MEDICAL SPA LIABILITY APPLICATION

INSTRUCTIONS

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

I. PRODUCER INFORMATION

A. FIRM INFORMATION

FIRM NAME _____ INDIVIDUAL NAME _____

MAILING ADDRESS _____ PHONE _____

CITY/STATE/ZIP _____ E-MAIL _____

II. APPLICANT INFORMATION

A. CONTACT INFORMATION

APPLICANT NAME _____

MAILING ADDRESS _____ COUNTY _____

STREET ADDRESS (IF DIFFERENT) _____

WEBSITE ADDRESS _____

FEDERAL TAX ID NUMBER _____

B. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM): _____
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF THE APPLICANT'S CURRENT POLICY.

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

III. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	POLICY TYPE	DEDUCTIBLE (PRIMARY COVERAGE)
☐ **PROFESSIONAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	
☐ **GENERAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	
☐ **EXCESS - PROFESSIONAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	
☐ **EXCESS - GENERAL LIABILITY FACILITY**		☐ OCCURRENCE ☐ CLAIMS-MADE RETRO-DATE: _____	

(*) IF THE APPLICANT HAS ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.), PLEASE COMPLETE SECTION II. (SCHEDULE OF RELATED ENTITIES) OF THE MEDICAL SPA SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF THE APPLICANT'S ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED.

IV. GENERAL INFORMATION

A. TYPE OF LEGAL ENTITY (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

☐ PROFESSIONAL CORPORATION
☐ PARTNERSHIP OR PROFESSIONAL ASSOCIATION
☐ FOR PROFIT
☐ NON PROFIT
☐ LIMITED LIABILITY CORPORATION (LLC)
☐ JOINT VENTURE
☐ OTHER (PLEASE EXPLAIN): _____

B. ENTITY OWNERSHIP (PLEASE PUT AN "X" IN THE APPLICABLE SPACES)**:**

☐ PHYSICIAN OWNED
☐ HOSPITAL OWNED
☐ INDEPENDENTLY OWNED (PLEASE EXPLAIN): _____
☐ OTHER (PLEASE EXPLAIN): _____

C. HOW MANY YEARS HAS THE FACILITY BEEN IN OPERATION? _____

D. HOW MANY LOCATIONS DOES THE FACILITY HAVE? _____

PLEASE LIST ALL MEDICAL SPA LOCATIONS. IF MORE THAN 3 LOCATIONS, PLEASE ATTACH A SEPARATE PIECE OF PAPER SHOWING THE ADDITIONAL LOCATIONS.

LOCATION #1:

_____
STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED: _____ ESTIMATE NUMBER OF PATIENTS AT THIS LOCATION: _____

LOCATION #2:

_____
STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED: _____ ESTIMATE NUMBER OF PATIENTS AT THIS LOCATION: _____

LOCATION #3:

_____
STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED: _____ ESTIMATE NUMBER OF PATIENTS AT THIS LOCATION: _____

E. DURING THE NEXT 12 MONTHS, ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS, OR DOES THE APPLICANT PLAN ON ADDING ANY ADDITIONAL LOCATIONS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

F. LICENSES HELD BY THE FACILITY: _____

G. CERTIFICATIONS/ACCREDITATIONS HELD BY THE FACILITY: _____

PLEASE PROVIDE A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

H. MEDICAL DIRECTOR:

_____
NAME OF MEDICAL DIRECTOR

_____ - _____ - _____
PHONE NUMBER

I. HOW OFTEN IS THE MEDICAL DIRECTOR ON-SITE AT THE FACILITY? _____

J. DOES THE MEDICAL DIRECTOR ALSO PROVIDE PROFESSIONAL SERVICES AT THE FACILITY? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

K. ANNUAL PAYROLL:

TOTAL ANNUAL PAYROLL: $ _____

L. TOTAL PROJECTED ANNUAL REVENUE: $ _____ **PRIOR YEAR REVENUE:** $ _____

V. MED SPA OPERATIONS

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH SERVICE PROVIDED AT THE APPLICANT'S FACILITY:

