☐ New Effective Date: _____

ALLIED HEALTH CARE FACILITIES
COMMON APPLICATION

Some of the coverages being applied for are Claims Made. If there are questions concerning these coverages, please contact your insurance agent.

Instructions:

A. 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.
B. All application questions must be fully answered. If a question does not apply, please write "N/A".
C. If more space is needed, continue on a separate sheet of the applicant's letterhead and indicate the question number.
D. Please review Section III. Professional Services on page 4 of this application. **You may be required to complete a supplemental application in addition to this Common Application in order to secure coverage**.
E. To this application, please attach copies of:
   1. Marketing or Advertising brochures or descriptive materials provided to clients.
   2. Latest annual financial statement.
   3. Loss runs, dated within 60 days of submission, covering the past 5 or more years for all coverages being requested (in Excel if available).
   4. Submit professional qualifications (i.e., resume or c.v.) of each owner, partner, officer and key employee if the applicant is a new business.
   5. Most recent state survey reports, licensure reports and accreditation survey reports as applicable.
   6. Quality Improvement/Risk Management plan.
F. This application must be completed, signed and dated by a principal of the business.

I. GENERAL INFORMATION:

Name of Applicant (legal name): _____

Corporate Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Mailing Address: (if different) _____

Corporate Contact: _____ E-Mail Address: _____

Tel. Number: (_____) _____ Fax Number: (_____) _____ Website: _____

Medicare Provider ID: _____

A. Named Insured: Provide names and descriptions of all legal entities that are intended for coverage under the policy being applied for. If more space is required, provide by attachment. Please fill in all sections.

Name	Description	% Owned	Date Acquired	Retroactive Date

B. Description of Services provided: _____

C. Physical Premises: Please list below all buildings the applicant owns, controls or occupies. Attach a separate schedule if more space is needed. Address must include street address, city, state, zip code and county.

Address	Sq. Ft.	Usage Occup.	# of Stories	Construction Type (e.g., Frame, Brick)	Sprinkler System Y/N	Central Smoke Detectors Y/N	Central Alarm Y/N	Owned or Leased

D. What states is the applicant operating in? _____

E. If the applicant provides management services, describe in detail the management services performed for others:

_____

F. Who has a financial interest in the applicant's facility? _____

G. Does the applicant own any other business not shown on this Application? ☐ Yes ☐ No

If Yes, explain: _____

H. Gross Revenue:

Gross Revenue	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
	$	$	$	$	$

I. How many years has the applicant been in operation? _____ years

J. Within the next 12 month period, does applicant plan to:

1. Obtain another operation or entity? ☐ Yes ☐ No
2. Add to the number of employees? ☐ Yes ☐ No
3. Expand the number of locations? ☐ Yes ☐ No
4. Eliminate/add current services? ☐ Yes ☐ No
5. Operate in other states? ☐ Yes ☐ No

K. Within the past five years has the applicant acquired, sold, or discontinued any operations? ☐ Yes ☐ No

If the response was "Yes" to J and K, provide details on a separate sheet of paper.

L. Where does the applicant provide services for the client? Must equal 100%

☐ Applicant's locations _____% ☐ Patient's Home _____ %

☐ Long Term Care Facility _____% ☐ Hospital _____%

☐ Mobile Facility _____% ☐ Schools _____%

☐ Jail/Prison _____% ☐ Other _____% *Explain* _____

M. Indicate percentage of children/adolescent patients: _____%

N. Are all services provided by a medical prescription or physician order? ☐ Yes ☐ No

If No, what services do not require medical prescription or a physicians order? _____

O. Applicant is: (check appropriate boxes)

☐ For Profit ☐ Non-Profit ☐ Governmental Entity ☐ Sole Partnership

☐ Corporation ☐ Professional Association ☐ Partnership ☐ Franchise

☐ Other: Describe: _____

P. Organizational Accreditation/Certification/Licensure

1. Accredited? ☐ Yes ☐ No

   If Yes, by whom and specific to what operation? _____

2. Certified? ☐ Yes ☐ No

   If Yes, by whom and specific to what operation? _____

3. Licensed? ☐ Yes ☐ No

   If Yes, by whom and specific to what operation? _____

4. Has the applicant's accreditation, certification or license been suspended or revoked? ☐ Yes ☐ No

   If Yes, explain: _____

II. COVERAGE REQUESTED: (check all that apply)

A. Professional Liability:

1. Current Insurance Carrier: _____ Premium: $_____
2. Current Form of Insurance:

   Check one: ☐ Claims Made - Retroactive Date: _____ ☐ Occurrence
3. Limits of Liability: $_____ each claim/$_____ aggregate
4. Do you have a: ☐ Deductible or ☐ Self Insured Retention?

