☐ New ☐Renewal Effective Date:

BLOOD BANK APPLICATION

Some of the coverages being applied for are Claims Made. Claims-Made coverage, subject to the provisions of the policy, apply only to a claim first made during the policy period. No coverage exists for claims made coverage for claims first made after the end of the policy period unless, and to the extent, an extended reporting period applies. If there are questions concerning these coverages, please contact your insurance agent or broker.

Instructions:

1. 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.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If more space is needed, continue on a separate sheet of the applicant's letterhead and indicate the question number.
4. To this application, please attach copies of:
   a. Latest annual financial statement.
   b. Claim loss runs for the past 5 or more years for all coverages being applied for, in Excel if available
   c. Most recent state survey reports, licensure reports and accreditation survey reports as applicable.

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. 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	Total Sq. Ft.	Usage/ Occup.	No. of Stories	Type of Construction (e.g., Frame / Fire Resistant / Brick)	Sprinkler System Y/N	Smoke Detectors Y/N	Central Alarm Y/N	Owned or Leased

C. What states is the applicant operating in? _____

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

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

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

If yes, explain: _____

G. Gross Revenue:

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

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

I. 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

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

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

K. Applicant is: (check off each that apply)

☐ Accredited by American Association of Blood Banks ☐ Accredited by JCAHO
☐ Member of Applied Research Center ☐ Member of American Society of Hematology
☐ Member of American Blood Centers ☐ Clinical Laboratory Improvement Act (CLIA) deemed status
☐ Accredited by the College of American Pathologists ☐ Accredited by the American Association of Tissue Banks
☐ Other _____

II. COVERAGE REQUESTED: (check all that apply)

Coverage requested to be effective on: _____/_____/_____

A. Professional Liability:

☐ Claims Made - Retroactive Date: _____

Limits of Liability: $ _____ each claim / $ _____ aggregate

☐ Deductible; or ☐ Self Insured Retention Amount $ _____

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

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) $ _____

☐ Deductible or ☐ Self Insured Retention Amount $ _____

C. Umbrella Liability *

☐ Yes ☐ No Limit: $ CSL

*Submit Umbrella Accord Application for this coverage

D. Employee Benefit Liability

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

1. Is this optional coverage desired? ☐ Yes ☐ No
2. Are benefit plans administered jointly by management and union? ☐ NA ☐ Yes ☐ No
   If Yes, indicate type of plan: _____
3. On programs permitting the option to enroll, does the applicant require a signed written acceptance or rejection from each employee? ☐ Yes ☐ No
   If No explain: _____
4. Is the business corporation or organization subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) ☐ Yes ☐ No
   a. If the response was "No" and there are more than 20 employees explain on a separate sheet of paper why not.
   b. If the response was "Yes", has the applicant, to the best of your knowledge, complied with the written notice requirements of that act? ☐ Yes ☐ No

III. PREVIOUS PROFESSIONAL LIABILITY COVERAGE:

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible ☐ Self-Insured Retention $ _____	☐ Deductible ☐ Self-Insured Retention $ _____	☐ Deductible ☐ Self-Insured Retention $ _____
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date			
Policy Period			
Premium	$	$	$

IV. PREVIOUS COMMERCIAL GENERAL LIABILITY COVERAGE

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible ☐ Self-Insured Retention $	☐ Deductible ☐ Self-Insured Retention $	☐ Deductible ☐ Self-Insured Retention $
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date			
Policy Period			
Premium	$	$	$

V. PREVIOUS UMBRELLA LIABILITY COVERAGE

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability			
Deductible or Self-Insured Retention and Amount	☐ Deductible ☐ Self-Insured Retention $	☐ Deductible ☐ Self-Insured Retention $	☐ Deductible ☐ Self-Insured Retention $
Coverage Form	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made	☐ Occurrence ☐ Claims-Made
Retroactive Date			
Policy Period			
Premium	$	$	$

VI. UNDERWRITING INFORMATION

A Premium Rating Exposures (Annual)

Paid Donations	
Volunteer Donations (non-autologous)	
Autologous Donations	
Foreign (not USA) Donations Purchased	
Pheresis Procedures	
Cord Blood Activities	
Outpatient Transfusions	
Therapeutic Plasma Exchange	
Parentage Testing	
Hematopoietic Progenitor Cell Activities	
Immunohematology Reference Lab Procedures	
Other	
TOTAL	

B. Are you involved in tissue, organ, sperm, embryo or bone marrow banking? ☐ Yes ☐ No

If yes,

Type	Total Number

C. Are there any research activities? ☐ Yes ☐ No

If yes, explain:

D. 1. Do you provide testing for other donor facilities? ☐ Yes ☐ No

If yes,

Type of Test	Total Number

2. Do you require the other facility to carry professional liability insurance equal to your limits? ☐ Yes ☐ No

3. Does a contract exist between you and the other facility? ☐ Yes ☐ No

If yes, provide a copy of the contract.

