Northland INSURANCE

HEALTH CARE PROVIDER & HEALTH CARE FACILITY APPLICATION

1. Proposed First Named Insured & Other Named Insured(s):

2. Mailing Address — Street | City | County | State | ZIP Code

3. Location Address — Street | City | County | State | ZIP Code

4. Telephone: | Fax:

5. Contact Person/Phone No.: | Inspection: | Accounting/Records:

6. Business Type: ☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ Trust ☐ Other (specify):

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

4. Effective Date Desired: | Term Desired:

TYPE OF FIRM

1. Check your specific professional occupation:

☐ Aide/Homemaker
☐ Artificial Limb Fitter
☐ Audiologist — *Do you operate a mobile unit?* ☐ Yes ☐ No
☐ Counselor ☐ Psychiatrist ☐ Psychologist ☐ Social Worker
☐ Dental Hygienist
☐ Dietitian/Nutritionist — *Do you market products under your own label?* ☐ Yes ☐ No
☐ Druggist/Pharmacist — *Do you prescribe medications?* ☐ Yes ☐ No
☐ Hearing Aid Specialist
☐ Massage Therapist
☐ Nurse - *Type:* _____ *Check if appropriate:* ☐ Midwife ☐ Nurse Anesthetist
☐ Occupational Therapist ☐ Respiratory Therapist
☐ Optician ☐ Speech Therapist
☐ Optometrist ☐ X-Ray Technician/X-Ray Specialist
☐ Physical Therapist ☐ Other:

2. Indicate type of services performed and percentage:

☐ Abortion/Family Planning	%	☐ Occupational	%
☐ Alcohol/Drug	%	☐ Optician	%
☐ Child Abuse/Sexual Offenders	%	☐ Optometrist	%
☐ Criminal	%	☐ Physical Therapist	%
☐ Crisis Intervention	%	☐ Respiratory Therapist	%
☐ Family/Marital	%	☐ School/Youth	%
☐ General Guidance	%	☐ Speech Therapist	%
☐ Hot Line	%	☐ X-Ray Technician	%
☐ Nurse - *Type:*	%	☐ Other:	%
Check if appropriate: ☐ X-Ray Specialist ☐ Midwife ☐ Nurse Anesthetist			
☐ Counseling Agency:	%		
Type: ☐ Drug/Alcohol Rehab. Center ☐ Halfway House ☐ Mentally Handicapped Facility			
☐ Other:	%		
Type: ☐ Group Home ☐ Mental Health Center ☐ Physical/Occup. Rehab. Center ☐ Shelter			

3. Describe operations:

4. Do you perform shock therapy, use restraints, heavy sedation or offer any experimental treatments?
☐ Yes ☐ No If yes, describe:

OPERATIONS – Health Care Provider

1. Do you treat children exclusively? ☐ Yes ☐ No
2. Indicate percentage of time spent in the following work locations:

Administrative Office	%	Hospice	%	Professional Office	%
Classroom	%	Outpatient Clinic	%	Nursing Home	%
Emergency Dept. of Hospital	%	Laboratory	%	Other:	%
Hospital Ward (Specify):			%	Patient's Home	%

3. Are you engaged in, associated with, or involved in any other enterprises? ☐ Yes ☐ No
If yes, explain:
4. Are you self-employed? ☐ Yes ☐ No
If no, name of employer:

		Yes	No	N/A
5.	Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following? General Liability	☐	☐	☐
	Professional Liability	☐	☐	☐
6.	Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?	☐	☐	
	If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?	☐	☐	
7.	Have you entered into any contractual agreements?	☐	☐	
	If yes, is legal advice sought to write and approve?	☐	☐	
	Does the agreement require you to hold any third party harmless?	☐	☐	

8. Indicate: Receipts: $ Payroll: $
Outpatient Visits (Number of patient encounters per year):
9. How are funds obtained? (i.e. Medicare, donations, fees, government grants, etc.):
10. Do you have recordkeeping procedures? ☐ Yes ☐ No
11. Do you practice: ☐ Full Time (30+ hours/week) ☐ Part Time (30 hours or less/week)

12. Do you have independent contractors working for you? ☐ Yes ☐ No If yes, describe:
Number of Contractors including Type:

Total hours per month worked by all contractors:

Capacity the independent contractor is working:

13. Do you require independent contractors working for you to carry their own professional insurance and provide proof of this coverage? ☐ Yes ☐ No

14. Do you use the services of volunteers or students? ☐ Yes ☐ No
If yes, describe:
Selection:

Duties:

Training:

Extent to which they are used:

		Yes	No
15.	Do you comply with all applicable laws and ordinances pertaining to licensing or codes? If no, describe:	☐	☐
16.	Do you diagnose or prescribe medications? If yes, describe:	☐	☐
17.	Are any of the psychiatrists, welfare workers and any professionals who are full-time employees of a hospital?	☐	☐
18.	Are overnight facilities provided? If yes, describe:	☐	☐
19.	Are you affiliated with, owned by, or attached to a hospital or risks of a government nature?	☐	☐
20.	Is Additional Insured status required for hospital staff or medical staff?	☐	☐
21.	Do you operate a telephone hotline or referral service?	☐	☐
22.	Do you specialize in Family Planning Services? If yes, describe:	☐	☐

OPERATIONS – Health Care Facility

			Yes	No
1.	Does your facility:	Diagnose patients/residents?	☐	☐
		Prescribe treatment or medications to patients/residents?	☐	☐

2. Describe all services provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*

3. Are outpatient services provided? ☐ Yes ☐ No Number of outpatient visits annually:

4. Number of beds: | Average Occupancy: | Licensed # of beds:

5. Resident age groups (# for each):
Under 18 Years: | 18-59 Years: | 60 Years & Over:

6. Patient admission is: ☐ Forced ☐ Voluntary

		Yes	No
7.	Are patients/residents accepted on a court order?	☐	☐
8.	Are there procedures in place for patient screening and acceptance?	☐	☐
9.	Are current records and files maintained on each patient?	☐	☐
10.	Have any patients/residents been given a probable diagnosis of having Alzheimer's? If yes, how many at the following stages: Stage 1: All other stages:	☐	☐
11.	Have any patients/residents been diagnosed with a mental illness (e.g. schizophrenia, psychopathic, sociopathic diagnosis)?	☐	☐

12. Average length of stay for patients/residents:

		Yes	No
13.	Are residents/patients allowed to leave premises unattended?	☐	☐
14.	Number of non-ambulatory residents:		
15.	Any non-ambulatory patients above the second floor?	☐	☐
16.	Describe management's/administrator's education and experience:		

			Yes	No
17.	Is there a record keeping system in place that documents:	Operational procedures	☐	☐
		Incidents	☐	☐
18.	Do you train new paraprofessionals (e.g. aides, homemakers)?		☐	☐
	If yes, explain:			
19.	Do you provide ongoing training for paraprofessionals?		☐	☐
20.	Are sleeping facilities separated by gender?		☐	☐
21.	Are facilities affiliated with, owned by, or attached to a hospital or risks of a government nature?		☐	☐
22.	Describe the duties of volunteers or students:			
23.	Describe Additional Insured's interest in Insured's operation:			

24.	Total all locations:	Receipts: $	Outpatient visits:
25.	How are funds obtained? (i.e. Medicare, donations, fees, government grants, etc.):		

		Yes	No
26.	Do you sell or lease any medical equipment or other products **to others**?	☐	☐
	If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.		
	Receipts: $		
27.	Do you require lessees to provide certificates of insurance?	☐	☐
28.	Do you lease or rent any equipment **from others**?	☐	☐

EMPLOYEE PROCEDURES & STAFFING – Health Care Provider

1. Check the highest level of education you have completed relating to practice in your field:

☐ None required ☐ Bachelor's Degree ☐ Other:

☐ Associate Degree ☐ Doctorate Degree *School where degree was obtained:*

☐ Master's Degree ☐ Post-Doctorate Degree

For multiple employees, attach list with names, degree(s), and school(s).

