Name of Insurance Company
To Which Application is Made: **Lexington Insurance Company**
(*Herein called the Company*)

APPLICATION FOR HEALTHCARE FACILITY
PROFESSIONAL & COMMERCIAL GENERAL LIABILITY INSURANCE

Instructions:
1. Please type or print clearly.
2. Answer ALL questions completely, leaving no blanks. If any questions or part thereof, do apply, print "N/A" in the space.
3. If the applicant needs more space for responses, continue on a separate sheet of the applicant's letterhead and indicate question number.
4. This form must be completed, dated and signed by a principal of the applicant's facility.

I. GENERAL INFORMATION

Producer Name:

Address:

Telephone Number:

Applicant's Name:

Business Address:

Mailing Address:

Years in Business: Employer Federal Tax I.D No.: Telephone No:

Reporting/Fiscal Year Start Date:

Requested effective date: Retroactive date:

:

Current Form of Insurance:		**Retro Date for Claims Made**

Requested Coverage		**Retro Date for Claims Made**

Applicant is a:

Applicant operates:

Limits of Liability

**Professional Liability and General Liability Limits must be the same, but apply separately*.

Deductible (*applies separately to Professional Liability and General Liability*)

List all subsidiaries, date acquired, and description of operations & ownership in percentages:

Subsidiaries	Date Acquired	Description of Operations	% Ownership

II. PROFESSIONAL LIABILITY

1. Services Provided: Indicate all services provided by the applicant's facility, giving requested information for each classification. Information given should be projected numbers for the next 12 months. "Visits" are defined as the number of patients entering the applicant's facility for health related services. DO NOT tally the number of departments visited or the number of procedures or treatments performed. "Beds" are defined as the average number of occupied beds.

Laboratory	Current Year Annual Receipts	Projected 12 Months Annual Receipts
X- Ray/Imaging		
Mobile X- Ray/Imaging		
Other (Please Specify):		

Surgical Center	Current Year # of Procedures	Projected 12 Months # of Procedures	Overnight Beds
Emergicenter			
Surgicenter			
Urgicenter			

Schools for Health Care Providers	# of Students	# of Faculty
Chiropractic		
Dental		
Medical		
Nursing		
Other (*please describe*):		

Outpatient Clinic	Current Year # of Outpatient Visits	Projected 12 Months # of Outpatient Visits	Current Year # of Beds
Multi-specialty			
Other (*please describe*):			

Organ Banks	Current Annual Receipts	Projected 12 Month Annual Receipts
Organ or Tissue Procurement Center: No direct processing or contact		
Organ or Tissue Procurement center: Direct processing or contact		

Rehabilitation Center	Current Year Outpatient Visits	Projected 12 Months Outpatient Visits	Beds
Cardiac Rehabilitation			
Physical or Occupational Rehabilitation			
Trauma Rehabilitation Therapy			
Transitional Living			
Skilled Medical			

Treatment Center	Current Year Outpatient Visits	Projected 12 Months Outpatient Visits	Beds
College or University Health Centers			
Community Health Centers			
Crisis Stabilization			
Mental Health & Counseling Services			
Municipal Health Department			
Other (*please describe*)			

Professional Employees/Independent Contractors. Please provide information requested for each physician/ surgeon providing services at the applicant's facility.

Medical Director* Name	Specialty	Insurance Carrier & Policy Number	Type of Surgery**	Procedures/ Month***	Employee/ Contractor	Hours/ Month
Other Physicians & Surgeons Names	Specialty	Insurance Carrier & Policy Number	Type of Surgery	Procedures/ Month	Employee/ Contractor	Hours/ Month

***A PHYSICIAN WILL ONLY BE COVERED IN HIS/HER CAPACITY AS A MEDICAL DIRECTOR FOR ACTIVITIES RELATING TO ADMINISTRATION OF THE FACILITY.**

******Surgery Definitions:

No Surgery – No surgery procedures performed other than circumcisions, incision of boils and superficial abscess or suturing of skin and superficial fascia. Includes closed fractures of the fingers and toes.

Minor Surgery –Assisting in surgery on physician's own patients, including closed bone fractures, except those of the fingers and toes, and D&Cs or vasectomies performed under local anesthesia.

Major Surgery – Includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen pelvis; any other operation which, because of the condition of the patient or length or circumstances of the operation presents a distinct hazard to life. It also includes removal of tumors, open bone fractures, amputations, abortions, cesarean sections, the removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies and any operations done using general anesthesia.

NOTE: If any physician/surgeon is to be provided coverage under this policy, a supplemental application must be completed and an additional charge will be applied

2. Other Health Care Professionals. Indicate the number in each category, full-time and part-time.

	Employees		Contractors		Volunteers	
Profession	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
Totals						

3. Does the applicant currently comply with any state licensing requirements for the applicant's facility? If yes, describe. If no, state reasons for non-compliance and corrective actions being taken.

4. If the facility is a member of any professional organizations or associations, enter name(s).

5. If the facility is accredited and/or inspected by any governmental body or other organization indicate below:

Number of Facilities	Organization	Status	Date of Last Inspection

Describe the type(s) of inspections (physical plant, nursing protocols) and include a copy of any accreditation report(s).

6. If the applicant has written requirements that the following providers carry Professional Liability Insurance indicate the limits required.

