

MAXUM

SPECIALTY INSURANCE GROUP

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
Street City County State ZIP Code
3. Location of premises: Same as mailing address
 Other _____
4. Telephone (____) _____ Fax (____) _____
5. Contract person/phone #: Inspection _____
Accounting/Records _____
6. Business type: Individual Partnership Corporation
 Trust Other _____
7. Operating as: For Profit Nonprofit Other _____
8. Interest of Named Insured in premises: Owner General Lessee Tenant Other _____
9. Part occupied by Named Insured: Entire Portion(____%) Other (Lessor's Risk Only)
10. Date business established _____

DESIRED TERMS AND CONDITIONS

1. Coverage desired: General liability Professional Liability
2. Limit of Liability Desired: \$100,000/\$300,000 \$300,000/\$600,000 \$500,000/\$1,000,000
 \$1,000,000/\$1,000,000 Other _____

Note: Standard coverage includes the following:

Damage to Premises Rented to You	\$100,000
Medical Payments	\$5,000
Personal and Advertising Injury	Same as Occurrence Limit

3. Contractual Liability: (Attach copy of contract) No separate limit
4. Effective Date Desired _____ Term Desired _____

TYPE OF FIRM

1. Type of firm: Counseling Agency Type _____ Other Type _____
 Drug/Alcohol Rehab. Center Type _____ Group Home Type _____
 Halfway House Type _____ Mental Health Center
 Mentally Handicapped Facility Physical/Occup. Rehab. Center
 Shelter

2. Description of operations. _____

20. Describe the duties of volunteers or students. _____
21. Additional insureds (state their interests in insured's operation). _____
22. Total all locations: Receipts \$ _____ Outpatient Visits _____
23. How are funds obtained? (i.e., Medicare, donations, fees, government grant, etc.) _____
24. Do you sell or lease any medical equipment or other products **to others**? Yes No
If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.

Receipts: _____
- Do you require lessees to provide certificates of insurance? Yes No
25. Do you lease or rent any equipment **from others**? Yes No

EMPLOYEE PROCEDURES & STAFFING

1. Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution? Yes No

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		RN/LPN/LVNs	
Nurse Practitioners		Technicians	
Nurse Midwives		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other (define)	

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. Do you comply with minimum required staff standards for each shift? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are all staff certified/licensed according to federal, state, or local requirements? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are any staff working on a contract basis? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, do you require proof of separate professional liability insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
3. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:
- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| | None | Written | Verbal |
| Educational background or residency program check, when applicable | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Previous employers check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Personal references check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Criminal background check | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Are copies of background checks kept on file? Yes No

EDUCATION, LICENSING, ACCREDITATION

1. Do you currently comply with any state or municipal licensing requirements in the operation of your facility?
 Yes No No licensing requirements

If no, state reasons for non-compliance and steps being taken to correct this.

Have you had any licensing or code violations in the past three years? Yes No

If yes, describe. _____

Does state licensing differentiate patient's/resident's ability for self preservation in the event of an emergency?

Yes No

2. Is the facility accredited by any governmental or other body (e.g. JCAH, AAAHC)?

Yes No No accreditation available

If yes, describe. _____

3. Are you a member of any professional association or organization? Yes No

Name of association or organization. _____

RISK MANAGEMENT

- | | | Yes | No |
|----|--|--------------------------|--------------------------|
| 1. | Do you have a formal written risk management program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | Is there a designated risk management person?
If no, how are these duties delegated? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | Do you have a written requirement that physicians, oral surgeons, and dentists providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. | Do you have: | | |
| | a. Written job descriptions? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b. Policies and/or procedures manual? | <input type="checkbox"/> | <input type="checkbox"/> |
| | c. Full-time administrator or medical director on staff? | <input type="checkbox"/> | <input type="checkbox"/> |
| | d. Formalized loss control and claim prevention training program? | <input type="checkbox"/> | <input type="checkbox"/> |
| | e. Emergency shelter arrangements for residents? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Have you entered into any other contractual agreements? | <input type="checkbox"/> | <input type="checkbox"/> |
| | a. If yes, is legal advice sought to write and approve? | <input type="checkbox"/> | <input type="checkbox"/> |
| | b. Does the agreement require you to hold any third party harmless? | <input type="checkbox"/> | <input type="checkbox"/> |

PREVIOUS EXPERIENCE

- | | | Yes | No |
|----|--|--------------------------|--------------------------|
| 1. | Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of his/her professional activities?
If yes, explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.
Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years? <i>If yes, give name of company, date and reason.</i> | <input type="checkbox"/> | <input type="checkbox"/> |

3. **PRIOR INSURANCE CARRIER AND LOSSES WHETHER COVERED BY INSURANCE OR NOT FOR THE PAST THREE FULL YEARS:**

Year	Carrier/Policy Number/ Premium	Coverage	# of Losses	Amount	Description of Losses (Use separate sheet, if necessary)

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant _____ Title _____ Date _____

Signature of Producing Agent _____ Date _____

Agent Name and Address _____