDER CONTRACT WITH THE APPLICANT OR RELATED ENTITY (SERVICES LIMITED TO DUTY AND SCOPE OF SERVICES). **CHECK ONE**:

☐ LIMITED TO DUTY AND SCOPE OF APPLICANT AS INDICATED ABOVE

☐ REQUESTING 24-HOUR COVERAGE

IV. SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND / OR ORAL SURGEONS, PLEASE PROVIDE THE INFORMATION BELOW. ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED (SHARED LIMIT OR SEPARATE LIMIT COVERAGE). CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

NAME OF MEDICAL PROFESSIONAL	EMPLOYMENT STATUS: (C)ONTRACT (E)MPLOYED (F)ACULTY (R)ESIDENT	NUMBER OF PROCEDURES PERFORMED AT THE REHAB CENTER	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOYMENT WITH NAMED INSURED	RESTRICTED (RE) TO NAMED INSURED'S OPERATION OR 24-HOUR (24)	LIMITS: SHARED (SH), SEPARATE (SE)

V. SCHEDULE OF MEDICAL PROFESSIONALS - CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND / OR SURGICAL ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION BELOW. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED. CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF CLAIMS MADE COVERAGE IS BEING REQUESTED, COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE DATE OF EMPLOYMENT WITH THE NAMED INSURED ENTITY. (*) IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE DATE OF THE EMPLOYMENT WITH THE NAMED INSURED, PRIOR ACTS COVERAGE WILL BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

INSTRUCTIONS FOR COMPLETING EACH COLUMN

#1) EMPLOYMENT STATUS: (C) CONTRACT, (E) EMPLOYED or (F) FACULTY.
#2) SPECIALTY: CRNA, CRNP, NURSE MIDWIFE, PA, PODIATRIST, SURGICAL ASSISTANT.
#3) IF CRNP OR PA, DOES INDIVIDUAL PRESCRIBE MEDICATION? INDICATE YES OR NO.
#4) IF CLAIMS MADE COVERAGE TYPE, INDICATE RETRO DATE.
#5) DATE OF EMPLOYMENT WITH FIRST NAMED INSURED (FNI).
#6) FULL TIME EQUIVALENCY (FTE) - CALCULATE FTE BY DIVIDING THE TOTAL # OF HOURS OF PROFESSIONAL SERVICE PER WEEK BY 40 HOURS.
#7) LICENSE NUMVBER.
#8) COVERAGE SCOPE: (RE) RESTRICTED TO NAMED INSURED'S OPERATION OR (24) 24-HOUR COVERAGE.
#9) LIMITS: (SH) SHARED OR (SE) SEPARATE.

COLUMN #	1	2	3	4	5	6	7	8	9
NAME OF MEDICAL PROFESSIONAL	**(C), (E) or (F)**	**SPECIALTY**	**PRESCR. YES/NO**	**IF CM, RETRO DATE**	**DATE OF EMPL. WITH FNI**	**FTE**	**LICENSE #**	**(RE) OR (24)**	**(SH) OR (SE)**