



MEDI-SPA FACILITY PROFESSIONAL LIABILITY APPLICATION INSTRUCTIONS

PLEASE READ THIS SECTION OF THE APPLICATION CAREFULLY. YOUR PREMIUM QUOTATION IS BASED ON THE INFORMATION YOU PROVIDE.

PLEASE ATTACH THE FOLLOWING DOCUMENTS WITH THE APPLICATION:

- Copy of your loss reports (loss runs) from your current and previous Medical Professional Liability Insurers. Please include loss reports/loss runs for each physician if they carry their own insurance. The loss reports/loss runs for the Clinic should represent at least 10 years of history or as far back as the clinic has been open (if less than 10 years). The loss history for the physician (if applicable) should represent at least 10 years of history or as far back as the physician has been practiced (if less than 10 years). **We can quote without Loss Runs and if applicable you can complete the Claims Supplement. However, Loss Runs are needed to bind coverage.**
- Provide a list of your current Physicians, NPs, PA-Cs, and RNs by name. Please list the specialty of the physician and if they are Board Certified (see attached 'List of Covered Staff').
- Please attach a CV for each Physician, NP, PA-C, and RN.
- Provide a list of your departed Physicians, NPs, PA-Cs, and RNs. (We ask for this information so if we are going to assume prior acts that we assume the past liabilities of your past providers.) See the attached 'List of Departed Staff'.
- Provide proof of training for each professional for each type of service they perform.
- Copy of your declarations page and portions of your policy that show the named insured, list of providers insured, and the retroactive dates.
- Copy of any advertising you do, marketing material and copies of brochures about your Medi-spa (if applicable).
- Copy of your policy and procedures manual (P&P) (Table of Contents is acceptable).
- Copy of your informed consent documents for each procedure performed.
- Copy of your aftercare instructions for each type of procedure performed.
- If not included in your P&P manual, please include protocols on how you handle patient screening, transfers, infectious disease (inclusive of training), follow up with patients, dispensing prescriptions (if applicable), emergency treatment protocols, copy of your Risk Management/QA Policy (if applicable) or **for any other aspect of your operations that are not listed and you feel reflects the high level of quality care you provide.**
- List of medical equipment and devices used (lasers, IPL, etc.) and what their purpose is.
- Copy of your most recent year end and month end financial statements. (This is not required, but if supplied you could be eligible for additional credits).
- Please provide narratives for any of the questions in the application that you would like to provide more details. (See comments page on back of application.)
- If you have more than two locations please complete the additional locations addendum found in the back of the application.

Please Return the Application to:

The Wood Insurance Group, 4835 East Cactus Road, Suite #440, Scottsdale, AZ 85254
FAX (602) 230-8207 * Email: davidw@woodinsurancegroup.com

MEDI-SPA FACILITY PROFESSIONAL LIABILITY APPLICATION

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON A CLAIMS-MADE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. IF A POLICY IS ISSUED, THE APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED ACCURATELY AND COMPLETELY.

Please Return the application to:

The Wood Insurance Group, 4835 East Cactus Road, Suite #440, Scottsdale, AZ 85254

Fax (602) 230-8207 * Phone (602) 230-8200 * Toll Free (800) 695-0219

E-mail davidw@woodinsurancegroup.com Website www.woodinsurancegroup.com

Section I - General Information:

Applicant Name: _____

Contact Person: _____ Telephone: _____ E-Mail: _____

Business Address: _____
 Street _____ City, State _____ ZIP _____

Mailing Address: _____
 Street _____ City, State _____ ZIP _____

Website: _____ Years in Business: _____ Hours of Operation: _____

Please indicate ownership and operational structure:

- | | | | |
|---|-------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Individually owned | <input type="checkbox"/> Profit | <input type="checkbox"/> Corporation | <input type="checkbox"/> Non-Profit |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Charitable | <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government |

Please indicate the coverage being requested:

Coverage Effective Dates: From: _____ To: _____

Professional Liability (Claims-Made Only):

Limit: \$ _____ per claim / \$ _____ aggregate Clinic Retroactive Date: _____

Deductible: \$5,000 \$10,000 \$25,000 \$50,000 \$100,000 Other: _____

Please list all current and past DBAs, subsidiaries, and affiliated entities associated with your organization and indicate the percentage of ownership:

Name	Address	Nature of Operations	% of Ownership

Subsidiaries – List all subsidiaries, date acquired, description of operations, & ownership in percentages:

(Please use an additional sheet if necessary.)

