**Virginia Surplus Lines Warning Statement**

VIRGINIA FORM SLB-9 DATE

Applicant/Insured

Name of Non-Admitted Insurer (If available)

Policy No.

NOTICE TO INSURED

This policy is being procured from or has been placed with an insurer approved by the Commission of Insurance for issuance of surplus lines insurance in this Commonwealth, but not licensed or regulated by the Commission. Additionally, there is no protection under the Virginia Property and Casualty Insurance Guaranty Association, established under Chapter 16 (§ 38.2-1600 et seq.) of this title, against financial loss to claimants or policyholders because of the insolvency of this unlicensed insurer issuing this policy.

(Surplus Lines Broker Name)

(Address)

(License Number)

VIRGINIA FORM SL33-9 (9/96)

**Issuing Company:**

**National Fire & Marine Insurance Company**

**Omaha, Nebraska**

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| **BLOOD/ORGAN/TISSUE BANK LABORATORY LIABILITY APPLICATION** |

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| **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.

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| 1. **PRODUCER INFORMATION**
 |

**A. FIRM INFORMATION**

FIRM NAME INDIVIDUAL NAME

 MAILING ADDRESS PHONE

 CITY/STATE/ZIP E-MAIL

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| 1. **APPLICANT INFORMATION**
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**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.

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| 1. **COVERAGES, LIMITS AND DEDUCTIBLES**
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| **COVERAGE (\*)** | **REQUESTED LIMITS** | **POLICY TYPE** | **DEDUCTIBLE****(PRIMARY COVERAGE)** |
| [ ]  **PROFESSIONAL LIABILITY FACILITY** |  | [ ]  OCCURRENCE[ ]  CLAIMS-MADERETRO-DATE:       |  |
| [ ]  **GENERAL LIABILITY FACILITY** |  | [ ]  OCCURRENCE[ ]  CLAIMS-MADERETRO-DATE:       |  |
| [ ]  **EXCESS - PROFESSIONAL LIABILITY FACILITY** |  | [ ]  OCCURRENCE[ ]  CLAIMS-MADERETRO-DATE:       |  |
| [ ]  **EXCESS - GENERAL LIABILITY FACILITY** |  | [ ]  OCCURRENCE[ ]  CLAIMS-MADERETRO-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 BLOOD/ORGAN/TISSUE BANK LABORATORY SUPPLEMENTAL APPLICATION, OR ATTACH A COPY OF THE APPLICANT’S ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED.**

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| 1. **GENERAL INFORMATION**
 |

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

[ ]  PROFESSIONAL CORPORATION [ ]  LIMITED LIABILITY CORPORATION (LLC)

 [ ]  PARTNERSHIP OR PROFESSIONAL ASSOCIATION [ ]  JOINT VENTURE

 [ ]  FOR PROFIT [ ]  OTHER (PLEASE EXPLAIN):

 [ ]  NON PROFIT

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

 [ ]  PHYSICIAN OWNED [ ]  INDEPENDENTLY OWNED (PLEASE EXPLAIN):

 [ ]  HOSPITAL OWNED [ ]  OTHER (PLEASE EXPLAIN):

**C. HOW MANY LOCATIONS DOES THE FACILITY HAVE?**

PLEASE LIST ALL 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 SPECIMENS AT THIS LOCATION

 **LOCATION #2:**

 STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED       ESTIMATE NUMBER OF SPECIMENS AT THIS LOCATION

 **LOCATION #3:**

 STE STREET CITY STATE ZIP

DATE THIS LOCATION OPENED       ESTIMATE NUMBER OF SPECIMENS AT THIS LOCATION

**D. 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:

**E. LICENSES HELD BY THE FACILITY:**

**F. CERTIFICATIONS/ACCREDITATIONS HELD BY THE FACILITY:**

[ ]  CLIA [ ]  AABB [ ]  AATB [ ]  OTHER:

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

**G. ARE ALL LOCATIONS ACCREDITED BY AT LEAST ONE OF THE ORGANIZATIONS LISTED IN QUESTION F., ABOVE?** [ ]  YES [ ]  NO

IF NO, PLEASE EXPLAIN:

**H. HOW OFTEN IS THE MEDICAL DIRECTOR ON-SITE AT THE FACILITY?**

**I. MEDICAL DIRECTOR:**

NAME OF MEDICAL DIRECTOR

     -     -

 PHONE NUMBER EMAIL

**J. ANNUAL PAYROLL:**

TOTAL ANNUAL PAYROLL:$

**K. TOTAL PROJECTED ANNUAL REVENUE:** $       **PRIOR YEAR REVENUE:** $

|  |
| --- |
| 1. **LABORATORY OPERATIONS**
 |

1. **IS THE APPLICANT OPERATING AS A:**

 [ ]  BLOOD BANK

 [ ]  ORGAN BANK

 [ ]  TISSUE BANK

 [ ]  FERTILITY CLINIC

 [ ]  RESEARCH FACILITY

 [ ]  OTHER (PLEASE DESCRIBE):

|  |
| --- |
| **V. LABORATORY OPERATIONS (CONTINUED)** |

**B.**

|  |  |  |  |
| --- | --- | --- | --- |
| **BLOOD AND BLOOD RELATED EXPOSURES** | **UPCOMING YEAR PROJECTED ANNUAL DONATIONS** | **CURRENT YEAR ANNUAL DONATIONS** | **LAST PRIOR YEAR ANNUAL DONATIONS** |
| PAID BLOOD DONATIONS |       |       |       |
| VOLUNTEER BLOOD DONATIONS |       |       |       |
| AUTOLOGOUS BLOOD DONATIONS |       |       |       |
| FOREIGN (NON-US) DONATIONS PURCHASED |       |       |       |
| PHERESIS PROCEDURES |       |       |       |
| OUTPATIENT TRANSFUSIONS |       |       |       |
| THERAPEUTIC PLASMA EXCHANGE |       |       |       |
| STEM CELL HARVESTING |       |       |       |
| OTHER (PLEASE DESCRIBE): |       |       |       |
|       |       |       |       |

**C.**

|  |  |  |  |
| --- | --- | --- | --- |
| **OTHER BANKING AND HARVESTING** | **UPCOMING YEAR PROJECTED ANNUAL RECEIPTS** | **CURRENT YEAR ANNUAL RECEIPTS** | **LAST PRIOR YEAR ANNUAL RECEIPTS** |
| ORGAN BANKING – DIRECT PROCESSING |       |       |       |
| ORGAN BANKING – NO DIRECT PROCESSING |       |       |       |
| TISSUE BANKING |       |       |       |
| SPERM BANKING |       |       |       |
| EGG BANKING |       |       |       |
| OTHER (PLEASE DESCRIBE): |       |       |       |
|       |       |       |       |

**D. IS THE MEDICAL HISTORY OF EACH ORGAN/TISSUE DONOR REVIEWED BY A PHYSICIAN?** [ ]  YES [ ]  NO

 IF NO, PLEASE EXPLAIN:

**E. IS THERE A WRITTEN INFORMED CONSENT PROCESS IN PLACE?** [ ]  YES [ ]  NO

**F. IS THERE A WRITTEN POLICY/PROCEDURE IN PLACE TO ADDRESS:** (CHECK ALL THAT APPLY)

[ ]  IDENTIFICATION OF SPECIMENS [ ]  DOCUMENTATION OF ALL SPECIMENS

 [ ]  HANDLING OF SPECIMENS [ ]  CHAIN OF CUSTODY FROM THE DONOR TO THE RECIPIENT

IS AN AUDIT PERFORMED ON A REGULAR BASIS TO ENSURE THAT THESE WRITTEN POLICIES/PROCEDURES ARE FOLLOWED?[ ]  YES [ ]  NO

 IF YES, PLEASE ELABORATE ON THE PROCESS:

**G. DO STORAGE FACILITIES HAVE SYSTEMS AND PLANS FOR SAFE STORAGE DURING NATURAL DISASTERS**

 **AND POWER OUTAGES?** [ ]  YES [ ]  NO

 IF YES, DOES THIS SYSTEM INCLUDE A BACKUP GENERATOR? [ ]  YES [ ]  NO

**H. IN THE APPLICANT’S FACILITY:**

1. DO ALL SPECIMENS GO THROUGH DISINFECTION OR STERILIZATION AS PART OF THE PRODUCT PREPARATION? [ ]  YES [ ]  NO
2. ARE SPECIMENS STORED IN THE APPROPRIATE MANNER ACCORDING TO THE FDA GUIDELINES? [ ]  YES [ ]  NO
3. IS STERILITY/FREEDOM FROM CONTAMINATION MAINTAINED AND AUDITED THROUGHOUT THE CUSTODY CHAIN? [ ]  YES [ ]  NO

**I. DOES THE FACILITY PROVIDE TESTING FOR OTHER DONOR FACILITIES?** [ ]  YES [ ]  NO

 PLEASE LIST THE OTHER FACILITIES AND THEIR LOCATIONS (CITY/STATE):

 IS THE OTHER FACILITY REQUIRED TO CARRY PROFESSIONAL LIMITS EQUAL TO THE APPLICANT’S LIMITS? [ ]  YES [ ]  NO

**J. WHAT PERCENTAGE OF THE APPLICANT’S BLOOD IS TESTED BY ANOTHER FACILITY?**       %

 PLEASE LIST THE OTHER FACILITIES AND THEIR LOCATIONS (CITY/STATE):

**K. DOES THE APPLICANT HAVE:**

1. AN ELECTRONIC TRACKING SYSTEM FOR ALL SPECIMENS THAT ARE PROCESSED? [ ]  YES [ ]  NO

 2. A MEDICAL REVIEW OFFICER? [ ]  YES [ ]  NO

 3. A WRITTEN SAFETY MANUAL USED BY ALL EMPLOYEES? [ ]  YES [ ]  NO

 4. REGULARLY-SCHEDULED MAINTENANCE AND CALIBRATION OF ALL EQUIPMENT? [ ]  YES [ ]  NO

 5. A WRITTEN COMPLIANCE MANUAL DETAILING THE APPROPRIATE CLEANING AND HANDLING OF ALL SPECIMENS? [ ]  YES [ ]  NO

**L. DO ALL EMPLOYEES PARTICIPATE AT THE TIME OF HIRE AND IN REGULARLY-SCHEDULED TRAINING REGARDING**

 **SAFETY AND OPERATIONAL PROCEDURES?** [ ]  YES [ ]  NO

 IF NO, PLEASE EXPLAIN:

|  |
| --- |
| **V. LABORATORY OPERATIONS (CONTINUED)** |

**M. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS?** [ ]  YES [ ]  NO

 IF YES, PLEASE DESCRIBE:

**N. DOES THE APPLICANT HAVE A LABORATORY SOFTWARE SYSTEM THAT IS CAPABLE OF INTERFACING WITH THE**

 **LOCAL HOSPITAL(S) AND/OR OTHER LABS AND PROVIDERS?** [ ]  YES [ ]  NO

 IF NO, PLEASE EXPLAIN:

 IF YES, IS THIS SYSTEM “AUDITABLE?” [ ]  YES [ ]  NO

 IF NO, PLEASE EXPLAIN:

**O. DOES THE FACILITY CONTRACT WITH COURIERS TO PICK UP SPECIMENS OR DO STAFF TRANSPORT SPECIMENS**

 **IN FACILITY-OWNED VEHICLES?** [ ]  YES [ ]  NO

IF YES, DOES THE APPLICANT PERFORM QUALITY AUDITS ON AN ANNUAL BASIS OR HAVE A CONTRACT OF QUALITY STANDARDS? [ ]  YES [ ]  NO

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| 1. **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).**

**IMPORTANT NOTE: IF COVERAGE IS REQUESTED FOR PHYSICIANS, PLEASE SO STATE ON SECTION III (SCHEDULE OF MEDICAL PROFESSIONALS) OF THE BLOOD/ORGAN/TISSUE BANK LABORATORY FACILITIES 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** |
|       |       |       |       |       |
|       |       |       |       |       |
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|       |       |       |       |       |

**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:**

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

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| --- | --- | --- | --- |
| **ALLIED PROFESSIONALS EXCEPT PHYSICIANS** | **# EMPLOYED** | **# VOLUNTEERS** | **# CONTRACTED** |
| CLINICAL BIOLOGIST |       |       |       |
| PATHOLOGIST ASSISTANT |       |       |       |
| MICROBIOLOGIST ASSISTANT |       |       |       |
| MEDICAL BIOCHEMIST ASSISTANT |       |       |       |
| LABORATORY MANAGER |       |       |       |
| DEPARTMENT SUPERVISOR |       |       |       |
| CHIEF TECHNOLOGIST (LEAD TECHNOLOGIST) |       |       |       |
| CYTOTECHNOLOGIST |       |       |       |
| MEDICAL TECHNOLOGIST |       |       |       |
| HISTOTECHNOLOGIST |       |       |       |
| MEDICAL TECHNOLOGIST |       |       |       |
| HISTOTECHNOLOGIST |       |       |       |
| MEDICAL LABORATORY TECHNICIAN |       |       |       |
| PHLEBOTOMIST |       |       |       |
| TRANSCRIPTIONIST |       |       |       |
| MEDICAL LABORATORY ASSISTANT |       |       |       |
| SPECIMEN PROCESSOR (SECRETARY) |       |       |       |
| OTHER (PLEASE SPECIFY): |       |       |       |
|       |       |       |       |
|       |       |       |       |

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| **VI. MEDICAL STAFF (CONTINUED)** |

**D. DOES THE APPLICANT SUPERVISE ANYONE OTHER THAN ITS OWN EMPLOYEES?** [ ]  YES [ ]  NO

 IF YES, DESCRIBE THE RESPONSIBILITY OF BOTH THE SUPERVISORY AND SUPERVISED INDIVIDUALS, AND THE RELATIONSHIPS BETWEEN THE

 INDIVIDUALS:

ALSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL, THE NUMBER OF INDIVIDUALS THE FACILITY SUPERVISES:

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| 1. **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 ON-GOING TRAINING FOR COMPLIANCE, SAFETY AND EQUIPMENT USAGE?** [ ]  YES [ ]  NO

**D. IS THERE A FORMALIZED INFECTION CONTROL PLAN, PARTICULARLY FOR THE CLEANING OF EQUIPMENT?** [ ]  YES [ ]  NO

**E. ARE STAFF TRAINED AND TESTED ON EMERGENCY PROCEDURES ON A REGULAR BASIS AND ARE DIRECTIONS**

 **FOR SUMMONING HELP AND/OR TRANSFER CLEARLY POSTED?** [ ]  YES [ ]  NO

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

 NAME TITLE

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

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| 1. **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

 4. CHECK FOR PENDING LICENSE SUSPENSIONS, REVOCATIONS, OR DISCIPLINARY ACTIONS BY OTHER FACILITIES? [ ]  YES [ ]  NO

 5. CHECK CRIMINAL HISTORY? [ ]  YES [ ]  NO

 6. 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. HAS AN 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 ANY**

 **REIMBURSEMENT PROGRAMS.** [ ]  YES [ ]  NO

IF YES, PLEASE EXPLAIN:

**E. 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

**F. 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

**G. HAS THE LICENSE OF ANY PHYSICIAN, PODIATRIST, OR DENTIST PROVIDING SERVICES AT THE CENTER BEEN**

 **RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS?** [ ]  YES [ ]  NO

IF YES, PLEASE EXPLAIN:

**H. HAS THE APPLICANT MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK OF ANY PEER REVIEW ACTION,**

 **SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF**

 **DURING THE LAST FIVE YEARS?** [ ]  YES [ ]  NO

IF YES, PLEASE EXPLAIN:

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| 1. **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:

|  |
| --- |
| 1. **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

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| --- |
| 1. **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 |  |  |  |  |  |

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| --- |
| 1. **LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)**
 |

**FOR EACH CLAIM, POTENTIAL CLAIM OR SUIT MENTIONED BELOW, PLEASE COMPLETE SECTION I (LOSS HISTORY) OF THE BLOOD/ORGAN/TISSUE BANK LABORATORY 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

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| 1. **ATTACHMENTS**
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**A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION. IF NOT AVAILABLE, PLEASE EXPLAIN.**

**A. A COPY OF THE APPLICANT’S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.**

**B. FINANCIAL INFORMATION.** THE MOST RECENT THREE (3) YEARS OF FINANCIAL STATEMENTS INCLUDING THE AUDITOR’S OPINION, IF APPLICABLE.

**C. MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.**

**D. COPY OF THE APPLICANT’S LETTERHEAD.**

**E. LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.**

**F. 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.

**G.** **ANNUAL REPORT** (IF ONE IS PUBLISHED).

**H.** ALL CURRENT **ADVERTISING MATERIALS.**

**I.** ORGANIZATIONAL CHART INCLUDING THE **NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.**

**J. COPY OF THE APPLICANT’S CURRENT INSURANCE POLICY.**

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| 1. **IMPORTANT NOTICE**
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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.

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| 1. **FRAUD NOTICE**
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**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.

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| 1. **STATE SPECIFIC NOTICES**
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**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.”

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| **XVI. STATE SPECIFIC NOTICES (CONTINUED)** |

**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.**

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| 1. **PLEASE READ AND SIGN**
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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.

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

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| 1. **SUPPLEMENTAL INFORMATION**
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