GeneralStar™

DVA

NEW BUSINESS APPLICATION

MISCELLANEOUS HEALTHCARE FACILITIES PROGRAM

Wholesaler:_____ Location:_____
City State

Contact Name:_____ Phone #:_____ E-Mail :_____

NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

Instructions to the Applicant.

A. Please answer **all** the questions on this application and on applicable supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
C. The application must be signed and dated by an owner, partner, officer or director of your facility.
D. Please attach the following to your completed application:
   1. brochures, pamphlets, advertisements or other descriptive literature of operations and services,
   2. copies of any surveys conducted by outside organizations within the past three years,
   3. copy of the current practice license(s),
   4. company loss runs, valued within the last 90 days, for past 5 years, or for as long as you have been in business if less than 5 years. ***Losses should be provided on a report year basis***, and
   5. Current income statement and balance sheet.

I. GENERAL INFORMATION

Applicant's/Entity's Name:_____ Tax ID #: _____

1. Mailing Address:_____
   Street/P.O. Box City County State Zip Code
2. Business Address:_____
   Street City County State Zip Code
3. Telephone Number:_____ Web Site:_____
4. Applicant is a: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Other:_____
   Applicant is: ☐ For Profit ☐ Not for Profit
5. Years in Business:_____ Hours of Operation:_____
6. Description of Operation: (complete & attach the appropriate SUPPLEMENTAL APPLICATION)
   - ☐ Blood / Donor Bank
   - ☐ Home Health Care / Hospice Care
   - ☐ Laboratory / Imaging
   - ☐ Out-Patient Facility / Ambulatory Surgery Center
   - ☐ Air or Ground Ambulance Service
   - ☐ Durable Medical Equipment Supplier
   - ☐ Birthing Center
   - ☐ Other (describe) _____

   Please provide additional details as necessary: _____
   _____
   _____

7. List below all subsidiaries, date acquired, description of operation and percentage of ownership:

Subsidiaries	Date Acquired	Description of Operation	% of Ownership
			%
			%

8. Within the next 12 months, does the applicant plan to: (check all that apply and provide details)
   - ☐ Purchase or acquire another operation or entity?
   - ☐ Add any services?
   - ☐ Expand the number of locations?
   - ☐ Expand operation into other states?

   Details:_____

9. Has the applicant sold, discontinued or acquired any operations since the retroactive date of your current policy? If yes, please provide details:_____ ☐ Yes ☐ No

II. OPERATIONS

1. Provide applicant's total **gross** annual revenues:

   Projected $_____
   Current Year $_____
   Past Year $_____
   2nd Previous Year $_____

2. If your operation is an outpatient facility, please provide the number of outpatient visits:

   Projected #_____
   Current Year #_____
   Past Year #_____
   2nd Previous Year #_____

3. Is the applicant accredited by or a member of any professional organization or association? If yes, please name:_____ ☐ Yes ☐ No

   If accredited, please provide a copy of the accreditation report.

3. Is applicant certified for Medicare reimbursement? ☐ Yes ☐ No
4. Does the applicant maintain a current state license? If yes, please provide copy. ☐ Yes ☐ No
5. Has 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? This includes but is not limited to Medicare, Medicaid, or other reimbursement programs. If yes, please provide details:_____ ☐ Yes ☐ No
6. Are all operations provided out of the main location? If no, please attach a listing of all locations including a description of services conducted at each location. ☐ Yes ☐ No
7. Are any services provided for or at Nursing Homes, Assisted Living Facilities, or Long Term Care Facilities? If yes, please describe. _____ ☐ Yes ☐ No
8. a. Does applicant have any contractual agreements with independent contractors to provide services at applicant's facility? ☐ Yes ☐ No
   b. Does contractual agreement contain a hold harmless or indemnification clause favorable to applicant? ☐ Yes ☐ No
   c. Does applicant obtain certificates of insurance in the amount of $1m/$3m (minimum) from all Healthcare Professionals, e.g., Resident, intern, Physician, Surgeon, Dentist, Psychiatrist, Licensed or Certified Registered Nurse Anesthetist, Nurse, Midwife, Podiatrist and Chiropractor rendering professional services at the facility? ☐ Yes ☐ No
9. a. Does applicant provide services to others on a contractual agreement? If yes, please describe services provided:_____ ☐ Yes ☐ No
   b. Does the applicant agree to hold harmless or indemnify others under contract? If yes, please provide details:_____ ☐ Yes ☐ No

10. Does applicant sell or lease any medical supplies and/or equipment to others? If yes, please complete and attach the Durable Medical Equipment Supplemental Application. ☐ Yes ☐ No

11. Does applicant provide any overnight bed facilities? If yes, advise number of beds:_____ ☐ Yes ☐ No

12. Do you have written protocols and transfer agreements to transfer patients in the event of a life-threatening emergency? Please provide a copy of those documents and advise: ☐ Yes ☐ No

Name of the facility _____
Number of miles to the facility _____ Miles
Driving time to facility _____ Minutes

13. Please provide the following information for each medical director providing services at the applicant's facility:

Medical Director's Name	Specialty	Insurance Carrier & Policy Number	Limits	Employee/ Contractor	Hours per Month

Please note: Coverage for Medical Director is limited to administrative duties as described in the policy form.

14. Identify the number of other employed health care professionals providing services at the applicant's facility:

Type of Professional	# Full Time Employees	# Part Time Employees	# Full Time Contractors	# Part Time Contractors	Contractors Annual Hours
EMT					
Nurse					
Nurses Aid					
Nurse Practitioner					
Occupational Therapist					
Paramedic					
Pharmacist					
Phlebotomist					
Physical Therapist					
Physician Assistant					
Radiation Technician					
Respiratory Therapist					
Social Worker					
Speech Therapist					

III. RISK MANAGEMENT/LOSS CONTROL

1. Does applicant utilize a formal written Risk Management Program? ☐ Yes ☐ No
If yes, attach a written summary of, the Table of Contents, or copy of the written policy/procedure document.

2. Who has the overall responsibility for Risk Management & Loss Control?
Name:_____
Title:_____
Telephone Number:_____

4. Who is to be contacted for loss control survey, if different than above? ☐ Same as #2
Name:_____
Title:_____
Telephone Number:_____

4. a. Does applicant own any equipment used for diagnosis, monitoring or treatment purposes? ☐ Yes ☐ No

b. Is there a written procedure followed for the inspection and maintenance of any equipment that is owned or leased? ☐ Yes ☐ No

c. Who is responsible for inspecting and maintaining the equipment? ☐ Employees ☐ Independent Contractors

d. If Independent Contractors are utilized, are certificates of Insurance obtained? ☐ Yes ☐ No

e. Is inspection and maintenance performed according to the manufacturer's recommendations? ☐ Yes ☐ No

5. Indicate which hiring/screening procedures are used for employees and contractors: (check all that apply)
   - ☐ References checked: ☐ In writing ☐ By telephone
   - ☐ Criminal records checked
   - ☐ Require information on any professional liability or work related claim or suit
   - ☐ Verify any pending license suspensions, revocations or pending disciplinary actions by other facilities

6. Are "INFORMED CONSENT" forms used? If yes, please provide a copy. ☐ Yes ☐ No

7. Is there a written policy or procedure document describing:

a. Employee training?	☐ N/A	☐ Yes	☐ No
b. Incident Reporting?	☐ N/A	☐ Yes	☐ No
c. Medical equipment training?	☐ N/A	☐ Yes	☐ No
d. Infection Control?	☐ N/A	☐ Yes	☐ No
e. patient acceptance?	☐ N/A	☐ Yes	☐ No
f. patient evaluations?	☐ N/A	☐ Yes	☐ No
g. safety for workers in offsite locations?	☐ N/A	☐ Yes	☐ No
h. lifting requirements?	☐ N/A	☐ Yes	☐ No
i. drug administration procedures?	☐ N/A	☐ Yes	☐ No
j. food preparation?	☐ N/A	☐ Yes	☐ No
k. patient discharge procedures?	☐ N/A	☐ Yes	☐ No
l. advance directives such as a "Living Will"?	☐ N/A	☐ Yes	☐ No