SERVICES PROVIDED AT FACILITY	CURRENT # OF PROCEDURES ANNUALLY AT THE FACILITY	PROJECTED # OF PROCEDURES TO BE PERFORMED AT THE FACILITY ANNUALLY	PROFESSIONAL(S) PERFORMING PROCEDURES (E.G. AESTHETICIAN, PA, NP, PHYSICIAN)
ACUPUNCTURE			
BOTOX			
CHELATION THERAPY: DESCRIBE: _____			
CHEMICAL PEELS: SPECIFY STRENGTH: _____			
CRYOTHERAPY: DESCRIBE: _____			
DAY SPA ACTIVITIES: WAXING, WRAPS, EXFOLIATIONS, FACIALS, HAIR CARE, LASH EXTENSIONS, MAKE-UP APPLICATIONS, NAILS, REFLEXOLOGY, TANNING			
HAIR TRANSPLANT: SPECIFY TYPE: _____			
HERBAL OR VITAMIN SUPPLEMENTS OR REMEDIES			
HORMONE THERAPY/VITAMIN INJECTIONS: SPECIFY TYPE AND METHOD OF DELIVERY: _____			
INJECTIONS/FILLERS, RESTYLANE AND JUVEDERM			
KYBELLA FOR RECOMMENDED USES ONLY			
LASER HAIR REMOVAL/ELECTROLYSIS			
LASER LIPOSUCTION (SMART LIPO)			
LASER SKIN TIGHTENING: VELASMOOTH (CELLULITE TREATMENT WITH RADIO FREQUENCY), THERMAGE, ENDERMOLOGIE			
LASER SKIN TREATMENT: TITAN, GENESIS, FRAXEL			
LIPOINJECTION/FAT TRANSFER			
LIPOSUCTION (REGULAR)			
LIPOSUCTION (TUMESCENT)			
MASSAGE			
MESOTHERAPY/LIPODISSOLVE: SPECIFY TYPE: _____			
MICRODERMABRASION			
MICROPIGMENTATION (PERMANENT MAKEUP)			
MINI FACELIFT			
PHOTO THERAPY: LEVULAN, PHOTO REJUVENATION (RPL), FOTO FACIALS			
PRP/PROLOTHERAPY: SPECIFY TYPE AND WHERE USED ON BODY: _____			
RADIOFREQUENCY FACE LIFT PROCEDURES			
SKIN TAG REMOVAL			
SCLEROTHERAPY			
TATTOO REMOVAL: SPECIFY TYPE: _____			
WEIGHT CONTROL/HCG: SPECIFY TYPE: _____			
OTHER (PLEASE DESCRIBE):			
OTHER (PLEASE DESCRIBE):			
OTHER (PLEASE DESCRIBE):			
OTHER (PLEASE DESCRIBE):			

B. DOES THE FACILITY PROVIDE ANY SERVICES OR TREATMENT OUTSIDE OF THE LOCATIONS PREVIOUSLY LISTED ON THE APPLICATION? (I.E. IN THE HOME) ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

C. DO ALL EMPLOYEES RECEIVE REGULAR TRAINING REGARDING SAFETY AND OPERATIONAL PROCEDURES BEGINNING AT TIME OF HIRE AND CONTINUING THROUGHOUT EMPLOYMENT? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

D. DOES THE APPLICANT HAVE A WRITTEN SAFETY MANUAL USED BY ALL EMPLOYEES? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

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

IF YES, PLEASE DESCRIBE: _____

F. DOES THE APPLICANT HAVE REGULARLY SCHEDULED MAINTENANCE AND CALIBRATION OF ALL EQUIPMENT? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

G. DOES THE APPLICANT HAVE A WRITTEN COMPLIANCE MANUAL DETAILING THE APPROPRIATE CLEANING OF ALL EQUIPMENT? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

V. MED SPA OPERATIONS (CONTINUED)

H. IS THERE A PHYSICIAN ON LOCATION AT ALL TIMES? ☐ YES ☐ NO

IF NO, PLEASE IDENTIFY THE SPECIALTY OF THE PRIMARY HEALTHCARE PROVIDER WHO *IS* ON-SITE, AS WELL AS A DETAILED DESCRIPTION OF THE RESPONSIBILITIES OF THIS INDIVIDUAL:

_____

I. ARE PATIENTS REQUIRED TO SIGN INFORMED CONSENT FORMS REGARDING THE SPECIFIC PROCEDURES BEING PERFORMED? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

J. ARE PARENTS/GUARDIANS REQUIRED TO SIGN INFORMED CONSENT FORMS FOR PATIENTS UNDER THE AGE OF 18? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

K. DOES A PHYSICIAN MEET WITH EACH PATIENT PRIOR TO THE SCHEDULED PROCEDURE? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN WHY THIS DOES NOT OCCUR: _____

L. ARE "BEFORE" AND "AFTER" PICTURES TAKEN OF EVERY PATIENT? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

M. DOES ANYONE AT THE FACILITY TREAT PATIENTS UNDER EITHER CONSCIOUS SEDATION OR GENERAL ANESTHESIA? ☐ YES ☐ NO

IF YES, WHAT IS THE DISTANCE TO THE NEAREST HOSPITAL? _____

N. DOES THE APPLICANT MANUFACTURE, SELL, HANDLE, DISTRIBUTE OR DISPOSE OF GOODS OR PRODUCTS? ☐ YES ☐ NO

IF YES, ARE THESE PRODUCTS AVAILABLE FOR SALE AND/OR USE BY INDIVIDUALS OTHER THAN THE APPLICANT'S PATIENTS? ☐ YES ☐ NO

VI. MEDICAL STAFF

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN THAT PRACTICES AT THE APPLICANT'S FACILITY. (IF MORE ROOM IS NEEDED, PLEASE ATTACH A SEPARATE ROSTER OF MEDICAL STAFF).

<u>IMPORTANT NOTE</u>: IF COVERAGE IS REQUESTED FOR PHYSICIANS, PLEASE SO STATE ON SECTION III (SCHEDULE OF MEDICAL PROFESSIONALS) OF THE MEDICAL SPA SUPPLEMENTAL APPLICATION. ALSO COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR EACH PHYSICIAN.

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

B. ARE THE PHYSICIANS PRACTICING AT THE APPLICANT'S FACILITY BOARD CERTIFIED? ☐ YES ☐ NO

IF NO, HOW MANY ARE NOT BOARD CERTIFIED? _____

C. IN THE TABLE BELOW, STATE BY TYPE THE NUMBER OF HEALTH PROFESSIONALS (OTHER THAN PHYSICIANS) WHO WORK AT THE FACILITY:

<u>IMPORTANT NOTE</u>: IF COVERAGE IS REQUESTED FOR HEALTH PROFESSIONALS OTHER THAN PHYSICIANS, PLEASE REQUEST SUCH COVERAGE ON SECTION IV (SCHEDULE OF MEDICAL PROFESSIONALS) OF THE MEDICAL SPA SUPPLEMENTAL APPLICATION. IF SEPARATE LIMITS ARE NEEDED FOR ANY INDIVIDUAL, ALSO SUBMIT AN APPLICATION FOR EACH SUCH INDIVIDUAL.

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED

VII. 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 A FORMALIZED INFECTION CONTROL PLAN, PARTICULARLY FOR THE SANITIZING OF EQUIPMENT? ☐ YES ☐ NO

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

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

F. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING RISK MANAGEMENT PROTOCOLS?

_____ _____
NAME TITLE

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

VIII. CREDENTIALING

A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF, DOES THE APPLICANT:

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 THE 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 THE APPLICANT'S 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 REQUIRED FOR NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT THE APPLICANT'S FACILITY TO CARRY? $ _____ / $ _____

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

F. HAVE ANY CURRENT OR FORMER EMPLOYEES OR CONTRACTORS: (PLEASE ATTACH AN EXPLANATION OF ANY "YES" ANSWERS)

1) EVER BEEN THE SUBJECT OF DISCIPLINARY OR INVESTIGATIVE PROCEEDINGS, OR A REPRIMAND BY A GOVERNMENTAL LICENSE BOARD OR ADMINISTRATIVE AGENCY, HOSPITAL OR PROFESSIONAL ASSOCIATION? ☐ YES ☐ NO

