POLICY NUMBER _____

COMPANY USE ONLY

THE MEDICAL PROTECTIVE COMPANY

DIALYSIS CENTER LIABILITY APPLICATION

This coverage may be limited to claims first made and reported to the Company during the policy period as stated in the Declarations or any applicable Extended Reporting Period.

I. ORGANIZATION INFORMATION

PLEASE PRINT LEGIBLY. IF THE APPLICATION IS APPROVED, THE POLICY WILL BE BASED ON THE INFORMATION PROVIDED. PLEASE ANSWER ALL QUESTIONS. IF A QUESTION IS NOT APPLICABLE, STATE "N/A". IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SUPPLEMENTAL FORM.

A.

_____
BROKERAGE FIRM/AGENCY NAME

_____
CITY, STATE, AND ZIP CODE

_____
BROKER/AGENT NAME

_____ - _____ - _____ _____ - _____ - _____ _____

PHONE **FAX** **E-MAIL**

B. CONTACT INFORMATION

_____
APPLICANT NAME (LEGAL CORPORATION NAME)

_____ _____
MAILING ADDRESS **COUNTY**

_____
STREET ADDRESS (IF DIFFERENT)

_____ _____
CONTACT PERSON NAME **TITLE**

_____ - _____ - _____ _____ - _____ - _____ _____ - _____ - _____

BUSINESS PHONE **BUSINESS FAX** **RESIDENCE PHONE**

_____
WEBSITE ADDRESS

C. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM): _____

This date cannot be earlier than the expiration date of your current policy.

D. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM): _____

Annual policy terms will begin and end on the same month and day.

II. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	POLICY TYPE	DEDUCTIBLE (PRIMARY COVERAGE)
☐ PROFESSIONAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ GENERAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ EXCESS - PROFESSIONAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	
☐ EXCESS - GENERAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	

If you are requesting shared limit or separate limit coverage for employed or contracted Physicians, Surgeons, Residents, Interns, Fellows, Dentists, Oral Surgeons, CRNAs, Nurse Midwives, CRNPs, Podiatrists, Physician Assistants Or Surgical Assistants, please complete Section III (Coverages, Limits And Deductibles Schedule) of the Dialysis Center Supplemental Application.

(*) IF YOU HAVE ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.), PLEASE COMPLETE SECTION II (SCHEDULE OF RELATED ENTITIES) OF THE DIALYSIS CENTER SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF YOUR ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED.

III. GENERAL INFORMATION

A. TYPE OF LEGAL ENTITY (Please put an "X" in the applicable spaces):

- ☐ Professional Corporation
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Corporation (LLC)
- ☐ Other (Please Explain): _____

B. ENTITY OWNERSHIP (Please put an "X" in the applicable spaces):

- ☐ Physician Owned
- ☐ Hospital Owned
- ☐ Independently Owned
- ☐ Other (Please Explain): _____

C. TAX STATUS (Please put an "X" in the applicable spaces):

- ☐ For Profit
- ☐ Not For Profit
- ☐ Other (Please Explain): _____

D. LICENSES HELD BY YOUR FACILITY: _____

E. CERTIFICATIONS/ACCREDITATIONS HELD BY YOUR FACILITY:

☐ CMS ☐ JCAHO ☐ AAAHC ☐ IMQ ☐ OTHER: _____

PLEASE PROVIDE A COPY OF YOUR CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

F. HOW MANY DIALYSIS CENTER LOCATIONS DO YOU HAVE? _____

1. IF YOU HAVE MULTIPLE LOCATIONS, ARE ALL LOCATIONS ACCREDITED? ☐ YES ☐ NO

   IF NO, PLEASE PROVIDE DETAILS: _____

G. DO YOU PLAN TO ADD ANY LOCATIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

_____

H. ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

I. MEDICAL DIRECTOR:

_____
NAME OF MEDICAL DIRECTOR

_____ - _____ - _____ _____
PHONE NUMBER **EMAIL**

J. ANNUAL PAYROLL

TOTAL ANNUAL PAYROLL: _____ TOTAL PROJECTED ANNUAL RECEIPTS: _____

IV. DIALYSIS CENTER OPERATIONS

A. INDICATE THE TYPE OF SERVICES PROVIDED:

UTILIZATION	CURRENT (LAST 12 MONTHS)	PROJECTED (NEXT 12 MONTHS)
HEMODIALYSIS TREATMENTS		
PERITONEAL DIALYSIS TREATMENTS (HOME CARE)		
DIALYSIS STATIONS		
OTHER (DESCRIBE):		

IV. DIALYSIS CENTER OPERATIONS (CONTINUED)

B. ARE ANY CHANGES PLANNED TO SERVICES YOU OFFER IN THE NEXT 12 MONTHS? ☐ YES ☐ NO

(i.e. ARE YOU ADDING OR DISCONTINUING ANY SERVICES?)

