TOKIO MARINE HCC

Cyber & Professional Lines Group
16501 Ventura Blvd. Suite 200, Encino, CA 91436
main (818) 382-2030

Miscellaneous Medical Professional Liability and General Liability Insurance Renewal Application

THIS IS AN APPLICATION FOR A CLAIMS MADE AND REPORTED POLICY. THIS APPLICATION IS NOT A BINDER.
This application for Professional Liability and General Liability Insurance is intended to be used for the preliminary evaluation of a submission. When completed in its entirety, this application will enable the Underwriter to decide whether or not to authorize the binding of insurance. Please type or print clearly and answer all questions. If space is insufficient to answer any question fully, attach a separate sheet. Complete all required supplemental forms/applications. "You" and "Your", as used in this application, means the Applicant.

1. GENERAL INFORMATION			
Name of Applicant			
Street Address		Phone	
City, State, Zip Code		County	
Website		Contact e-mail	
No. of Locations	**If multiple names and locations, please attach a list.**		

2. FORM OF BUSINESS/OPERATIONS		
a. Applicant is a(an):	☐ Corporation ☐ Partnership ☐ Professional Association ☐ Individual ☐ For Profit ☐ Not for Profit	
b. Date established:		
c. Where is the Applicant registered and licensed to practice (number of states)?		
d. Have there been any changes to the Applicant's operations in the past 12 months? **If "YES", please attach explanation.**		☐ Yes ☐ No
e. If the Applicant is an entity:		
(1) is the entity engaged in, owned or controlled by, or associated with, any other business?		☐ Yes ☐ No
(2) is the entity owned by any physician?		☐ Yes ☐ No
(3) is the entity owned by any hospital or are any services hospital-based?		☐ Yes ☐ No
(4) have there been any changes in ownership since the date the entity was established?		☐ Yes ☐ No
If "YES" to any of the above, please provide details:		

3. REVENUES

a. Please describe the sources and amount of the Applicant's total revenue:

Source	Amount Last Policy Year	Estimated Amount This Policy Year
Charitable Contributions	$	$
Government Funding	$	$
Fee for Services	$	$
Product Sales (attach a list of products)	$	$
Other: _____	$	$
TOTAL GROSS REVENUE:	$	$

b. For PHARMACIES, please describe the sources and amounts of total revenue:

Source	Amount Last Policy Year	Estimated Amount This Policy Year
Prescription Sales	$	$
Non-Prescription Sales	$	$
Other: _____	$	$

c. Are all drugs dispensed by the Applicant approved by the Food and Drug Administration (FDA)? ☐ Yes ☐ No
If "NO", attach explanation.

4. PROFESSIONAL ACTIVITIES AND SPECIALTY (attach narrative description, if necessary)

CHECK ALL THAT APPLY:

- ☐ Acupuncturist/Naturopathic Medicine
- ☐ Alcohol/Drug/Psychiatric Rehabilitation
- ☐ Ambulance Services
- ☐ Ambulatory Surgery Center
- ☐ Diagnostic Imaging
- ☐ Dialysis Center
- ☐ Health/Fitness Center
- ☐ Home Healthcare Agency
- ☐ Hospice
- ☐ Medical Spa (Please complete Medical Spa Supplemental)
- ☐ Medical Testing/Laboratory
- ☐ Nurse Registry
- ☐ Optometry
- ☐ Out-Patient Medical Clinic
- ☐ Out-Patient Mental Health Clinic
- ☐ Pharmacy (Please complete Pharmacy Supplemental)
- ☐ Residential Facility
- ☐ Speech Therapy
- ☐ Other (Please specify): _____

5. PATIENT BREAKDOWN

State approximate division of Applicant's patients among:

a.	Alcoholics	%	**k.**	Obstetrical	%
b.	Counseling/Family Planning	%	**l.**	Pediatric	%
c.	Communicable Disease	%	**m.**	Prisoners	%
d.	Dental	%	**n.**	Psychiatric	%
e.	Drug Addicts	%	**o.**	Research or Experimental	%
f.	General	%	**p.**	Senile or Aged	%
g.	Hemodialysis	%	**q.**	Stress Testing	%
h.	Holistic Medicine	%	**r.**	Surgical	%
i.	Medical	%	**s.**	Tubercular	%
j.	Intellectually Disabled	%	**t.**	Other: _____	%

6. SERVICES PROVIDED BREAKDOWN

State approximate division of services being provided among the following settings:

a.	Assisted Living Facilities	%	**e.**	Nursing Homes	%
b.	Clinics	%	**f.**	Physician Offices	%
c.	ER/ICU/Labor, Delivery	%	**g.**	Private Homes	%
d.	Hospitals	%	**h.**	Other: _____	%

7. EMPLOYEES AND VOLUNTEERS

a. List the number of the Applicant's employees and volunteers in each profession below. If None, state "0" by the designated profession.

Number	Type of Profession	Number	Type of Profession
i) _____	Acupuncturist	xv) _____	Opticians
ii) _____	Counselor	xvi) _____	Optometrist
iii) _____	Chiropractor	xvii) _____	Paramedics
iv) _____	Dentist	xviii) _____	Perfusionist
v) _____	Dental Assistant	xix) _____	Pharmacist
vi) _____	EMT	xx) _____	Pharmacist Tech
vii) _____	Home Health Aide	xxi) _____	Physician Assistant
viii) _____	Inhalation Therapist	xxii) _____	Physician/Surgeon
ix) _____	Laboratory Technician	xxiii) _____	Physiotherapist
x) _____	Licensed Practical, Nurse	xxiv) _____	Psychologist
xi) _____	Massage Therapist	xxv) _____	Registered Nurse
xii) _____	Medical Director	xxvi) _____	Social Worker
xiii) _____	Nurse Anesthetist	xxvii) _____	Speech Therapist
xiv) _____	Nurse Practitioner	xxviii) _____	Other _____

b. List the number and type of independent contractors who provide professional services on behalf of the Applicant.
Use a separate sheet of paper, if necessary. If None, state "None" here: _____

c. Are all of the individuals listed **7.a.** and **7.b.** licensed in accordance with applicable state and federal regulations? **If "NO", attach explanation.**	☐ Yes ☐ No
d. Are all employed/contracted physicians board-certified in their specialty?	☐ Yes ☐ No
e. Do all employed/contracted physicians carry their own Medical Malpractice coverage with limits of at least $1million/$3million? **If "NO", attach explanation.**	☐ Yes ☐ No
f. Are criminal background checks conducted on all employees, volunteers and independent contractors? **If "NO", attach explanation.**	☐ Yes ☐ No
g. Does the Applicant conduct pre-employment screenings and background investigations prior to hiring all employees, volunteers and independent contractors? **If "NO", attach explanation.**	☐ Yes ☐ No
h. In the last 12 months, have you or any of the individuals listed in question **7.a.** and **7.b.**:	
(1) been the subject of a disciplinary proceeding, investigation or reprimand by a governmental or administrative agency, hospital or professional association?	☐ Yes ☐ No
(2) been convicted for a violation of any law or ordinance other than traffic offenses?	☐ Yes ☐ No
(3) been treated for alcoholism or drug addiction?	☐ Yes ☐ No
(4) had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or voluntarily surrendered any such license? **If "YES" to any of the above, attach explanation.**	☐ Yes ☐ No

i. Does the Applicant:	
(1) have a written/formalized risk management/quality assurance program?	☐ Yes ☐ No
(2) have a written credentialing process for all staff?	☐ Yes ☐ No
(3) have written procedures for reporting all incidents?	☐ Yes ☐ No
If "NO" to any of the above, attach explanation.	

r) Number of estimated patient encounters and patient tests in the next 12 months (**Note: "patient encounters" refers to number of visits; not number of patients**):

Patient encounters: _____

Patient tests: _____

8. LOSS HISTORY

a. Have any claims, lawsuits, proceedings, actions, complaints, demand letters, administrative proceedings, formal or informal governmental investigations or inquiries been made against you or any other person or entity proposed for this insurance within the last 12 months?	☐ Yes ☐ No
b. If **"YES"** to question **8.a.**, have all such claims, lawsuits, proceedings, actions, complaints, demand letters or investigations/inquiries been reported to Tokio Marine HCC?	☐ Yes ☐ No ☐ None to Report

c. If **"NO"** to question **8.b.**, please complete a Claim Supplemental Form for each claim received within the last 12 months, but not yet reported to Tokio Marine HCC.

NOTICE TO APPLICANT

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 CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

The Applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by claim expenses and, in such event, the Insurer shall not be liable for claim expenses or any judgment or settlement that exceed the limit of liability.

I HEREBY DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact, and that I agree that this application shall be the basis of the contract with the Underwriters.

CERTIFICATION AND SIGNATURE

The Applicant has read the foregoing and understands that completion of this application does not bind the Underwriter or the Broker to provide coverage. It is agreed, however, that this application is complete and correct to the best of the Applicant's knowledge and belief, and that all particulars which may have a bearing upon acceptability as a Professional Liability and General Liability Insurance risk have been revealed.

It is understood that this application shall form the basis of the contract should the Underwriter approve coverage and should the Applicant be satisfied with the Underwriter's quotation. It is further agreed that, if in the time between submission of this application and the requested date for coverage to be effective, the Applicant becomes aware of any information which would change the answers furnished in response to any question of this application, such information shall be revealed immediately in writing to the Underwriter.

This application shall be deemed attached to and form a part of the Policy should coverage be bound.

Must be signed by an officer of the company.

Print or Type Applicant's Name	Title of Applicant
Signature of Applicant	Date Signed by Applicant