2) EVER BEEN INDICTED FOR, CHARGED WITH, OR CONVICTED OF, ANY ACT COMMITTED IN VIOLATION OF ANY LAW OR ORDINANCE, OTHER THAN TRAFFIC OFFENSES, OR HAD HOSPITAL PRIVILEGES, DEA LICENSE, OR MEDICARE/MEDICAID PRIVILEGES REFUSED, DENIED, REVOKED, SUSPENDED, RESTRICTED, SUBJECT TO A REPRIMAND, PLACED ON PROBATION OR VOLUNTARILY SURRENDERED? ☐ YES ☐ NO

IX. GENERAL LIABILITY

IS GENERAL LIABILITY COVERAGE BEING REQUESTED? ☐ YES ☐ NO
IF YES, COMPLETE THIS SECTION. IF NO, SKIP TO SECTION X.

A. PLEASE INDICATE WHICH OF THE FOLLOWING APPLY (IF ANY):

☐ DAYCARE CENTER
☐ HABITATIONAL RISKS (APARTMENT, DWELLING, HOTEL, ETC.)
☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS
☐ SWIMMING POOLS
☐ FITNESS CENTERS
☐ WATERCRAFT
☐ SECURITY SERVICE

IF ANY OF THE ABOVE APPLY, PLEASE EXPLAIN: _____

_____

_____

X. EXCESS LIABILITY

IS EXCESS LIABILITY COVERAGE REQUESTED? ☐ YES ☐ NO
IF YES, COMPLETE THIS SECTION. IF NO, SKIP TO SECTION XI.

A. HAS THE APPLICANT'S 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 TO THE APPLICANT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

_____

B. PLEASE CHECK WHICH TYPE OF NOTICE THE APPLICANT'S PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE IT WILL FORMALLY RECOGNIZE A CLAIM UNDER ITS POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

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

C. HAS THE APPLICANT CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS? ☐ YES ☐ NO

IF YES, HAS THE APPLICANT FORWARDED THEM TO THE APPLICANT'S 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 THE APPLICANT'S INSURANCE HISTORY FOR THE LAST FIVE YEARS:

POLICY PERIOD	MOST RECENT YEAR	1 YEAR PRIOR	2 YEARS PRIOR	3 YEARS PRIOR	4 YEARS 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 MEDICAL SPA SUPPLEMENTAL APPLICATION.

A. HAS THE APPLICANT (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 THE APPLICANT'S INSURER? ☐ YES ☐ NO

B. DOES THE APPLICANT OR ANY OF ITS EMPLOYEES/CONTRACTORS HAVE KNOWLEDGE OF ANY INCIDENT, OR UNEXPECTED ADVERSE OUTCOME RESULTING IN INJURY OR DEATH, CLAIM, POTENTIAL CLAIM, OR SUIT IN WHICH THE APPLICANT 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 THE APPLICANT'S INSURER? ☐ YES ☐ NO

XIII. ATTACHMENTS

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

A. A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.
B. MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.
C. COPY OF THE APPLICANT'S LETTERHEAD.
D. LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.
E. LOSS INFORMATION. RECENTLY VALUED LOSS RUNS FROM THE APPLICANT'S 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 THE APPLICANT'S CURRENT INSURANCE POLICY.

XIV. 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 AND REPORTED 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.

XV. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ THE FOLLOWING:
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DECEIVE, OR, DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.

XVI. STATE SPECIFIC NOTICES

If Delaware: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 and Delaware Bulletin No. 46 including the following: Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

If Illinois: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under Illinois Bulletin 2011-06 And The Religious Freedom Protection and Civil Union Act which states: "The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married" or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

If Rhode Island: **THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.**

XVII. PLEASE READ AND SIGN

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on his, her or the facility/entity's behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that neither I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (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.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

XVII. PLEASE READ AND SIGN (CONTINUED)

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

SIGNATURE OF OFFICER OR AUTHORIZED REPRESENTATIVE	TITLE	DATE

XVIII. SUPPLEMENTAL INFORMATION