IF YES, PLEASE DESCRIBE: _____

_____

C. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

_____

D. PATIENT BASE (TOTAL SHOULD EQUAL 100%)

_____ ADULT PATIENT BASE _____ PEDIATRIC PATIENT BASE

% OF PRACTICE % OF PRACTICE

E. IF PROVIDING PERITONEAL DIALYSIS TO HOME CARE PATIENTS:

1. HOW ARE HOME CARE PATIENTS DIRECTED IN AN EMERGENCY? _____

_____

2. WHAT IS THE PROCEDURE FOR THESE PATIENTS TO REPORT PROBLEMS OR SEEK DIRECTION? _____

_____

F. IN RELATION TO YOUR EQUIPMENT:

1. DO YOU ADHERE TO THE ADVANCEMENT OF MEDICAL INSTRUMENTATION PROTOCOLS? ☐ YES ☐ NO
2. DO YOU REUSE OR REPROCESS DIALYZERS? ☐ YES ☐ NO
3. DO YOU SUSTAIN OPERATION LOGS FOR:
   a. WATER TREATMENT? ☐ YES ☐ NO
   b. CIRCULATION AND DELIVERY SYSTEMS? ☐ YES ☐ NO
   c. REPROCESSING? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

_____

G. PLEASE PROVIDE THE APPLICABLE MEDICARE QUALITY MEASURES ASSOCIATED WITH YOUR FACILITY:

1. ANEMIA PERCENTAGE - MEASURE OF PATIENT ANEMIA MANAGEMENT.

   HEMATOCRIT OF 33 OR GREATER? ☐ YES ☐ NO

   IF NO, PLEASE EXPLAIN: _____

   _____

2. HEMODIALYSIS ADEQUACY - MEASURE OF ADEQUATE WASTE REMOVAL FROM PATIENT'S BLOOD DURING DIALYSIS TREATMENTS.

   UREA REDUCTION RATIO (URR) OF 65 OR GREATER? ☐ YES ☐ NO

   IF NO, PLEASE EXPLAIN: _____

   _____

3. PATIENT/FACILITY SURVIVAL RATE:

   ☐ BETTER THAN EXPECTED (BY 20% OR MORE) ☐ AS EXPECTED ☐ WORSE THAN EXPECTED (BY 20% OR MORE)

   IF WORSE THAN EXPECTED, PLEASE EXPLAIN: _____

H. DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY, PHARMACY ETC.)? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: _____

_____

I. HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE.

IV. DIALYSIS CENTER OPERATIONS (CONTINUED)

J. DO YOU HAVE THE FOLLOWING EQUIPMENT ON THE CAMPUS OR AT YOUR FACILITY:

1. CRASH CART WITH FULL CARDIAC LIFE SUPPORT CAPABILITIES AND NECESSARY IV FLUIDS? ☐ YES ☐ NO
2. DEFIBRILLATOR? ☐ YES ☐ NO
3. EKG? ☐ YES ☐ NO
4. OXYGEN? ☐ YES ☐ NO

K. WHAT PROVISIONS HAVE BEEN MADE FOR EMERGENCY CARE/TRANSFER PROTOCOL? PLEASE DESCRIBE: _____

_____

L. HOSPITAL PROVIDING EMERGENCY CARE:

_____
NAME

_____
ADDRESS

M. DO YOU HAVE WRITTEN POLICY AND PROCEDURES THAT ADDRESS:

1. FORMALIZED INFECTION CONTROL (TO INCLUDE WATER MONITORING PROCESS)? ☐ YES ☐ NO
2. DIALYZER PROTOCOLS (INCLUDING CLEANING, REUSE, RIGHT PATIENT/RIGHT DIALYZER)? ☐ YES ☐ NO
3. EMERGENCY TRANSFER PROTOCOLS? ☐ YES ☐ NO
4. WRITTEN AGREEMENT WITH A HOSPITAL TO PROVIDE EMERGENT HIGHER LEVEL OF CARE? ☐ YES ☐ NO
5. PROCESS FOR CLEANING, DISINFECTING AND STERILIZING THE EQUIPMENT AND INSTRUMENTS? ☐ YES ☐ NO
6. PERIODIC TRAINING AND IN-SERVICE EDUCATION? ☐ YES ☐ NO

V. MEDICAL STAFF

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN THAT PRACTICES AT YOUR FACILITY.

(If more room is needed, please attach a separate roster of Medical Staff)

IMPORTANT NOTE: IF COVERAGE IS DESIRED FOR PHYSICIANS, PLEASE INDICATE THAT ON SECTION III (COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE) AND SECTION IV (THE SCHEDULE OF MEDICAL PROFESSIONALS) OF THE DIALYSIS CENTER SUPPLEMENTAL APPLICATION. ALSO COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR EACH PHYSICIAN.

PHYSICIAN'S NAME AFTER EACH NAME, INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)	**PRIMARY LICENSE NUMBER**	**INDICATE PRIMARY SPECIALTY**	**INDICATE THE NUMBER OF HOURS PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT YOUR FACILITY**

B. ARE EACH OF THE PHYSICIANS PRACTICING AT YOUR FACILITY BOARD CERTIFIED? ☐ YES ☐ NO

IF NO, HOW MANY ARE NOT BOARD CERTIFIED? _____

C. DO YOU HAVE ANY PHYSICIANS ON STAFF THAT DO NOT MAINTAIN STAFF PRIVILEGES AT A HOSPITAL? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

D. PLEASE INDICATE THE NUMBER OF HEALTH PROFESSIONALS, OTHER THAN PHYSICIANS, WHO

WORK AT YOUR FACILITY: _____

V. MEDICAL STAFF (CONTINUED)

<u>IMPORTANT NOTE</u>: IF COVERAGE IS DESIRED FOR HEALTH PROFESSIONALS, OTHER THAN PHYSICIANS, PLEASE INDICATE THAT ON SECTION III (COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE) AND SECTION V (THE SCHEDULE OF MEDICAL PROFESSIONALS) OF THE DIALYSIS CENTER SUPPLEMENTAL APPLICATION. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED.

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED
NURSE PRACTITIONERS			
PHYSICIAN ASSISTANTS			
LPN'S/RN'S			
MEDICAL TECHNICIANS			
DIALYSIS TECHNICIANS			
BIOMEDICAL TECHNICIANS			
DIETICIANS			
SOCIAL WORKERS			
OTHERS (DESCRIBE)			

E. DO YOU SUPERVISE ANYONE OTHER THAN YOUR OWN EMPLOYEES? ☐ YES ☐ NO

IF YES, DESCRIBE THE RESPONSIBILITY OF THE INDIVIDUALS AND WHAT YOUR RELATIONSHIPS ARE TO THESE INDIVIDUALS:

_____

ALSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL, THE NUMBER OF INDIVIDUALS YOU SUPERVISE:

_____

VI. RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT PROGRAM? ☐ YES ☐ NO

B. IS THERE A FULL-TIME RISK MANAGER? ☐ YES ☐ NO

IF NO, WHAT ARE THEIR OTHER RESPONSIBILITIES AND HOW MUCH TIME IS DEVOTED TO RISK MANAGEMENT?

_____

C. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR RISK MANAGEMENT:

_____ _____

NAME TITLE

D. IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS? ☐ YES ☐ NO

E. IS THERE A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ YES ☐ NO

1. IF YES, DOES THIS PROCEDURE REQUIRE REVIEW AND APPROPRIATE CORRECTIVE ACTION BE TAKEN? ☐ YES ☐ NO
2. IS FOLLOW-UP MADE TO ASSURE COMPLIANCE? ☐ YES ☐ NO

F. IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE? ☐ YES ☐ NO

1. IF YES, IS THE PERSON RESPONSIBLE FOR RISK MANAGEMENT A MEMBER OF THIS COMMITTEE? ☐ YES ☐ NO
2. TO WHOM IS THE QUALITY ASSURANCE COMMITTEE ACCOUNTABLE?

_____ _____

NAME TITLE

3. WHAT QUALITY INDICATORS ARE MONITORED (PLEASE LIST)? _____

_____

4. DO YOU MONITOR INFECTION RATES AT YOUR FACILITIES? ☐ YES ☐ NO

G. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS WHICH IS PART OF THE QUALITY MGMT. PROGRAM? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

_____

H. IS THERE AN ON-GOING CONTINUING EDUCATION PROGRAM FOR: NURSING STAFF? ☐ YES ☐ NO

OTHER ALLIED HEALTH PROFESSIONALS? ☐ YES ☐ NO

I. NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:

_____ _____

NAME TITLE

VII. CREDENTIALING

A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF DO YOU:

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 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. DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN, PODIATRIST AND DENTIST WORKING AT YOUR 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

E. WHAT ARE THE MINIMUM LIMITS OF LIABILITY YOU REQUIRE NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT YOUR FACILITY TO CARRY? $ _____ / $ _____

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

F. HAS THE LICENSE OF ANY PHYSICIAN, PODIATRIST OR DENTIST BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

G. HAVE YOU 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 5 YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

_____

VIII. PHYSICAL PLANT

A. PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY YOU. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE, PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.

ADDRESS OF PROPERTY TO BE INSURED	USE/OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	FIRE PROTECTION*
PATIENT CARE BUILDINGS:						
OTHER BUILDINGS:						

*FOR EACH BUILDING INDICATE IF THERE IS A: SPRINKLER SYSTEM - FULL, PARTIAL OR NO SPRINKLER SYSTEM
SMOKE DETECTOR, HEAT DETECTOR
FIRE ALARM - CENTRAL STATION OR LOCAL ALARM

B. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

IX. GENERAL LIABILITY

DO YOU DESIRE GENERAL LIABILITY COVERAGE? ☐ YES ☐ NO
If yes, complete this section. If no, skip to Section X.

A. IS THERE A PREVENTIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR THE BIO-MEDICAL SURGICAL MACHINES OR DEVICES AT THE FACILITY? ☐ YES ☐ NO

1. HOW OFTEN ARE NON-EXPENDABLE MEDICAL OR SURGICAL MACHINES OR DEVICES INSPECTED AND MAINTAINED?

_____

2. WHO PERFORMS THE MAINTENANCE ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS
3. IF INDEPENDENT CONTRACTORS, WHAT ARE THE MINIMUM GENERAL LIABILITY LIMITS THAT YOU REQUIRE THEM TO CARRY?

$ _____ / $ _____

4. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

IX. GENERAL LIABILITY (CONTINUED)

B. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE PREVENTIVE MAINTENANCE, INSPECTION AND REPAIR OF THE EQUIPMENT?

_____

C. DO YOU LEND OR DONATE YOUR BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE? ☐ YES ☐ NO

IF YES, DESCRIBE: _____

_____

D. DO YOU RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? _____

_____

E. DO YOU USE AN ADVERTISING AGENCY? ☐ YES ☐ NO

1. IF YES, WHAT IS THE MINIMUM PROFESSIONAL LIABILITY LIMIT THAT YOU REQUIRE THEM TO CARRY?

   $ _____ / $ _____

2. ARE YOU INCLUDED AS AN ADDITIONAL INSURED ON THE ADVERTISING AGENCY'S POLICY? ☐ YES ☐ NO
3. IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF YOUR FACILITY? ☐ YES ☐ NO

F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE CHANGES PLANNED INCLUDING THE TIME FRAME AND THE ESTIMATED COST: _____

_____

G. PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJECTED NUMBER OR AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS:

HABITATIONAL RISK: INDICATE IF AN: ☐ APARTMENT ☐ DWELLING ☐ HOTEL

1. NUMBER OF UNITS: _____ YEAR BUILT: _____
   a. ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER? ☐ YES ☐ NO
   b. FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? ☐ YES ☐ NO

☐ PAY PARKING RECEIPTS PER YEAR: _____

☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS RECEIPTS PER YEAR: _____

2. DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED: _____

_____

H. DO YOU LEASE OR RENT SPACE TO OTHERS? ☐ YES ☐ NO

IF YES, INDICATE THE FOLLOWING:

_____

CITY, STATE, AND ZIP CODE

_____ _____

SQUARE FOOTAGE OCCUPANCY/USE OF SPACE

1. DOES YOUR LEASE REQUIRE THE TENANT TO CARRY GENERAL LIABILITY INSURANCE WITH AT LEAST A $1,000,000 LIMIT? ☐ YES ☐ NO
2. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO
3. IS THE TENANT REQUIRED TO LIST YOU AS AN ADDITIONAL INSURED ON THEIR GENERAL LIABILITY POLICY? ☐ YES ☐ NO

X. EXCESS LIABILITY

DO YOU DESIRE EXCESS LIABILITY COVERAGE? ☐ YES ☐ NO

If yes, complete this section. If no, skip to Section XI.