8. Does applicant have written job descriptions in place for:
   a. all professionals? ☐ Yes ☐ No
   b. all clinical support staff? ☐ Yes ☐ No

IV. BUILDING INFORMATION

1. Building Construction: _____ Year Built: _____
2. Number of Stories _____
   Number of Exits per Floor _____
3. Are there smoke detectors and fire extinguishers? ☐ Yes ☐ No
4. Is building completely sprinklered? ☐ Yes ☐ No
5. Are there fire alarms? If yes, advise number _____ and type _____ ☐ Yes ☐ No
6. Fire Department is: ☐ Paid ☐ Volunteer
7. Are the electrical, heating and plumbing systems up to code and regularly inspected? ☐ Yes ☐ No

V. PRIOR POLICY AND LOSS INFORMATION

1. Please provide the following information pertaining to applicant's past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	
				☐ CM ☐ Occ	

2. Has the applicant ever had any insurance company decline, cancel, rescind or non-renew any Professional and/or General Liability Insurance Policy? If yes, please provide details: ☐ Yes ☐ No

_____

3. Is the applicant aware of any of the following:
   a. known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ Yes ☐ No
   b. knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that has not been reported to a prior insurance carrier? ☐ Yes ☐ No
   c. knowledge of any request for medical records by a patient or his/her attorney which might result in a claim? ☐ Yes ☐ No
   d. knowledge or information relating to service(s) on a Board which might result in a claim? ☐ Yes ☐ No
   e. knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact? ☐ Yes ☐ No

   If yes to any of the above, please provide details: _____

   _____

VI. COVERAGE REQUESTED

Effective Date: _____ **Retroactive Date:** _____

Important: Declarations Page of your current policy must be attached if a retroactive date is requested.

Primary Liability: Professional Liability ☐ Claims Made
General Liability ☐ Claims Made ☐ Occurrence

Important: Limits for Professional Liability and General Liability must be the same when both provided, even though they apply separately.

Limits of Liability:
- ☐ $250,000/$750,0000
- ☐ $500,000/$1,500,000
- ☐ $1,000,000/$1,000,000
- ☐ $1,000,000/$3,000,000

Deductible:
- ☐ $ 5,000 (minimum)
- ☐ $ 7,500
- ☐ $10,000
- ☐ Other $_____

Excess Limit of Liability:
- ☐ $1,000,000/$1,000,000
- ☐ $2,000,000/$2,000,000
- ☐ $3,000,000/$3,000,000
- ☐ $4,000,000/$4,000,000
- ☐ $5,000,000/$5,000,000

VII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and

2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):

   - ☐ Ambulance Service Supplemental Application
   - ☐ Durable Medical Equipment Supplemental Application
   - ☐ Out-Patient / Ambulatory Surgery Center Supplementa Application
   - ☐ Laboratory & Imaging Supplemental Application
   - ☐ Blood / Donor Banks Supplemental Application
   - ☐ Home Health Care and Hospice Care Supplemental Application
   - ☐ Birthing Center Supplemental Application
   - ☐ Claim Information Supplemental Application
   - ☐ Other _____

3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:

   a. Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
   b. Representations you are making on behalf of all persons and entities proposed to be insured;
   c. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.

4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy, and incorporated into the policy, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy, and regardless of whether any of the Supplemental Applications are signed or dated.

5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or in any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

NEW YORK FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING (not applicable in Nebraska, Vermont or Virginia): Any person who knowingly and with the 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where General Star National Insurance Company is "non-admitted or "surplus lines"), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

An authorized representative who is an active owner, officer, or partner of your organization must sign this Application within thirty (30) days prior to the policy inception date.

_____ _____

Signature of Owner, Officer or Partner Date

_____

Print or Type Name and Title

ADDITIONAL INFORMATION FORM

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

QUESTION #	COMMENTS
	SIGNATURE: DATE: