General Allied Health Professional & General Liability Application

1. Name of Applicant: _____
(as it should appear on the policy)

2. Mailing Address: _____

3. Location Address: _____
(If more than one location address, please complete a separate application per location)

4. Telephone Number: _____ Website Address: _____

5. Exposure:

Gross Receipts for the Past 12 Months:	$
Estimated Gross Receipts for the Next 12 Months:	$
Payroll for the Past 12 Months:	$
Estimated Payroll for the Next 12 Months:	$
Number of Visits/Encounters (not patients) for the Past 12 Months:	
Estimated Number of Visits/Encounters (not patients) for the Next 12 Months:	

NOTE: Please provide # of visits or encounters, not the # of patients, in response to the above questions. Please count each time each client/patient has contact with a staff member, whether in person or via telehealth, as an individual visit.

6. Full description of services provided: _____

_____

7. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes ☐ No ☐

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of $1M/$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes ☐ No ☐

8. Are all services provided at the applicant's location address(s)? Yes ☐ No ☐

If no, please provide details of any off-site exposure including a breakdown as to where services are provided by % at each type of location:

_____

_____

9. Does the applicant provide any beds for overnight stays? Yes ☐ No ☐

If yes, give details: _____

10. Exposure: Please complete the table below showing the % exposure in each of the areas listed in terms. If this is a start-up business not yet in operation, please show estimated % exposures for the next 12 months in each of the areas listed.

	% Exposure
Alcohol/Drug Addiction	
Counseling/Psychiatric	
Dental	
Emergency Medical	
General/Family Practice	
Gynecological/Family Planning	
Holistic/Alternative Medicine (please provide details)	
Hormone Therapy	
Major Surgical (please provide details)	
Minor Surgical (please provide details)	
Obstetrical	
Pediatric	
Physical/Occupational Rehab	
Research/Experimental	
Speech Therapy	
Weight Loss	

11. Are any of the exposures listed in the above table expected to change over the next 12 months?

Yes ☐ No ☐ If yes, please provide details:

_____

_____

12. Does the applicant, or any of their employees, independent contractors or volunteers, offer or plan to offer weight loss services over the next 12 months?

Yes ☐ No ☐ **If yes, please complete the Weight Loss Supplement.**

13. Does the applicant, or do any of their employees, independent contractors or volunteers, prescribe any medications for any reason other than weight loss as shown above?

Yes ☐ No ☐ If yes, please answer the following:

a) Who is prescribing them (including professional designation): _____

b) Provide a list of all medications prescribed: _____

_____

_____

c) Under what circumstances/for what reasons: _____

d) Is an in-person examination performed prior to the prescription of any medication?

Yes ☐ No ☐

If no, please provide details: _____

e) Are any medications prescribed for use in off-label/non-FDA approved manner (i.e. are any medications prescribed for a use or for a condition not approved by the FDA? Or are any medications prescribed in a quantity, format, or for a duration other than that approved by the FDA?)

Yes ☐ No ☐

If yes, please provide details:

_____

_____

14. IV Therapy Exposure: Please answer the following questions if there is any current or anticipated IV therapy exposure

a) Professional designation/certification of person who pre-screens or will pre-screen all patients prior to IV therapy treatment being performed:

_____

b) Professional designation/certification of person who administers or will administer IV therapy treatment:

_____

c) Please list all substances administered, or that the applicant plans to administer, via IV: _____

_____

_____

15. a) List the number and type of employees/owners including any estimated over the next 12 months:

	Number		**Number**
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational Therapist		Speech Therapist	
Respiratory Therapist		Massage Therapist	
Psychiatrist		Psychologist	
Social Worker/Counselor		Medical Assistant/Technician	
CRNA		Surgical Technician	
Chiropractor		Acupuncturist	
Optician/Optometrist		Pharmacist	
Dentist		Non-Medical Aide/Caregiver	
Admin/Clerical		Other (please describe)	

b) List the number and type of independent contractors including any estimated over the next 12 months:

	Number		**Number**
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational Therapist		Speech Therapist	
Respiratory Therapist		Massage Therapist	
Psychiatrist		Psychologist	
Social Worker/Counselor		Medical Assistant/Technician	
CRNA		Surgical Technician	
Chiropractor		Acupuncturist	
Optician/Optometrist		Pharmacist	
Dentist		Non-Medical Aide/Caregiver	
Admin/Clerical		Other (please describe)	

c) Are all the individuals listed in response to Q17a & b licensed in accordance with applicable state and federal regulations?

Yes ☐ No ☐ If no, attach explanation.

16. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes ☐ No ☐

17. Do you require employed, contracted or volunteer physicians, nurse anesthetists, dentists, acupuncturists and/or chiropractors to carry their own Professional Liability Insurance at a minimum of $1M/$3M limits and secure Certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ **Please attach proof of coverage.**

18. Please confirm which of the following you obtain, review, verify and keep on file as part of the employee/ independent contractor hiring & screening process:

	Yes	No
Employment Application		
Criminal Background Checks		
Drug / HIV/ Hepatitis Testing		
Licenses Held		
Education/Training/Competence		
Multi-State Registry		

19. Additional employment related questions:

	Yes	No
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

20. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

_____

21. Do you sell, rent or otherwise provide any equipment to products or others?

Yes ☐ No ☐

If yes, please complete the supplement for Durable Medical Equipment Sales/Rentals.

22. Please complete the table below showing the applicant's Professional Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

23. Please complete the table below showing the applicant's General Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

24. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	No
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

25. Has any claim ever been made against the firm or any of its employees?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

26. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes ☐ No ☐ **If yes, please attached a separate sheet with date(s) and details.**

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)