

United National Group

MISC. MEDICAL PROFESSIONALS APPLICATION

(This application also requires a class specific supplemental application.)

Return to:

INSTRUCTIONS:

- A. Please type or print clearly. Answer ALL questions completely.
- B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
- C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.
- D. To this application, please attach copies of
 - Marketing or advertising brochures.
 - Descriptive materials provided to clients.
 - Copy of all accreditation reports, or other similar, if applicable.
 - Other attachments as required in response to application questions.
 - Most current annual financial statement prepared by a CPA.
- E. All materials submitted or required shall be held in confidence.

GENERAL INFORMATION

1. Insured _____
Main Location Address

Street City State/Zip County

2. Tax Identification Number _____ Telephone Number (____) _____

3. Years in Business _____ Are you currently enrolled in a PCF? Yes No

4. Mailing Address (if different than above)

Street City State/Zip County

5. List all locations and areas of operations

Street City State/Zip County

Street City State/Zip County

6. Provide names of all legal entities, including subsidiaries desiring coverage. Please provide a description of the entity, percentage owned and date acquired. If applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

7. Within the past 5 years, has applicant acquired, sold or discontinued any operations? Yes No

8. Applicant is: Individual Partnership Corporation Other _____

9. Describe operations:

10. Does the applicant provide any overnight bed facilities? Yes No

11. Does the applicant perform any treatment or services on the applicant's premises? Yes No

12. Is applicant owned by or operated at a hospital, whether main location or branch? Yes No

COVERAGE REQUESTED

13. Requested Effective Date _____
 (If new venture, please provide owner's resume' and description of related industry experience.)

14. _____ **Professional Liability** Occurrence Claims Made Prior Acts Date _____
 (Attach copy of prior claims made policy Declarations if requesting prior acts.)

- \$ 100,000 per Incident / \$ 300,000 Aggregate
- \$ 250,000 per Incident / \$ 750,000 Aggregate
- \$ 500,000 per Incident / \$ 500,000 Aggregate
- \$1,000,000 per Incident / \$1,000,000 Aggregate
- \$1,000,000 per Incident / \$2,000,000 Aggregate
- \$1,000,000 per Incident / \$3,000,000 Aggregate
- \$2,000,000 per Incident / \$4,000,000 Aggregate
- \$3,000,000 per Incident / \$5,000,000 Aggregate

15. _____ **General Liability** Occurrence Claims Made Prior Acts Date _____

(Attach copy of prior claims made policy Declarations if requesting prior acts.)

Each Occurrence (cannot be excess PL limit)	\$ _____
Medical Expense Limit (Per Person)	\$ _____
Fire Damage Limits of Liability (Any one Fire)	\$ _____
Products / Completed Operation Aggregate	\$ _____
General Aggregate (Other than Products)	\$ _____

For the next three coverage parts, please input the exposure information on page 8.

16. _____ **Employee Benefits Liability / Claims Made** (General Liability Coverage must be selected)

Each Person	\$ _____
Total Limit	\$ _____
Prior Acts Date	_____

(Attach copy of prior claims made policy Declarations, if applicable.)

17. _____ **Stop Gap Liability** (General Liability Coverage must be selected)

Each Person	\$ _____
Each Disease	\$ _____
Total Limit	\$ _____

18. _____ **Non-Owned Auto Liability** (General Liability Coverage must be selected)

\$ 100,000 per Incident / aggregate
 \$ 250,000 per Incident / aggregate
 \$ 500,000 per Incident / aggregate
 \$1,000,000 per Incident / aggregate

19. **Per Claim Deductible**

(Same deductible must be selected for both Professional and General Liability.)

<input type="checkbox"/> none	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> Other _____

20. List Professional Liability policies covering the firm indicated in Question #1 over the past 5 years. If **No** insurance was in effect for a given year, state "**None**" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr,							
4th Prior Yr.							

21. List General Liability policies covering the firm indicated in Question #1 over the past 5 years. If **No** insurance was in effect for a given year, state "**None**" where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr,							
4th Prior Yr.							

CLAIM HISTORY

22. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit, that has not been reported to your current insurance carrier? Yes No

If **YES**, please attach information for each claim, suit or incident: that includes the following:

- Date of Accident and Date of Notice
- Claimant Name
- Amount Paid or Reserved
- Status – Open or Closed
- Insurance Carrier
- Allegations
- Description of Treatment Rendered.

23. Has any company cancelled, declined or refused to issue similar insurance? Yes No

If **Yes**, please explain:

BUILDING INFORMATION

Location	1	2	3	4
a. Year of Construction				
b. Number of Stories				
c. Which Stories are Occupied by Applicant?				
d. Area Occupied (sq. ft.)				
e. Number of Fire Escapes / Exits				
f. Number of elevator				
g. Distance to fire station				
e. PROTECTIVE DEVICES	Yes No	Yes No	Yes No	Yes No
Automatic Sprinklers	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Heat Sensors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Smoke Detectors	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
g. CONSTRUCTION UPDATES	Year: _____	Year: _____	Year: _____	Year: _____
Plumbing	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
Wiring	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

24. Do you lease or sub-lease to others any portion of the locations listed above? Yes No
 If yes, do you require the tenant(s) carry liability insurance for occupancy? Yes No
 Do you require certificated of insurance? Yes No

25. Is a pool or gymnasium located on premises: Yes No
 If YES, please provide details regarding use and safety precautions:

EMERGENCY & SAFETY PROCEDURES:

26. How often are fire drills conducted? _____

27. Are smoke detectors installed in all hallways and rooms? Yes No

28. How are medical emergencies handled?
 a. On Call Physicians? Yes No
 b. Affiliated Physicians on Premises? Yes No
 c. Hospital and/or emergency center? Yes No
 If YES, is hospital and/or emergency center located within a 15 minute drive under
 typical conditions? Yes No

d. Other (explain) _____

29. Specify arrangements for storage and dispensing of drugs:

30. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Eff. Date	Policy Limits	State //License #	Specialty / Board Certified	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						
Name - Physician						
Name - Physician						

HIRING / SCREENING AND EMPLOYMENT PROCEDURES

31. Are employees' / contractors' references contacted before hiring or placement: Yes No
Check all that apply: _____ Written _____ Verbal

32. Check all the following that apply if obtained, verified, and filed as part of for each employee screening and hiring process:

Applications	_____	Multi-State Registry	_____
Drug / HIV / Hep. Testing	_____	Criminal Background Checks	_____
Education/Competency	_____	Licenses/Annual Confirmation	_____

33. Does applicant question prospects about previous claims or suits? Yes No

34. Are employees required to actively participate in continuing education? Yes No

35. Does applicant verify any pending license suspensions, revocations?
or pending disciplinary actions? Yes No

36. Are professional employees required to carry their own insurance: Yes No
If Yes, what minimum is required? \$_____

Are certificates of insurance kept on file? Yes No

ACCREDITATION AND LICENSING

37. Is your facility accredited? Yes No

If so, by whom? _____

(Please attach verification of accreditation.)

38. Is applicant licensed to do business in the states listed above where required? Yes No
Has applicant's license ever been suspended, revoked or restricted? Yes No
(If yes, please provide details). _____

39. Is applicant certified for Medicare reimbursement? Yes No

RISK MANAGEMENT

40. What management body oversees the quality of patient care?
(i.e. medical director, advisory board, etc.) _____

41. Do you have a formal written quality assurance and risk management program? Yes No
Person Responsible: _____ Title: _____

CONTRACTUAL AGREEMENTS

42. Does applicant enter into contractual agreements (i.e. hospitals, nursing homes)? Yes No

43. Do contractual agreements contain hold harmless or indemnification clauses?
favorable to the applicant? Yes No

44. Is applicant required to name any other entity as an additional insured?
If so, please list name and address of each entity and the business relationship Yes No

45. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? If so, please attach explanation (including name of physicians, details of financial relationship, type of referrals).

"Financial relationship" means all ownership or investment interests, compensation arrangements, and medical directorships with applicant.

GENERAL LIABILITY

46. Does applicant sponsor any sporting, fundraising or social events?
Please explain _____ Yes No

47. Does applicant sell any medical supplies and/or equipment? Yes No
If Yes, Annual Receipts \$ _____

48. Does applicant rent or lease any medical supplies and/or equipment? Yes No
If Yes, Annual Receipts \$ _____

49. Is the applicant named as an additional insured or vendor on the manufacturer's
policy for any/all products? Yes No

EMPLOYEE BENEFITS LIABILITY

50. Number of total employees _____

51. Average professional turnover _____ % Average non-professional turnover _____ %

52. Employee Benefits Provided: Health Life 401K Section 125

STOP GAP LIABILITY

53. Total Annual Payroll by State:

NON-OWNED AUTOMOBILE LIABILITY

54. Are driving records, MVR's checked annually? Yes No

55. Estimated annual number of non-medical patient transports _____

56. Are employees required to carry personal auto insurance? Yes No

If Yes, what minimum is required? \$_____

Are certificates of insurance kept on file? Yes No

DIALYSIS CENTERS SUPPLEMENTAL APPLICATION

(This application is a supplemental to the
Misc. Medical Professionals application.)

(Please note that this Supplemental Application must be completed for each facility/location providing outpatient dialysis treatment. The Misc. Medical Professionals Application must be completed and submitted with all Dialysis Centers Supplemental Application.

LICENSING

1. Licensed by state

of: _____

2. License #:

3. Expiration

Date: _____

4. Has License ever been revoked, suspended, placed on probation or restricted in any way? Yes No

If YES, please explain:

PATIENT / TREATMENT INFORMATION

5. Fully describe the exact purpose of the operations, activities, services and professional procedures administered:

6. Are medication or drugs given:

a. Only under a physician's written orders? Yes No

b. Only by authorized medical professionals? Yes No

If the answer to a. or b. above is NO, please explain

7. Is a complete medical history of each patient or client retained on premises?

Yes No

8. Are medical records released to third parties without the written consent of the patient? Yes No

YES, please

explain: _____

9. Is a supervising physician on premises at the time of all hemodialysis treatments at the facility? Yes No

If NO, please explain:

10. As respects the dialysis machine(s):

No

- a. Does the facility service its own machines: Yes

- b. Is the facility an additional insured under the manufacturer's or distributor's products liability coverage? Yes No

If the answer to b. is YES, please identify

- named insured under such policy:

- insurance company

- limits of liability

- coverage is claims made occurrence

11. Is treatment initiated only under a physicians work order? Yes No

12. The number of treatments for each of the past three years was:

200 ____; 200 ____; 200 ____.

STAFF

13. Health Care Professionals

	# Employees/ Contractors Shift 1	# Employees/ Contractors Shift 2	# Employees/ Contractors Shift 3
Administrators			
Clerical			

Medical Records			
Nurses / Nurse Aides			
Nurse Practitioner / Clinical Nurse Specialist			
Pharmacists			
Physician / Physician Assistant			
Social Workers			

(Complete job descriptions must accompany this application for those professionals indicated in Question 13 above.)

14. Please provide information requested for each Medical Director and/or Physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Effective Date	Policy Limits	State of Licensure	License Number	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Pharmacist						

I **DECLARE** that the information contained in this supplement is true and that no material facts have been suppressed or misstated.

I **UNDERSTAND** that an incorrect or incomplete response could void my coverage.

Signature of Applicant

Date