	Yes/No	Limits
Physicians		
Surgeons		
Oral Surgeons		
Dentists		
Nurse Anesthetists		
Nurse Midwives		
Other (define)		

III. RISK MANAGEMENT/LOSS CONTROL

1. If the applicant has a Risk Management Program, list the Manager's name, title and phone number:

2. If the facility owns any biomedical or other equipment used for diagnosis, monitoring or treatment purpose that is responsible for inspection and maintenance of the equipment?

3. Do qualified personnel inspect and maintain the equipment on a regular basis?

4. Are manufacturers recommendations followed for all maintenance and repair of equipment?

5. Does the applicant have any contractual agreements with independent contractors/providers to provide services at the Applicant's facility?
If yes, please provide a copy of a sample contract.

6. Are certificates of insurance obtained from all contracted providers?

7. If the facility provides service to others on a contractual agreement please describe services provided and include a copy of the contract.

8. If the facility agreed to hold harmless or indemnify others under contract please describe and include a copy of the contract.

9. If the facility rents or leases any biomedical or other equipment, please describe:

10. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at the applicant's facility:

Check of educational background, or residency program, when applicable.
Check of previous employers
Check of personal references
Check on hospital privileges for physicians, oral surgeons and dentists
How often does the applicant update their list of specific privileges?
Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities
Require information on any professional liability or work-related claim that has previously been made against any individual
Does the applicant's facility have written job descriptions?

IV. COMMERCIAL GENERAL LIABILITY INFORMATION

1. Please provide physical plant information as requested:

Address/Occupancy	Square Footage	Age	Type of Construction	# Floors	Type of Fire Protection*	Designed for Patient Care?	Designed for Overnight Guests?	Number of Exits per Floor

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

2. Please indicate any additional insureds to be included under the applicant facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

3. If the applicant sells or leases any medical equipment or products to patients or others in connection with the Applicant's Operation please complete the following:

Total Annual Sales: $

Total Annual Lease/Rental Receipts: $

Category I. EXPENDABLE ITEMS – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)

Annual Sales: $

Category II. NON-EXPENDABLE ITEMS – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc. and prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.

Annual Sales: $ Annual Lease/Rental Receipts: $

Category III. DIAGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.

Annual Sales: $ Annual Lease/Rental Receipts: $

Category IV. LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDA monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.

Annual Sales: $ Annual Lease/Rental Receipts: $

Have any of the products that the applicant distributes ever been recalled?
Have any claims been made against the applicant?

4. If the applicant provides preventive maintenance or repairs on medical equipment leased to others please provide details:

V. POLICY AND LOSS INFORMATION

1. Please provide past policy information as requested. List all Commercial General Liability and Professional Liability policies for each of the past five years. Begin with the current policies on the top line.

Type	Policy Period	Insurer	Premium	Limits	CM Or Occurrence	If CM, enter Retro-Date

2. If the applicant is aware of any circumstances, accidents or loses which have occurred after the retroactive date, provide complete details.

3. If any claims have ever been made against the applicant, please give dates, allegations and disposition of each claim or suit.

4. If the facility ever had any Insurance Company or Lloyd's Syndicate decline, cancel, refuse to renew or accept only on special terms any Professional Liability Insurance provide explanation:

VI. FACILITY SPECIFIC INFORMATION

REHABILITATION FACILITIES

1. If patients are referred to the applicant by a physician, please describe referral procedures:

2. What is the length of the orientation and training period for new employees and volunteers?

   Does it include training for the proper use of equipment and special training for high tech areas?

INPATIENT FACILITIES

1. Are the electrical, heating and plumbing systems up to code and regularly inspected?

FIRE PROTECTION

1. Are there evacuation plans posted and drills held regularly?

2. Are there non-slip surfaces in bathing areas and handrails?

3. How are the beds licensed? (nursing home, ambulatory facility, etc.)

4. What is the minimum number of staff on duty at night?

5. What level of care is provided for the beds maintained?

   Is skilled nursing care provided including medication administration, injections, catherizations or other procedures ordered by physicians?

   Is assistance with daily living activities and some medication administration provided but no skilled nursing care?

   Are patients responsible for their own medication but some daily living activities planned, such as meals and social activities?

6. Does the applicant provide residential care to children or adolescents?

Please include the following information with the completed application:

Previous Insurance Company loss runs for the past five years.
Current audited financial statement.
Brochures, pamphlets or other advertising material utilized by the applicant's facility.
Copies of any inspection reports/surveys conducted by outside organizations within the past three years.
Copies of any contracts for professional services provided to the applicant's facility or by the applicant's facility.

THE UNDERSISGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

NOTICE TO ARKANSAS APPLICANTS: "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."

NOTICE TO COLORADO APPLICANTS: "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 AUTHORITIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO FLORIDA APPLICANTS: "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 IN THE THIRD DEGREE."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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."

NOTICE TO LOUISIANA APPLICANTS: "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."

NOTICE TO MAINE APPLICANTS: "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 OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "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 CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "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, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY" (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: "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."

NOTICE TO VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

APPLICANT

Name of Applicant:_____

Title: _____

Signature: _____

Date: _____

AGENT OR BROKER

Agency: _____
Name

_____
Address

_____

Agent: _____
Print Name

Signature: _____

Date: _____