Medical Risk

SM

ACE American Insurance Company
Illinois Union Insurance Company
Westchester Surplus Lines Insurance Company

Long Term Care Professional and General Liability Policy Application

Along with this completed and signed application, prospective insureds must also submit the following information:

1. Past five (5) year loss run currently valued within the last three (3) months. Please provide detailed information on all claims with a $25k incurred loss or greater.
2. Copy of the most current audited financial statement
3. Copy of current State License
4. Copies of most recent State Inspection Reports including any complaint investigations. Include all statements of deficiencies and plans of correction.
5. Updated Form CMA 671 Facility Staffing and 672 Resident Census (SNF/ICF only) for each facility
6. Resumes and Job Descriptions of the Administrator and Director of Nursing
7. Current Quality Indicator Profile for the past 3 months
8. Skin Care Policy and Procedure
9. Resident Admission Agreement
10. Elopement Policy and Procedure
11. Description of Fall Prevention Program
12. Restraint Protocols
13. Abuse & Prevention Policy and Procedure
14. Medication Administration Policy
15. Names and locations of all entities to be covered under this policy (Attachment #1)
16. Diagram/Map of the facility
17. Marketing brochures and advertising materials

The requested information is necessary before a quotation can be obtained.

Instructions:

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet using the applicant's letterhead and reference the applicable question number.

Use þ for Yes or No answers and other selections.

This application supplement must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

. **General Information**

1. Named Insured: _____

2. Address: (street, city, zip) Website Address:

3. Contact Name: Contact Title:
   Contact Number: Contact Email:

4. Type of Facility:

   SubAcute Skilled Intermediate Assisted Living Independent Living

   Other, please describe: _____

5. Facility is: (please check all applicable categories)

For Profit	Individual	JCAHO Accredited
Not for Profit	Partnership	CARF Accredited
Hospital Affiliated	Governmental	Medicare Certified
Religious Affiliated	CCRC	Medicaid Certified

6. Is the facility part of a chain? Yes No

7. Corporate/Parent Name: _____

8. Corporate Address (street, city, zip): _____
9. Number of years facility has been:

   a) Operating: _____

   b) Owned by Present Management: _____

   c) Managed by Present Management: _____

10. Does an outside management company operate any locations? Yes No

11. Have any locations been acquired in the past three (3) years? Yes No

12. Have any locations been closed, sold or otherwise divested in the past three (3) years? Yes
    No

12. Have any locations been closed, sold or otherwise divested in the past three (3) years? Yes No

13. Is your organization planning to acquire or open any new locations in the next year? Yes No If yes, please provide details (location and # of licensed beds):

_____

_____

_____

. **Prior Insurance History**

Primary Coverage

Policy Period	Carrier	PL/GL Limits	Deductible/SIR	CM/OCC	Retro Date	Premium

Excess/Umbrella Coverage

Policy Period	Carrier	PL/GL Limits	Deductible/SIR	CM/OCC	Retro Date	Premium

1. During the past five (5) years, have any claims been presented to your current or prior insurance carrier(s) or to you? Yes No

   If yes, please provide detailed descriptions on all claims with a $25k incurred loss or greater on a separate sheet of paper .

2. In the last three (5) years, has any malpractice insurance carrier denied, restricted, limited or terminated coverage? Yes No
   If yes, please explain:

   _____

   _____

   _____

3. Has the applicant facility, or any other person for whom insurance is being requested, aware of any fact(s), incidents(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No

   If yes, please provide detail:

   _____

   _____

   _____

4. Has the applicant facility experienced any allegations or substantiated incidents of physical or sexual abuse (resident upon resident, staff upon resident, visitor upon resident) in the past three (3) years? Yes No

   If yes, please provide detail:

   _____

   _____

   _____

. **Licensing/Certification**

. **Licensing/Certification**

1. Has your state license for any locations been revoked, suspended or limited within the last three (3) years? Yes No

   If yes, please explain:

   _____
   _____
   _____

2. Has your Medicare or Medicaid certification for any location been limited, suspended or revoked, for any reason, within the last three (3) years? Yes No

   If yes, please explain:

   _____
   _____
   _____

3. Has your facility been placed under Immediate Jeopardy during the past three (3) years? Yes No

   If yes, please explain:

   _____
   _____
   _____

4. Date of last State Inspection/Survey:

Total Number of Deficiencies:	
Number of D, E & F Deficiencies:	
Number of G, H & I Deficiencies:	
Number of J, K, L Deficiencies:	

Corrective action plan accepted by the State? ● Yes ● No Date Accepted:_____

● Not Applicable, no deficiencies

5. Number of complaints investigated by State in the past three (3) years: _____

   Number of substantiated complaints in the past three (3) years: _____

. **Classification**

Percent of residents

1. By age range: < 30 ____ 30-64 ____ 65-74 ____ 75-84 ____ 85-94 ____ >95 ____

   If there are residents below age 64, please explain:

   _____
   _____

2. Please state percentage of payment/reimbursement in each category:

   Medicare: _____ Medicaid: _____ Private Pay: _____

Sub-Acute: Ventilator care, post-operative/trauma recovery, wound management, intravenous antibiotic and/or hydration therapy, spinal cord/head injury, oncology, total prenateral nutrition (TPN), blood plasma transfusion, central line care, tracheostomy, dialysis.			
● For-Profit	● Non-Profit	Total Licensed Beds:	Average Occupied Beds:
Skilled Nursing: Administration of medication by injection, catheter insertion and sterile irrigation, physical and occupational therapy, administration of oxygen and inhalation therapy, routine changing of dressings, tube feeding, Alzheimer's patients.			
● For-Profit	● Non-Profit	Total Licensed Beds:	Average Occupied Beds:

feeding, Alzheimer's patients.			
● For-Profit	● Non-Profit	Total Licensed Beds:	Average Occupied Beds:
Intermediate Care: Administration of oral medications, assistance with activities of daily living, preventive turning/positioning, restorative rehabilitation.			
● For-Profit	● Non-Profit	Total Licensed Beds:	Average Occupied Beds:
Assisted Living: Combination of housing, personalized supportive services, health care services designed for persons who are mostly able to take care of themselves. Provides protective environment, meals, assistance with medications, group socials, spiritual activities, etc.			
● For-Profit	● Non-Profit	Total Licensed Beds:	Average Occupied Beds:
Personal Care: Security, transportation, nutritional meals, recreation, self administration/assistance with medications, guidance with activities of daily living (bathing, dressing, eating, walking). Residents normally not safe to stay by themselves.			
● For-Profit	● Non-Profit	Total Licensed Beds:	Average Occupied Beds:
Independent Care: Residents of retirement age, total self care, live self-sufficiently, occupy apartment/dwelling units including cooking facilities, do not receive health care services, administer own medications without assistance, full-time caretaker on premises.			
For-Profit	Non-Profit	Total Units: ____	Total Residents at Full Occupancy: _____

Are there Common Dining Facilities?	Yes	No
Do individual units have cooking appliances (excluding microwaves)?	Yes	No
If Yes, Please check type:	Gas	Electric
Are residents checked every day?	Yes	No
If yes, explain procedure: _____		
_____		
_____		
Are Residents allowed to have Home Health Care Aides?	Yes	No
If yes, do you require then to maintain separate professional liability insurance?	Yes	No
Are the Aides contracted independently?	Yes	No
Through Facility?	Yes	No

E. Administrator

1. Name: _____ License Number: _____ State: _____
2. Length of time at this facility: _____ Number of years as a NHA: _____

F. Nurse Staffing

1. Name of Director of Nursing: _____ Professional Credentials: RN LPN
2. Length of time at this facility: _____ Length of time as DON: _____
3. Total # of Nurse Employees: _____

	1st Shift	2nd Shift	3d Shift	Turnover %
RN				
LPN/LVN				
CNA/Personal Caregiver				
Agency Staff				

4. Does the facility utilize agency staff? Yes No
   If yes, what percentage is agency staff: _____
5. Do you verify nursing license upon hire and annually thereafter? Yes No
6. Do you obtain and review nurses' certificates of malpractice insurance? Yes No
7. Do you verify nursing assistant certification upon hire and annually thereafter? Yes No

6. Do you obtain and review nurses' certificates of malpractice insurance? Yes No

7. Do you verify nursing assistant certification upon hire and annually thereafter? Yes No

G. Medical Director

1. Name of Medical Director: _____ License Number/State: _____
2. Length of time at this facility: _____ Medical Specialty: _____
3. Is the Medical Director:

   Full Time at this facility Part Time at this facility

   Employed Contracted (If contracted, please provide a copy of the contract)
4. How many hours does the Medical Director spend onsite per month? _____
5. How many residents utilize the Medical Director as their attending physician? _____
6. Do you require the Medical Director to maintain separate medical malpractice liability for their non-administrative duties? Yes No
7. Is there an evaluation of the Medical Director's performance? Yes No

   If yes, by whom? _____
8. Is a Physician on site or on call on a 24 hour basis? Yes No

H. Medical Staff

1. Number Physicians Employed On Staff: _____ Affiliated: _____ Contracted: _____
2. Do you obtain and review physicians' certificates of malpractice insurance? Yes No
3. What limits do you require physicians to maintain? _____
4. Do you have a formal Medical Staff Credentialing Program? Yes No

5. Do credentialing activities include:

   Criminal background checks
   Verification of current professional license
   DEA Certificate
   Past malpractice history

I. Human Resources/Employee Screening

1. Does the employee screening/hiring process include verification of the following:

   Educational Background
   Work History with at least two previous employers In Writing By Telephone
   Personal references In Writing By Telephone
   Criminal Background
   Drug Testing
   Abuse Registry
   Driving Record (MVR, when appropriate)
   Any pending license suspensions, revocations, or pending disciplinary actions
2. Are background checks conducted on Agency staff? Yes No
3. Are employee competencies assessed and documented? Yes No
4. Do you conduct an orientation and regularly scheduled in-servicing for all staff/employees including agency staff? Yes No
5. Are volunteers utilized? Yes No

   If yes, please describe selection process and training process: _____

5. Are volunteers utilized? Yes No

If yes, please describe selection process and training process: _____

_____

J. Risk Management

1. Who is the individual responsible for risk management (Name/Title)? _____

Contact Number: _____ Contact Email: _____

Length of time at this facility: _____

2. What other responsibilities do they have?

_____

_____

3. Does the risk management program include the following:

Incident Reporting Process
Claims Management
Resident Complaints and Grievances Process and Procedures
Contract Review and Evaluation

4. Are incidents trended and presented to the Executive Committee and Board of Directors? Yes No
5. How many formal complaints have been reported by families, residents or advocates in the last 6 months? _____
6. Is there a formal safety program? Yes No

K. Policy and Procedures

Elopement

1. How and when are residents assessed for the potential to wander or elope? _____

_____

2. What is the number of elopements in the past 12 months? _____
3. What is the number of elopements in the past 12 months that resulted in injury to resident? _____
4. What is the number of elopements in the past 12 months that resulted in death of resident? _____
5. Are Wander Guards or similar devices used as part of elopement prevention practices? Yes No

If yes, provide type: _____

6. Are Wander devices for residents inspected according to manufacturer's specifications? Yes No
7. Are buildings inspected and maintained under life safety codes? Yes No
8. What security measures are used to control unauthorized entrance/exits from facility? _____

_____

Fall Prevention

1. Do you have a Fall Prevention Program? Yes No
2. Are Nursing Assessment Protocols in place to identify residents at risk for falls? Yes No
3. Are falls monitored and tracked to identify patterns or problems? Yes No
4. Are handrails provided in halls and bathrooms? Yes No
5. Are call buttons operational in each room and bathroom? Yes No
6. Are residents accounted for at least once every 24 hours? Yes No
7. What is the current number of residents with the following:

Lap Buddies/Seat Belts or Waist Belts: _____

Geri Chairs: _____

Chest/Vest Restraints: _____

Bed Rails (any): _____

Chest/Vest Restraints: _____
Bed Rails (any): _____

Abuse

1. Are policies in place for the immediate suspension/termination of staff suspected or involved in Resident Abuse? Yes No
2. Does facility have a written procedure for reporting Resident Abuse? Yes No

   Who is responsible for the investigation? _____
3. Do you provide abuse training beyond the mandatory requirements? Yes No
4. Number of alleged abuse incidents investigated and/or reported in the 12 months year: _____

Skin Care and Pressure Ulcer Prevention

1. Are there written policy and procedures for the prevention and treatment of skin breakdown? Yes No
2. Are all residents evaluated for skin breakdown and risk of breakdown at the time of admission? Yes No
3. How often does the nursing staff perform total body skin care assessments? _____
4. Do you have a wound care team or designated individual responsible for this program? Yes No
5. What is your current resident population with facility acquired Stage III or IV Pressure Ulcers?

   _____

Additional Services

1. Do you have a specialized Alzheimer's Unit within the facility? Yes No
   If yes, is this a locked unit? Yes No
   If yes, please provide number or residents and capacity: _____
2. Do you have an in-house pharmacy? Yes No Who dispenses medications? _____
3. Are monthly reviews of drug regimens performed? Yes No
   By Whom? _____
4. Is there a system in place to identify, track and trend medication errors? Yes No

L. Independent Contractors and Services

Below please address:

1. **Which of the following medical services are performed at your facility?**
2. **Indicate Yes or No if the services provided are on a contractual basis?**
3. **If yes, indicate the required limits of liability contractors are mandated to cover:**

Services Provided		Contracted or Non Contracted Service	Limits of Liability
Physicians	● Yes ● No	● Yes ● No	
Dental	● Yes ● No	● Yes ● No	
Nursing	● Yes ● No	● Yes ● No	
Pharmaceutical	● Yes ● No	● Yes ● No	
Psychologists	● Yes ● No	● Yes ● No	
Podiatrists	● Yes ● No	● Yes ● No	
Chiropractors	● Yes ● No	● Yes ● No	
Physical Therapy	● Yes ● No	● Yes ● No	
Occupational Therapy	● Yes ● No	● Yes ● No	
Speech Therapy	● Yes ● No	● Yes ● No	
Dietary	● Yes ● No	● Yes ● No	
X-Ray	● Yes ● No	● Yes ● No	
Medical Records	● Yes ● No	● Yes ● No	
Laboratory	● Yes ● No	● Yes ● No	
Social Services	● Yes ● No	● Yes ● No	

Medical Records	● Yes ● No	● Yes ● No	
Laboratory	● Yes ● No	● Yes ● No	
Social Services	● Yes ● No	● Yes ● No	
Recreational Services	● Yes ● No	● Yes ● No	
Transportation	● Yes ● No	● Yes ● No	
Barber/Beautician	● Yes ● No	● Yes ● No	
Food	● Yes ● No	● Yes ● No	
Laundry	● Yes ● No	● Yes ● No	
Day Care	● Yes ● No	● Yes ● No	
Other	● Yes ● No	● Yes ● No	

4. Have Certificates of Insurance been obtained from Independent Contractors? Yes No
Are these reviewed annually? Yes No

M. Non-Resident Services

Please indicate the annual number of visits or clients for the following.

Home Health Care: Yes No # of Home Health Care Calls per year: _____
Home Health Care provided by Independent Contractors: Yes No
Describe Home Health Care Services Offered: _____

Day Care (total licensed #): _____ # of employees' children: _____ Hours of Operation: _____
Licensed Day Care Center: Yes No Open to the Public: Yes No
Adult Day Care (total licensed #): _____ Hours of Operation: _____
Do you provide transportation to and from your facility(ies): Yes No
Respite Care: Yes No If Yes, # annual visits: _____
Hospice Care: Yes No If Yes, # annual visits: _____

Do you provide the following services:

		# of Residents			# of Residents
AIDS	Yes No		Alcohol Abuse Rehabilitation	Yes No	
Alzheimer's/Dementia	Yes No		Behavioral Health	Yes No	
Developmentally Disabled	Yes No		Drug Rehabilitation	Yes No	
Hospice	Yes No		IV Infusion Therapy	Yes No	
Rehabilitation	Yes No		Ventilation Therapy	Yes No	

N. Other Exposures

Recreational Activities: Please check all that apply:
Swimming Pool, if checked:
Open to the Public Locked when not in use Fenced
Have a F/T Life Guard on Duty Have a Diving Board/Sliding Board

Saunas/Hot Tubs
Exercise Weight Room
Tennis/Racquetball/Handball Courts
Other bodies of water – If yes, please describe: None

_____
_____

Safety and Security

1. Is the applicant: Building Owner Tenant General Lessee

   a) Type of Construction: _____ Number of Floors: _____ Number of Elevators: _____

   b) Was the building designed and constructed for elder care occupancy? Yes No

   If No, please explain: _____

2. Are smoke detectors hard wired to central station? Yes No

3. Do alarms ring into central security desk or nurses station? Yes No

4. Are all alarm signals monitored by a UL approved Central Station or the responding Fire Department: Yes No

5. How many exits (other than front doorway) are there? _____

   Are these equipped with panic alarms? Yes No

6. Total # of fire extinguishers: _____

7. Has the fire department pre-planned emergency procedures at this location? Yes No

   If Yes, describe:

   _____

   _____

   _____

8. Are fire drills conducted regularly? Yes No

   How Often? _____ Date of Last Drill? _____

9. If multi-story building, are non-ambulatory residents on lower floors (1st/2nd)? Yes No

10. Is facility protected (100%) throughout by an automatic sprinkler system and are these systems tested by a qualified contractor with results documented? Yes No

    If not 100%, please specify which areas are not protected:

    _____

    _____

    If not tested, please explain why:

    _____

    _____

11. Is electronic surveillance used? Yes No

    If Yes, How long do you maintain the film?

    _____

    _____

12. When was the last time the written emergency management plan was reviewed? _____

    Does it address natural disasters such as fire, earthquakes, hurricanes, tornadoes, and floods? Yes No

FRAUD WARNING STATEMENTS

NOTICE TO ARKANSAS APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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NOTICE TO COLORADO APPLICANTS: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: 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.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with intent to defraud any

information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

NOTICE TO PENNSYLVANIA APPLICANTS: 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.

NOTICE TO RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO TENNESSEE APPLICANTS: 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.

NOTICE TO VIRGINIA APPLICANTS: 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.

NOTICE TO WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

NOTICE TO WEST VIRGINIA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO ALL OTHER APPLICANTS:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DECLARATION AND CERTIFICATION

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRENSENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE.

THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.

THE APPLICANT AGREES 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 MEDICAL PROFESSIONAL EXPOSURES.

Signature of Applicant	Signature of Broker/Agent
Title	Date
Date	Signed by Licensed Resident Agent (Where Required By Law)