   What is Deductible or SIR Amount $ _____
5. Does the state the applicant is operating in have a Patient Compensation Fund? ☐ Yes ☐ No

   If yes, is the applicant currently enrolled in the Patient Compensation Fund? ☐ Yes ☐ No

B. Commercial General Liability

Current Insurance Carrier: _____ Premium: $_____

Current Form of Insurance: Check one:

☐ Occurrence ☐ Claims Made – Retroactive Date: _____

Limit - Each Claim (cannot exceed PL limit) $_____

Limit - Fire Damage Limit of Liability (Any one Fire) $ _____

Limit - Products-Completed Ops Aggregate Limit $ _____

Limit - General Aggregate (Other than Products) $ _____

Do you have a: ☐ Deductible or ☐ Self Insured Retention?

What is Deductible or SIR Amount $ _____

C. Umbrella Liability *

☐ Do not have an Umbrella policy ☐ Want an Umbrella policy

Current Insurance Carrier: _____ Premium: $ _____

Limit: $ _____ Combined Single Limit

Submit Umbrella Accord Application for this coverage. Include Auto and EL information if you desire to have this coverage scheduled on your umbrella policy.

D. Employee Benefit Liability: ☐ Do not desire this coverage ☐ Want coverage

Limits of Liability: $ _____ each claim / $ _____ aggregate Total number of Employees _____

III. PROFESSIONAL SERVICES

A. Provide the supplemental application(s) in addition to this Common Application if a supplemental application is indicated in the right hand column. If information is being requested in the right hand column provide appropriate numbers. **Supplemental applications and numbers given are the basis for rating the submission.** All Information given here or the supplemental application should be **projected numbers for the next 12 months**. **"Visits"** are defined as the number of patients entering the facility for health related services per year. 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. **"Receipts"** are defined as Gross Receipts.

Risk Classification	Information Needed
Ambulatory Surgery Center	Complete Ambulatory Surgery Application
Behavioral Health Services	Complete Behavioral Health Application
Blood/Plasma Bank Services	Complete Blood/Plasma Bank Application
Camp	Complete Camp Application
Cancer Treatment Services	Complete Cancer Treatment Application
Community Health Center	Complete Community Application
Cardiac Catheterization Lab	Complete Cardiac Cath Lab Application
Convenient Care Services aka Retail Health Clinic	Enter # of Visits in this space
Crisis Stabilization Services	Complete Behavioral Health Application
Dialysis Services	Complete Dialysis Services Application
EmergiCenter Services	Enter # of Visits in this space
Crisis Stabilization Services	Complete Behavioral Health Application
Endoscopy Center	Complete Ambulatory Surgery Application
Eye Bank	Complete Eye Bank Application
Fertility Services	Enter # of Visits in this space
Health Dept Services	Enter # of Visits & Beds in this space
Home Health/DME Services	Complete Home Health Application
Hospice Care Services	Complete Home Health Application
Imaging Services	Complete Imaging Services Application
Laboratory Services	Complete Laboratory Application
Lithotripsy Services	Complete Lithotripsy Application
Medical Administrative Services	Enter # of Visits & Beds in this space
Medical Registry/Staffing/Medical Employee Contract	Complete Home Health Application
Medical Spas	Complete Medical Spa Application
Mobile Equip Services/Diagnostic & Therapeutic	Complete Home Health Application
Optical Services	Enter Annual Receipts in this space
Pharmacy Services	Complete Pharmacy Application
Recovery Center	Complete Behavioral Application
Rehabilitation Services	Complete Rehabilitation Application

Risk Classification	Information Needed
Schools for Healthcare Professionals	Complete School Application
Sleep Centers	Enter # of Visits & Beds in this space
Student Health Services	Complete Student Health Application
Substance Abuse Services	Complete Behavioral Application
Telemedicine	Enter # of Patient Encounters in this space
Transport Non-Emergency	Enter # Transports in this space
Urgent Care Centers	Enter # of Visits in this space
Weight Loss Services	Enter # of Visits & Beds in this space
All Other Services: Describe	Annual Revenue/# of patients/#beds