2. Describe any professional training, licensing, or certification needed for this operation:

3. Are you certified/licensed? ☐ Yes ☐ No

If yes, name of board/licensing body:

			Yes	No	N/A
4.	Has your license ever been:	Restricted?	☐	☐	☐
		Suspended?	☐	☐	☐
		Revoked?	☐	☐	☐
	a. Have you ever been denied a license or board certification?		☐	☐	☐
	b. Have you ever been a patient in any chemical dependency program?		☐	☐	☐
	c. Have your privileges ever been restricted, suspended, or revoked by any heath care facility?		☐	☐	☐
	d. Do you prescribe drugs?		☐	☐	☐
	e. Do you participate in any peer review or utilization review activities?		☐	☐	☐

Explain all YES answers:

5. Years practicing current professional occupation:

6. Years in business under the above name:

7. List any professional association or organization of which you are a member. Show complete name. ☐ None

		Yes	No
8.	Do you have employees?	☐	☐
9.	Do you conduct criminal background checks of employees?	☐	☐
	If yes, are copies kept on file?	☐	☐

10. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care services at your facility:

	None	Written	Verbal
a. Educational background or residency program check, when applicable.	☐	☐	☐
b. Previous employers check.	☐	☐	☐
c. Personal references check.	☐	☐	☐
d. 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.	☐	☐	☐

EMPLOYEE PROCEDURES & STAFFING – Health Care Facility

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

2.

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:	

		Yes	No
3.	Do you comply with minimum required staff standards for each shift?	☐	☐
4.	Is all staff certified/licensed according to federal, state, or local requirements?	☐	☐
5.	Is any staff working on a contract basis?	☐	☐
	If yes, do you require proof of separate professional liability insurance?	☐	☐

6. Check all procedures you use when hiring professionals, paraprofessionals, or any other employee providing patient care at your facility:

	None	Written	Verbal
a. Educational background or residency program check, when applicable.	☐	☐	☐
b. Previous employers check.	☐	☐	☐
c. Personal references check.	☐	☐	☐
d. 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.	☐	☐	☐
e. Criminal background check.	☐	☐	☐

f. 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 corrective action taken:

a. Have you had any licensing or code violations in the past three years? ☐ Yes ☐ No
If yes, describe:

b. 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?	☐	☐
2.	Is there a designated risk management person? If no, how are these duties delegated:	☐	☐
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?	☐	☐
4.	Do you have: a. Written job descriptions	☐	☐
	b. Policies and/or procedures manual	☐	☐
	c. Full-time administrator or medical director on staff	☐	☐
	d. Formalized loss control and claim prevention training program	☐	☐
	e. Emergency shelter arrangements for participants	☐	☐
5.	Have you entered into any other contractual agreements?	☐	☐
	a. If yes, is legal advice sought to write and approve?	☐	☐
	b. Does the agreement require you to hold any third party harmless?	☐	☐

PREVIOUS EXPERIENCE

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 their professional activities? ☐ Yes ☐ No
If yes, explain:

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?
☐ No ☐ Yes - If yes, give name of company, date and reason.

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS

Policy Dates	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				☐	
				☐	
				☐	

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years. *Attach separate sheet if necessary.*

Dates (Month/Year)	Allegations	Amount	Paid	Reserve
			☐	
			☐	
			☐	

For information about how Northland compensates its agents, brokers and program managers, please visit this website:

http://www.northlandins.com/Producer_Compensation_Disclosure.asp

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northland Insurance Companies, c/o Law Department, 385 Washington St., St. Paul, MN 55102.

This application, including any material submitted in conjunction with the application or any renewal, does not amend the provisions or coverages of any insurance policy or bond issued by Northland. It is not a representation that coverage does or does not exist for any particular claim or loss under any such policy or bond. Coverage depends on the facts and circumstances involved in the claim or loss, all applicable policy or bond provisions, and any applicable law. Availability of coverage referenced in this document can depend on underwriting qualifications and state regulations.

FRAUD STATEMENTS

ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY, NEW JERSEY, NEW YORK, OHIO, AND PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.)

LOUISIANA, MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, and denial of insurance benefits.

IMPORTANT NOTICE

DECLARATION

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

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SIGNATURES

Applicant Signature	Title	Date

Producer Signature	Date

Producer Name and Address