E. 1. Do you contract with another facility to test blood on your behalf? ☐ Yes ☐ No

If yes, name of facility:

Type of Test	Total Number

2. What professional liability insurance limits are required?

3. Does a contract exist between you and the other facility? ☐ Yes ☐ No

4. Do you have on file a copy of their most recent FDA report? ☐ Yes ☐ No

F. Have you implemented the FDA recommendations for:

1. Preventative measures to reduce the possible risk or transmission of CJD and VCJD? ☐ Yes ☐ No

2. Assessment of Donor Suitability and Blood and Blood Product in cases of possible exposure to anthrax? ☐ Yes ☐ No

3. Questions related to potential donors who have recently received smallpox vaccine? ☐ Yes ☐ No

4. Quarantine and Disposition of prior collections from donors with repeatedly reactive screening tests for HCV: Supplemental testing, and the notification of consignees and transfusion recipients of donor test results for HCV (anti-HCV)? ☐ Yes ☐ No

   a. If yes, when did you implement the lookback? _____/_____/_____ mm / dd / yyyy

   b. How far back did you start the search of records of prior donations from donors with repeatedly reactive screening tests for HCV? _____/_____/_____ mm / dd / yyyy

G. Are you using nucleic acid tests? ☐ Yes ☐ No
If yes, what percentage of your blood is tested by this means? _____%

H. Are you using leukoreduction? ☐ Yes ☐ No
If yes, what percentage of your blood is screened by this method? _____%

I. Are you using pathogeninactivation? ☐ Yes ☐ No
If yes, what percentage of your blood is tested by this means? _____%

J. If you perform autologous donations, please explain how you ensure the units arrive for transfusion when needed. _____

K. Which manufacturer's HIV test are you using? _____

L. Date you first started HIV testing: _____

M. Which tests are used for detecting Hepatitis? _____

N. Date that HTLV-I testing started: _____

O. Attach a copy of most recent FDA inspection report (form 482, 483), and the blood bank response.

P. Are you involved in any operations other than blood banking? ☐ Yes ☐ No
If yes, describe in detail: _____

Q. Do you provide **Management Services** to other Blood Banks? ☐ Yes ☐ No
If yes, describe in detail the **Management Services** performed for others: _____

R. What are the Blood Bank CEO and Medical Director qualifications? Attach Curriculum Vitae.

S. Does the Blood Bank check with the National Blood Donor Registry before donor's blood is taken and/or transfused? ☐ Yes ☐ No

T. Has the applicant's accreditation, certification or license been suspended or revoked? ☐ Yes ☐ No
If Yes, explain: _____

VII. QUALITY IMPROVEMENT/RISK MANAGEMENT

A. 1. Is a formal Quality Improvement/Risk Management program in place? ☐ Yes ☐ No

2. Is the overall responsibility for Quality Improvement/Risk Management designated to one individual within the administrative structure of the organization? ☐ Yes ☐ No
If yes:

Title: _____ Telephone Number: (_____)_____-_____
If no, please describe how these functions are monitored by the Administration: _____

Are written policies and procedures are followed regarding the following:

- Reports of complaints of adverse reactions ☐ Yes ☐ No
- Use, calibration and maintenance of equipment ☐ Yes ☐ No
- Collection processing, compatibility testing, storage and distribution of blood and blood components ☐ Yes ☐ No
- Documentation, maintenance and retention of donor records ☐ Yes ☐ No
- Incident reports ☐ Yes ☐ No

B. Has any outside organization/government/insurance company conducted an inspection of your facility? ☐ Yes ☐ No
If yes, list the entity and date of inspection: _____

VIII. EMPLOYEES/INDEPENDENT CONTRACTORS INFORMATION

LICENSED/NON-LICENSED	Number Full-Time	Number Part-Time	Annual Payroll	Number of 1099's
Nurses (RN, LPN, LVN)				
Advanced Practice Nurses/Nurse Practitioners				
Physician Assistants				
Phlebotomist				
Physicians				
Processing Technologist				
Volunteers				
Students				
Other (Specify)				
Other (Specify)				

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

B. Hiring/Screening and Employment Procedures

1. Are employees/contractors references contacted before hiring or placement? ☐ Yes ☐ No
2. How are references checked? ☐ Written ☐ Verbal ☐ Both
3. Are 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
5. Does the applicant utilize criminal background checks? ☐ Yes ☐ No
   If Yes, check those applicable: ☐ Pre-hire ☐ Current employees
   If Yes, what level are criminal searches conducted?
   ☐ State/County ☐ Federal ☐ Misdemeanor Convictions
6. Are criminal checks done for all employees/contractors? ☐ Yes ☐ No
   If No, describe employee/contractor categories not checked: _____

IX. CONTRACTUAL AGREEMENTS:

A. Does the applicant have written agreements with third parties? ☐ Yes ☐ No

1. If the response was Yes, does each agreement include the following?
   a. Mutual indemnification and hold harmless clause. ☐ Yes ☐ No
   b. A requirement the other party carry liability insurance with liability limits equal to or exceeding the applicant's. ☐ Yes ☐ No
   c. A requirement that the other party supply the applicant with a current copy of a certificate of insurance. ☐ Yes ☐ No

X. 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

XI. 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