B. Is the applicant involved in Alternative/Complementary Medicine? ☐ Yes ☐ No

If Yes, please explain: _____

C. Does the applicant house patients overnight? ☐ Yes ☐ No

If Yes, please explain: _____

D. Does the applicant participate in clinical research trials? ☐ Yes ☐ No

If Yes, list active trials: _____

Provide total number of participants in active trials: _____

E. Medical Director/Physician/Surgeon. Provide information for the Medical Director and each physician/surgeon providing services at applicant's facility.

Medical Directors Name	Specialty Board Certified Y/N	Insurance Carrier & Policy Number/Limits	State of Licensure	License Number	Employee/ Contractor	Hours per Month

Other Physicians/ Surgeons Names	Specialty Board Certified Y/N	Insurance Carrier & Policy Number/Limits	State of Licensure	License Number	Employee/ Contractor	Hours per Month

F. Do any of the physicians named in question "E." above have direct patient care responsibilities at the applicant's facility? ☐ Yes ☐ No

If Yes, what is the physician's role in providing services for the applicant's facility? _____

G. Is physician credentialing and privileging formalized and documented? ☐ Yes ☐ No

H. Does the applicant require:

1. Health care professionals providing services for the facility to carry professional liability insurance? ☐ Yes, in by-laws ☐ Yes, in contract ☐ No

2. Employed or contracted physicians or surgeons providing services for the facility to carry professional liability insurance? ☐ Yes, in by-laws ☐ Yes, in contract ☐ No

I. Indicate the minimum professional liability insurance limits required for:

1. Employed or Contracted physicians or surgeons $ _____ each claim $ _____ aggregate

2. Contracted Allied Health Care Professionals $ _____ each claim $ _____ aggregate

3. Is proof of coverage required? ☐ Yes ☐ No If No, explain: _____

J. Has there been any review by a state medical board or other federal, state, or non-governmental oversight entity of any physician with privileges at the organization? ☐ Yes ☐ No

K. Has any physician/practitioner's license with privileges in the applicant's organization been suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No

L. Has any limitations or conditions on any physician/practitioner's privileges in the applicant's organization been implemented? ☐ Yes ☐ No

M. List the following details for each medical professional that has a financial interest in the applicant's facility.

Name	Profession	Interest (owner, director, etc.)	Patient Care	
			For the Facility %	Outside Practice %

IV. EMPLOYEES/INDEPENDENT CONTRACTORS INFORMATION – Review A and B

A. LICENSED

LICENSED	Number Full-Time	Number Part-Time	Annual Payroll	Number of 1099's
Nurses (RN, LPN, LVN)				
Advanced Practice Nurses/Nurse Practitioners/Midwives				
Physician Assistants/Surgeon Assistants				
Pharmacists				
Residents				
Interns				
Other (Specify)				
Other (Specify)				

B. NON-LICENSED

NON-LICENSED	Number Full-Time	Number Part-Time	Annual Payroll	Number of 1099's
Students				
Certified Nurse Assistants				
Certified Medical Assistants				
Phlebotomists				
Therapy Aides/Assistants				
Technicians - Explain				
Technologists				
Other (Specify)				
Other (Specify)				

C. Independent Contractors

1. Does applicant want coverage to include independent contractors? ☐ Yes ☐ No

   If no, what limits does applicant require them to carry? $ _____

2. Does applicant obtain certificates of insurance from independent contractors? ☐ Yes ☐ No

   If no, how does applicant verify that the required insurance is maintained? _____

D. Percentage of turnover for licensed staff: _____ % Non-licensed staff:_____ %

E. Percentage of total licensed staff that is agency workers? _____ %

F. Hiring/Screening and Employment Procedures

1. Are employees/contractors references contacted before hiring or placement? ☐ Yes ☐ No
3. Are written job descriptions provided for all staff members? ☐ Yes ☐ No
4. Does applicant verify any pending license suspensions, revocations, or pending disciplinary actions by other facilities? ☐ Yes ☐ No

G. Please check all that apply with an "X".

Type	Pre-hire criminal background check	Current criminal background check	State or County check	Federal check	Misdemeanor check	Sexual Offender Registry
Employees						
Contractors						
Volunteers						

