



DIALYSIS RENEWAL APPLICATION

Instructions:

1. Review your application completed last year in conjunction with this renewal application.
2. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
3. This application must be completed, signed and dated by an authorized officer of the entity.
4. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. Name of Applicant: _____
(Provide names of all legal entities past and present that are intended for coverage. This would include any additional entities acquired this past year).
2. Do you want to change your current insurance structure? Yes No
3. Has the applicant had any change to their business operations over the past 12 months? Yes No
If "Yes" have the exposures and losses been included with this application? Yes No
4. Are there any plans to acquire other facilities within the next 12 months? Yes No
5. Has there been any change in where services are provided? Yes No

If the answer is "yes" to any of the above provide details on a separate sheet of your letterhead.

6. Medicare Survey Date: _____
a) Were any deficiencies cited in the most recent survey? If yes, explain. _____
b) Submit most recent CMS Annual Facility Survey Form (CMS-2744A).
7. Accreditation: By What Organization: _____ Date of Accreditation Survey: _____
a) Were any deficiencies cited in the most recent survey? If yes, explain. _____
b) Submit your most recent survey with the completed application.
8. Medical Staff
a) Do you continue to require physicians who have privileges to treat patients at your facility to have their own professional liability insurance? Yes No.
b) If yes, what limits are required? \$ _____ each claim / \$ _____ aggregate.
9. Equipment
a) Have any serious adverse events required reporting to the FDA? Yes No.
b) If yes, explain: _____
10. Metrics (past 12 months). If you operate in more than one state please break out treatments by state on a separate sheet.

Metrics	PROJECTED
# of hemodialysis treatments	
# of home care peritoneal dialysis treatments	
# of Hospital inpatient treatments	
# of Long Term Care facility treatments	
# of dialysis stations	
Revenue	\$

11. Outside Laboratory Services
If you provide laboratory testing for patients outside of your dialysis clinics what revenue is associated with this service? \$



12. MEDICAL EQUIPMENT/SUPPLIES SALES AND LEASING OPERATIONS (if applicable)

Category I: EXPENDABLE ITEMS - Intended for one-time usage and disposed (e.g. adhesive tape, bandages, hypodermic needles, etc.)

Annual Sales \$ _____

Category II: NON-EXPENDABLE ITEMS - Excluding diagnostic or treatment equipment or devices. Includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts/hoists, traction apparatus, ambulatory aids, walkers, strollers, canes, crutches, wheelchairs, prosthetic devices, IV stands, medical and surgical instruments, etc.

Annual Sales \$ _____

Annual Lease/Rental Receipts \$ _____

13. General Liability - Has there been a change in the number of locations you own or lease? yes no

If yes, explain: _____

14. Provide an updated loss history dated within 60 days for the past 5 years (including the current year) on a report-year basis. Loss data must include the incident/occurrence date, report date/claim made date, expense payments, indemnity payments, expense reserves, indemnity reserves, description of allegation and close date.

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: 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.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Signature in full _____

Date _____

Name - please print _____

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation.