



NEW BUSINESS APPLICATION

MISCELLANEOUS HEALTHCARE FACILITIES PROGRAM

- General Star Indemnity Company
- General Star National Insurance Company

Wholesaler: _____ Location: _____
City State

Contact Name: _____ Phone #: _____ E-Mail : _____

NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

Instructions to the Applicant.

- A. Please answer **all** the questions on this application and on applicable supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- C. The application must be signed and dated by an owner, partner, officer or director of your facility.
- D. Please attach the following to your completed application:
 - 1. brochures, pamphlets, advertisements or other descriptive literature of operations and services,
 - 2. copies of any surveys conducted by outside organizations within the past three years,
 - 3. copy of the current practice license(s),
 - 4. company loss runs, valued within the last 90 days, for past 5 years, or for as long as you have been in business if less than 5 years. **Losses should be provided on a report year basis**, and
 - 5. Current income statement and balance sheet.

I. GENERAL INFORMATION

Applicant's/Entity's Name: _____ Tax ID #: _____

1. Mailing Address: _____
Street/P.O. Box City County State Zip Code

2. Business Address: _____
Street City County State Zip Code

3. Telephone Number: _____ Web Site: _____

4. Applicant is a: Individual Partnership Corporation Joint Venture Other: _____
 Applicant is: For Profit Not for Profit

5. Years in Business: _____ Hours of Operation: _____

6. Description of Operation: (complete & attach the appropriate SUPPLEMENTAL APPLICATION)

- Blood / Donor Bank
- Home Health Care / Hospice Care
- Laboratory / Imaging
- Out-Patient Facility / Ambulatory Surgery Center
- Air or Ground Ambulance Service
- Durable Medical Equipment Supplier
- Birthing Center
- Other (describe) _____

Please provide additional details as necessary: _____

7. List below all subsidiaries, date acquired, description of operation and percentage of ownership:

Subsidiaries	Date Acquired	Description of Operation	% of Ownership
			%
			%

8. Within the next 12 months, does the applicant plan to: (check all that apply and provide details)

- Purchase or acquire another operation or entity?
- Add any services?
- Expand the number of locations?
- Expand operation into other states?

Details: _____

9. Has the applicant sold, discontinued or acquired any operations since the retroactive date of your current policy? If yes, please provide details: _____ Yes No

II. OPERATIONS

1. Provide applicant's total **gross** annual revenues:

Projected	\$ _____
Current Year	\$ _____
Past Year	\$ _____
2 nd Previous Year	\$ _____

2. If your operation is an outpatient facility, please provide the number of outpatient visits:

Projected	# _____
Current Year	# _____
Past Year	# _____
2 nd Previous Year	# _____

3. Is the applicant accredited by or a member of any professional organization or association? Yes No
If yes, please name: _____

If accredited, please provide a copy of the accreditation report.

3. Is applicant certified for Medicare reimbursement? Yes No

4. Does the applicant maintain a current state license? If yes, please provide copy. Yes No

5. Has applicant's license or certification ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any state or federal licensing board or regulatory agency? This includes but is not limited to Medicare, Medicaid, or other reimbursement programs. If yes, please provide details: _____ Yes No

6. Are all operations provided out of the main location? If no, please attach a listing of all locations including a description of services conducted at each location. Yes No

7. Are any services provided for or at Nursing Homes, Assisted Living Facilities, or Long Term Care Facilities? If yes, please describe. _____ Yes No

8. a. Does applicant have any contractual agreements with independent contractors to provide services at applicant's facility? Yes No

b. Does contractual agreement contain a hold harmless or indemnification clause favorable to applicant? Yes No

c. Does applicant obtain certificates of insurance in the amount of \$1m/\$3m (minimum) from all Healthcare Professionals, e.g., Resident, intern, Physician, Surgeon, Dentist, Psychiatrist, Licensed or Certified Registered Nurse Anesthetist, Nurse, Midwife, Podiatrist and Chiropractor rendering professional services at the facility? Yes No

9. a. Does applicant provide services to others on a contractual agreement? If yes, please describe services provided: _____ Yes No

b. Does the applicant agree to hold harmless or indemnify others under contract? If yes, please provide details: _____ Yes No

10. Does applicant sell or lease any medical supplies and/or equipment to others? If yes, please complete and attach the Durable Medical Equipment Supplemental Application. Yes No
11. Does applicant provide any overnight bed facilities? If yes, advise number of beds: _____ Yes No
12. Do you have written protocols and transfer agreements to transfer patients in the event of a life-threatening emergency? Please provide a copy of those documents and advise: Yes No

Name of the facility _____
 Number of miles to the facility _____ Miles
 Driving time to facility _____ Minutes

13. Please provide the following information for each medical director providing services at the applicant's facility:

Medical Director's Name	Specialty	Insurance Carrier & Policy Number	Limits	Employee/ Contractor	Hours per Month

Please note: Coverage for Medical Director is limited to administrative duties as described in the policy form.

14. Identify the number of other employed health care professionals providing services at the applicant's facility:

Type of Professional	# Full Time Employees	# Part Time Employees	# Full Time Contractors	# Part Time Contractors	Contractors Annual Hours
EMT	_____	_____	_____	_____	_____
Nurse	_____	_____	_____	_____	_____
Nurses Aid	_____	_____	_____	_____	_____
Nurse Practitioner	_____	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____	_____
Paramedic	_____	_____	_____	_____	_____
Pharmacist	_____	_____	_____	_____	_____
Phlebotomist	_____	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____	_____
Physician Assistant	_____	_____	_____	_____	_____
Radiation Technician	_____	_____	_____	_____	_____
Respiratory Therapist	_____	_____	_____	_____	_____
Social Worker	_____	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____	_____

III. RISK MANAGEMENT/LOSS CONTROL

1. Does applicant utilize a formal written Risk Management Program? Yes No
 If yes, attach a written summary of, the Table of Contents, or copy of the written policy/procedure document.
2. Who has the overall responsibility for Risk Management & Loss Control?
 Name: _____
 Title: _____
 Telephone Number: _____
4. Who is to be contacted for loss control survey, if different than above? Same as #2
 Name: _____
 Title: _____
 Telephone Number: _____
4. a. Does applicant own any equipment used for diagnosis, monitoring or treatment purposes? Yes No
- b. Is there a written procedure followed for the inspection and maintenance of any equipment that is owned or leased? Yes No
- c. Who is responsible for inspecting and maintaining the equipment? Employees Independent Contractors
- d. If Independent Contractors are utilized, are certificates of Insurance obtained? Yes No
- e. Is inspection and maintenance performed according to the manufacturer's recommendations? Yes No

5. Indicate which hiring/screening procedures are used for employees and contractors: (check all that apply)
- References checked: In writing By telephone
 - Criminal records checked
 - Require information on any professional liability or work related claim or suit
 - Verify any pending license suspensions, revocations or pending disciplinary actions by other facilities
6. Are "INFORMED CONSENT" forms used? If yes, please provide a copy. Yes No
7. Is there a written policy or procedure document describing:
- a. Employee training? N/A Yes No
 - b. Incident Reporting? N/A Yes No
 - c. Medical equipment training? N/A Yes No
 - d. Infection Control? N/A Yes No
 - e. patient acceptance? N/A Yes No
 - f. patient evaluations? N/A Yes No
 - g. safety for workers in offsite locations? N/A Yes No
 - h. lifting requirements? N/A Yes No
 - i. drug administration procedures? N/A Yes No
 - j. food preparation? N/A Yes No
 - k. patient discharge procedures? N/A Yes No
 - l. advance directives such as a "Living Will"? N/A Yes No
8. Does applicant have written job descriptions in place for:
- a. all professionals? Yes No
 - b. all clinical support staff? Yes No

IV. BUILDING INFORMATION

1. Building Construction: _____ Year Built: _____
2. Number of Stories _____
Number of Exits per Floor _____
3. Are there smoke detectors and fire extinguishers? Yes No
4. Is building completely sprinklered? Yes No
5. Are there fire alarms? If yes, advise number _____ and type _____ Yes No
6. Fire Department is: Paid Volunteer
7. Are the electrical, heating and plumbing systems up to code and regularly inspected? Yes No

V. PRIOR POLICY AND LOSS INFORMATION

1. Please provide the following information pertaining to applicant's past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	
				<input type="checkbox"/> CM <input type="checkbox"/> Occ	

2. Has the applicant ever had any insurance company decline, cancel, rescind or non-renew any Professional and/or General Liability Insurance Policy? If yes, please provide details: Yes No
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3. Is the applicant aware of any of the following:
- a. known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? Yes No
 - b. knowledge of facts or circumstances that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that has not been reported to a prior insurance carrier? Yes No
 - c. knowledge of any request for medical records by a patient or his/her attorney which might result in a claim? Yes No
 - d. knowledge or information relating to service(s) on a Board which might result in a claim? Yes No
 - e. knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact? Yes No

If yes to any of the above, please provide details: _____

VI. COVERAGE REQUESTED

Effective Date: _____ **Retroactive Date:** _____
Important: Declarations Page of your current policy must be attached if a retroactive date is requested.

Primary Liability: Professional Liability Claims Made
 General Liability Claims Made Occurrence

Important: Limits for Professional Liability and General Liability must be the same when both provided, even though they apply separately.

Limits of Liability: \$250,000/\$750,000 **Deductible:** \$ 5,000 (minimum)
 \$500,000/\$1,500,000 \$ 7,500
 \$1,000,000/\$1,000,000 \$10,000
 \$1,000,000/\$3,000,000 Other \$ _____

Excess Limit of Liability: \$1,000,000/\$1,000,000
 \$2,000,000/\$2,000,000
 \$3,000,000/\$3,000,000
 \$4,000,000/\$4,000,000
 \$5,000,000/\$5,000,000

VII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and
2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):
 - Ambulance Service Supplemental Application Durable Medical Equipment Supplemental Application
 - Out-Patient / Ambulatory Surgery Center Supplementa Application Laboratory & Imaging Supplemental Application
 - Blood / Donor Banks Supplemental Application Home Health Care and Hospice Care Supplemental Application
 - Birthing Center Supplemental Application
 - Claim Information Supplemental Application Other _____

3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:
 - a. Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
 - b. Representations you are making on behalf of all persons and entities proposed to be insured;
 - c. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy, and incorporated into the policy, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy, and regardless of whether any of the Supplemental Applications are signed or dated.
5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or in any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

NEW YORK FRAUD WARNING: 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 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.

FRAUD WARNING (not applicable in Nebraska, Vermont or Virginia): Any person who knowingly and with the 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where General Star National Insurance Company is "non-admitted or "surplus lines"), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved surplus lines insurer in the state.

An authorized representative who is an active owner, officer, or partner of your organization must sign this Application within thirty (30) days prior to the policy inception date.

Signature of Owner, Officer or Partner

Date

Print or Type Name and Title

