GeneralStar™

DVA

SUPPLEMENTAL APPLICATION
FOR PROFESSIONAL LIABILITY INSURANCE
PHYSICIANS AND SURGEONS
CLAIMS-MADE COVERAGE
URGENT CARE CENTER

This supplemental application should be completed for your Urgent Care Center practice only, unless otherwise indicated.

Instructions to the Applicant.

A. Please answer **all** the questions on this 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. This supplemental application must be signed and dated by you.
D. A General Application must accompany this supplemental application.

I. GENERAL INFORMATION

1. Applicant's Name: Social Security No.

2. Urgent Care Facility: *(If more than one location, list on additional sheet)*

Number of years practicing at this location:	Fed Tax ID:	
Street Address: City:	County:	State: Zip:

3. Provide a list of all owners including their percentage of ownership:

Name	% Ownership
	%
	%
	%

Must total 100%

II. URGENT CARE FACILITY OPERATIONS

1. Hours of operation: _____
   How many shifts are maintained? _____

2. Number of Weekly Visits: _____

3. Please state sources and amounts of annual revenues:

	Current	Projected
Medicare/Medicaid		
Fee for Service		
HMO/PPO/POS		
Other		

III. STAFF

1. Please provide the following information on any physicians providing professional services at your facility:

Physician Name	Specialty	Employee or Contractor?	# Hours/ Week	Current Insurance Carrier*	Policy Effective Dates	Limits of Liability

* Please provide evidence of insurance.

2. 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
Medical Assistant					
Nurse					
Nurses Aid					
Nurse Practitioner					
Occupational Therapist					
Phlebotomist					
Physical Therapist					
Physician Assistant					
Radiation Technician					
Respiratory Therapist					
Other _____					

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

IV. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

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.

_____	_____	_____
Signature of Applicant	Print or Type Name	Date (month-day-year)