V. CONTRACTUAL AGREEMENTS:

A. Does the applicant have a formal contract management program that includes the following elements:

1. Copies of all contracts in force and expired ☐ Yes ☐ No
2. Mutual indemnification and hold harmless clauses in every contract ☐ Yes ☐ No
3. Requirement that the contracting party carry liability insurance with limits equal to/or exceeding the applicant's ☐ Yes ☐ No
4. Requirement that the contracting party supply the applicant with an in force copy of a certificate of insurance. ☐ Yes ☐ No

VI. MEDICAL EQUIPMENT/SUPPLIES SALES AND LEASING OPERATIONS

A. Does applicant sell any medical or therapeutic supplies and/or equipment? ☐ Yes ☐ No

If Yes, Annual Receipts $ _____

B. Does applicant rent or lease any medical or therapeutic supplies and/or equipment to others: ☐ Yes ☐ No

If Yes, Annual Receipts $ _____

If the response was "No" to both A and B, please skip the next section and go on. ***If the response was "Yes" to either A or B, please check the appropriate categories below and indicate the receipts.***

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

Annual Sales $_____ Annual Lease/Rental Receipts $_____

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 $_____

Category III: **DIAGNOSTIC OR TREATMENT DEVICES** - 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 life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, and transmitting 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 or any other life dependent monitors or any other equipment or devices where malfunction/failure or improper function could result in death or serious deterioration in health condition.(Please attach list of Category IV equipment or devices).

Annual Sales $_____ Annual Lease/Rental Receipts $_____

VII. BIOMEDICAL EQUIPMENT PREVENTIVE MAINTENANCE

A. Does the applicant have a formal documented preventative maintenance management program that includes the following elements:

1. PM work being conducted by specially trained personnel ☐ Yes ☐ No
2. Readily available copies of all user/operator equipment manuals ☐ Yes ☐ No
3. Recall and hazard alert program ☐ Yes ☐ No

VIII. RISK MANAGEMENT/QUALITY ASSURANCE

A. Does applicant utilize a formal written Quality Improvement Plan? ☐ Yes ☐ No

B. Does the applicant utilize a formal written Risk Management Program? ☐ Yes ☐ No

C. Is there a formal, documented peer review and credentialing process in place? ☐ Yes ☐ No

D. Medical/Patient Records:

1. Are records stored: ☐ electronically or ☐ paper files or ☐ both?
   a. If electronic, how often are backups made? _____
   b. If paper, where are records stored? ☐ on site ☐ off site?
   c. Are the buildings in which paper records stored sprinkled? ☐ Yes ☐ No

E. Who has the overall responsibility for Risk Management & Quality Assurance?

Name: _____ Title: _____

Telephone Number: _____ E-Mail Address: _____

IX. GENERAL LIABILITY

A. Does applicant sponsor any sporting or special events? ☐ Yes ☐ No

If Yes, please explain? _____

B. Does the applicant provide alcoholic beverages at any of these events? ☐ Yes ☐ No

If Yes, please explain? _____

C. Is all advertising/public relations media/website reviewed by legal counsel or risk management? ☐ Yes ☐ No

X. LITIGATION/CLAIMS HISTORY/ SANCTIONS/FINES

If the response is yes to any question below additional information must be provided on the applicant's letterhead. Please submit actual loss runs from the previous carriers for the past five or more years.

A. Has the applicant had any Professional, General Liability, Employee Benefits or Umbrella claims or suits brought against them in the past 5 years? ☐ Yes ☐ No

B. Is the applicant aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ☐ No

C. Has the facility/operational license ever been suspended, revoked or voluntary suspended? ☐ Yes ☐ No

D. Has any Insurance Company or Lloyd's declined, canceled, or refused to renew or accept any of the applicant's liability insurance? ☐ Yes ☐ No

E. Has any Company with whom the applicant been previously affiliated with become insolvent? ☐ Yes ☐ No

F. Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the applicant's organization? ☐ Yes ☐ No

G. Has the applicant ever been sanctioned or decertified by Medicare? ☐ Yes ☐ No

H. Has the organization or any of its officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional medical society, accreditation agency or other governmental or non-governmental oversight entity? ☐ Yes ☐ No

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.