A. HAVE YOUR 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?

_____

XI. 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? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

_____

B. PLEASE CHECK WHICH TYPE OF NOTICE YOUR PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE THEY WILL FORMALLY RECOGNIZE A CLAIM UNDER THEIR POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

☐ WRITTEN NOTICE FROM YOU THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

C. HAVE YOU CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS AND HAVE YOU FORWARDED THEM TO YOUR 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 AND TITLE

D. PLEASE PROVIDE YOUR INSURANCE HISTORY FOR THE LAST FIVE YEARS:

POLICY PERIOD	MOST RECENT YEAR	YEAR 1 PRIOR	YEAR 2 PRIOR	YEAR 3 PRIOR	YEAR 4 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					

XII. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)

For <u>EACH</u> claim, potential claim or suit mentioned below, please complete Section I (Loss History) of the Dialysis Center Supplemental Application.

A. Has your organization (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 your insurer? ☐ YES ☐ NO

B. Does your organization or any of your employees/contractors have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you 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 your insurer? ☐ YES ☐ NO

XIII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION:

A. A COPY OF YOUR 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 YOUR LETTERHEAD.

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

F. LOSS INFORMATION. RECENTLY VALUED LOSS RUNS FROM 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 YOUR CURRENT INSURANCE POLICY.

XIV. IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES

IMPORTANT NOTICE:

THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES MAY BE LIMITED TO LIABILITY FOR CLAIMS FIRST MADE DURING THE POLICY PERIOD, OR MADE AND REPORTED DURING THE (60) DAY AUTOMATIC EXTENDED REPORTING PERIOD IN ACCORDANCE WITH ARK. CODE ANN §23-79-306(2), OR DURING ANY OPTIONAL EXTENDED REPORTING PERIOD ISSUED IN ACCORDANCE WITH ARK. CODE ANN. §23-79-306(3A).

PLEASE READ AND REVIEW THE POLICY CAREFULLY.

FRAUD NOTICE:

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

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.

INITIAL HERE

PLEASE READ AND SIGN

ON BEHALF OF THE ENTITY APPLYING FOR COVERAGE HEREIN:

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO MATERIAL FACT HAS BEEN KNOWINGLY SUPPRESSED OR MISSTATED.

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 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 TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY PHYSICIAN, DENTIST, FIRM, OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND COVERAGE.

BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT THERE IS NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED A COMPLETED APPLICATION; (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. IN ADDITION, I UNDERSTAND THAT IF THE PREMIUM OR FIRST INSTALLMENT IS PAID BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF THESE TERMS ARE NOT COMPLIED WITH, THERE WILL BE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER INDIVIDUALS OR ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND, IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REQUESTED, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

SIGNATURE OF AUTHORIZED INDIVIDUAL | TITLE | DATE

THE MEDICAL PROTECTIVE COMPANY

DIALYSIS CENTER SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF YOU HAVE BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE AND MARINE FOR LESS THAN TEN YEARS OR IF YOUR FACILITY PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE INSURANCE COMPANY.

THE LOSS INFORMATION SHOULD ADDRESS BOTH YOUR PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION.

CLAIM NUMBER _____

A. CLAIMANT NAME: _____ AGE: _____

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU. ____ ____
MM YYYY

0

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. ____ ____
MM YYYY

D. NAME OF DOCTOR(S), HEALTH CARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLVED IN THE CLAIM OR SUIT:

_____

E. DEFENDING INSURANCE CARRIER NAME:

_____

F. WAS A CLAIM MADE OR A SUIT FILED? ☐ YES ☐ NO

G. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT: ☐ OPEN ☐ CLOSED

IF CLOSED, DATE OF CLOSING /SETTLEMENT OR AWARD: ____ ____
MM YYYY

IF CLOSED, WAS PAYMENT MADE? ☐ YES ☐ NO

IF NO, WAS CLAIM OR SUIT WITHDRAWN? ☐ YES ☐ NO

AMOUNT PAID ON YOUR BEHALF: $ _____

TOTAL AMOUNT OF SETTLEMENT OR AWARD: $ _____

WAS THIS MATTER CLOSED WITH YOUR CONSENT? ☐ YES ☐ NO

IF OPEN, HAS SETTLEMENT BEEN OFFERED? ☐ YES ☐ NO

IF OPEN, HAS TRIAL DATE BEEN SET? ☐ YES ☐ NO

TRIAL DATE: ____ ____
MM YYYY

H. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: _____

TREATMENT PROVIDED: _____

ALLEGED NEGLIGENCE: _____

ALLEGED INJURY: _____

I. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY INCLUDING YOUR LEVEL OF INVOLVEMENT).

_____

_____

_____

_____

II. SCHEDULE OF RELATED ENTITIES

LIST OF ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.)

NAME OF ENTITY	DESCRIPTION OF OPERATIONS	DATE ACQUIRED, CREATED OR MERGED	INDICATE YOUR OWNERSHIP PERCENTAGE IN THIS ENTITY	COVERAGE DESIRED? If yes, indicate shared or separate limits.

III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (IF SHARED OR SEPARATE PHYSICIAN OR ALLIED COVERAGE IS BEING REQUESTED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW

COVERAGE	REQUESTED LIMITS	OCCURRENCE / CLAIMS-MADE	DEDUCTIBLE / SIR
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE DIALYSIS CENTER LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE DIALYSIS CENTER LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE DIALYSIS CENTER LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE DIALYSIS CENTER LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SEPARATE LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE: THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE DIALYSIS CENTER.**	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SEPARATE LIMIT COVERAGE.**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE: THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE DIALYSIS CENTER.**	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE

IMPORTANT NOTE:

UNLESS OTHERWISE INDICATED BELOW, REQUESTED COVERAGE WILL BE LIMITED TO PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED, WHILE EMPLOYED OR UNDER CONTRACT WITH THE APPLICANT OR RELATED ENTITY (SERVICES LIMITED TO DUTY AND SCOPE OF SERVICES). **CHECK ONE**:

☐ LIMITED TO DUTY AND SCOPE OF APPLICANT AS INDICATED ABOVE

☐ REQUESTING 24-HOUR COVERAGE

IV. SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND / OR ORAL SURGEONS, PLEASE PROVIDE THE INFORMATION BELOW. ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED (SHARED LIMIT OR SEPARATE LIMIT COVERAGE). CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

NAME OF MEDICAL PROFESSIONAL	EMPLOYMENT STATUS: (C)ONTRACT (E)MPLOYED (F)ACULTY (R)ESIDENT	NUMBER OF PROCEDURES PERFORMED AT THE DIALYSIS CENTER	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOYMENT WITH NAMED INSURED	RESTRICTED (RE) TO NAMED INSURED'S OPERATION OR 24-HOUR (24)	LIMITS: Shared (SH), Separate (SE)

V. SCHEDULE OF MEDICAL PROFESSIONALS - CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND / OR SURGICAL ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION BELOW. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED. CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF CLAIMS MADE COVERAGE IS BEING REQUESTED, COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE DATE OF EMPLOYMENT WITH THE NAMED INSURED ENTITY. (*) IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE DATE OF THE EMPLOYMENT WITH THE NAMED INSURED, PRIOR ACTS COVERAGE WILL BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

Instructions For Completing Each Column

#1) Employment Status: (C) Contract, (E) Employed or (F) Faculty
#2) Specialty: CRNA, CRNP, Nurse Midwife, PA, Podiatrist, Surgical Assistant
#3) If CRNP or PA, Does Individual Prescribe Medication? Indicate Yes or No.
#4) If Claims Made coverage type, indicate retro date.
#5) Date Of Employment With First Named Insured (FNI).
#6) Full Time Equivalency (FTE) - Calculate FTE by dividing the total # of hours of professional service per week by 40 hours.
#7) License Number.
#8) Coverage Scope: (RE) Restricted to Named Insured's Operation OR (24) 24-Hour coverage.
#9) Limits: (SH) Shared or (SE) Separate.

Column #:	1	2	3	4	5	6	7	8	9
Name of Medical Professional	(C), (E) or (F)	Specialty	Prescr. ? Yes/No	If CM, Retro Date	Date Of Empl. With FNI	FTE	License #	(RE) OR (24)	(SH) or (SE)