Subsidiaries	Date Acquired	Description of Operations	% Ownership

Revenue Data – Provide historical, current and projected revenues:

Revenues	Year	Year	Year	Year	Current Year	Projected Next 12 Months
<input type="checkbox"/> Fiscal						
<input type="checkbox"/> Calendar	\$	\$	\$	\$	\$	\$

Section II – Professional Liability Exposures:

1. Do all the listed Physicians, NPs, PA-Cs, RNs, Aestheticians, or Dentists carry their own Professional Liability coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, list the minimum limits required: _____</i>	
<i>If yes, a certificate of insurance and/or the Declarations page must be attached.</i>	
2. Is coverage requested for any of the listed Physicians, NPs, PA-Cs, RNs, Aestheticians, or Dentists?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, a completed Physician, NP, PA-C, and/or Dentist application for each professional must be attached.</i>	
3. A. Client/Patient Age Breakdown by percentage:	
<input type="checkbox"/> Less than 12 years old _____ %	
<input type="checkbox"/> 12 to 18 years old _____ %	
<input type="checkbox"/> Greater than 18 years old _____ %	
B. Is parental consent required for all patients less than 18 years of age?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does the Applicant take before and after photographs of every patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If no, please provide details.</i>	
5. Is sedation required for any procedures being offered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide details.</i>	
6. Does the facility provide overnight accommodations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide details including the number of beds and the average length of stay.</i>	
7. Describe any products sold and their related revenue for (1) Current Year and (2) Projected Next 12 Months:	
8. Does all labeling and use of drugs have FDA approval?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide details.</i>	
9. Are any FDA approved drugs used in an “off-label” manner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide details.</i>	
10. Is there any compounding of drugs or supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide details.</i>	
11. Do you offer private label supplements for treatment therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, provide more detail and list the types of supplements. (Use an additional sheet if necessary.)</i>	
12. Is a board certified Physician, NP, PA-C, or RN onsite during hours of operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. What is the facility’s staff turnover ratio? _____ %	
14. What is the facility’s provider turnover ration? _____ %	
15. What policies are in place for the safe procurement of drugs, injectibles, and supplements?	
<i>Please explain:</i>	

Indicate the **total number of annual procedures/revenue per type** of service that is performed:

	<u>Current Year</u> <u>Annual Procedures/Revenue</u>	<u>Projected Next 12</u> <u>Months</u> <u>Annual Procedures/Revenue</u>	<u>List the Professionals that</u> <u>Perform the Service (MD, NP,</u> <u>PA, RN, Aesthetician etc.)</u>
<input type="checkbox"/> Beauty Shop (nails, hair, facials)	_____	_____	_____
<input type="checkbox"/> Dental	_____	_____	_____
<input type="checkbox"/> Massage Therapy	_____	_____	_____
<input type="checkbox"/> Skin Care (List each type)	_____	_____	_____
<input type="checkbox"/> Laser Treatments	_____	_____	_____
<input type="checkbox"/> Acne Blue Light Treatment	_____	_____	_____
<input type="checkbox"/> Chemical Peels	_____	_____	_____
<input type="checkbox"/> Electrolysis	_____	_____	_____
<input type="checkbox"/> Hair Transplants	_____	_____	_____
<input type="checkbox"/> Laser Hair Removal	_____	_____	_____
<input type="checkbox"/> Laser Skin Treatment	_____	_____	_____
<input type="checkbox"/> Microdermabrasion	_____	_____	_____
<input type="checkbox"/> Micropigmentation	_____	_____	_____
<input type="checkbox"/> Permanent Makeup	_____	_____	_____
<input type="checkbox"/> Tattoo Reduction	_____	_____	_____
<input type="checkbox"/> Sclerotherapy	_____	_____	_____
<input type="checkbox"/> Myotonology	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____
<input type="checkbox"/> Injections (List each type)	_____	_____	_____
<input type="checkbox"/> Botox	_____	_____	_____
<input type="checkbox"/> Collagen	_____	_____	_____
<input type="checkbox"/> Fat	_____	_____	_____
<input type="checkbox"/> Silicone	_____	_____	_____
<input type="checkbox"/> Restylane	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____
<input type="checkbox"/> Weight Control (List each type)	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> _____	_____	_____	_____
<input type="checkbox"/> Piercing	_____	_____	_____
<input type="checkbox"/> Supplement Treatments	_____	_____	_____
<input type="checkbox"/> Hormone Replacement Therapy	_____	_____	_____
<input type="checkbox"/> Growth Hormones	_____	_____	_____
<input type="checkbox"/> Vitamin Therapy	_____	_____	_____
<input type="checkbox"/> Other: _____	_____	_____	_____
<input type="checkbox"/> Pre-Screening Physical	_____	_____	_____
<input type="checkbox"/> Lab Work	_____	_____	_____
<input type="checkbox"/> Acupuncture	_____	_____	_____
<input type="checkbox"/> Chiropractic	_____	_____	_____

Section III – Clinic Operations and Policy & Procedures

<u>Risk Management</u>	
1. Does your facility have a formalized Risk Management Program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Who coordinates your Risk Management Program?	
Name: _____	
Title: _____ Phone Number: _____	
3. a. Does the facility own any biomedical or other equipment used for diagnosis, monitoring, or treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, who is responsible for inspection and maintenance of the equipment? <input type="checkbox"/> Employees <input type="checkbox"/> Independent Contractor	
b. Do qualified personnel inspect and maintain the equipment on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Are manufacturers recommendations followed for all maintenance and repair of equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. a. Do you have any contractual agreements with independent contractors/providers to provide services at your facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please provide a copy of a sample contract.</i>	
b. Are certificates of insurance obtained from all contracted providers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the facility provide service to others on a contractual agreement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please describe services provided and include a copy of any such contract.</i>	
6. Has the facility agreed to hold harmless or indemnify others under contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please describe and include a copy of any such contract.</i>	
7. Do you provide any classes or training at your facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please describe.</i>	
8. Do you sell, rent or lease any medical equipment or products to patients or others in connection with your operation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If yes, please describe.</i>	
9. Do you have restrictions regarding telephone orders and advice without being seen by the physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Do you provide written discharge instructions to the patient upon checkout?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Quality Assurance</u>	
Is your Medi-Spa accredited?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List date of most recent survey: _____	
Please list any other accreditations: _____	
List all Associations which you are a member: _____	
Is this facility subject to Regulatory Inspections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a committee or provider that performs quality reviews?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are chart audits performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is there feedback given to the providers and staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, do the audits include specific high risk diagnosis reviews with feedback to the staff?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are medical records reviewed against specific outcome criteria on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If there is more than one location, are there common P&Ps, RM, and QA plans?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you have an internal training program for your support staff?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If Yes, please attach a description.</i>		
Do you use Electronic Medical Record Keeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, what company? _____</i>		
<u>Credentialing/Hiring Practices</u>		
Does the Credentialing/Hiring Policies ensure:		
Application criteria are applied consistently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Primary source verification is performed initially and at least every two years thereafter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The Provider Owner or Medical Director reviews all recommendations from the credentialing process <i>and</i> the credentialing file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Credentialing criteria are specific to the facility's scope of services?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Written protocols and guidelines for disclosure of a Provider's Quality Outcome data exist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
All credentialing policies include allied health professionals?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you obtain the provider's loss history before hiring/contracting them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are background checks performed on all contractors and employees?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are current licenses kept on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there written job descriptions for each category of employee and contractor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do all employees, contractors, and providers sign confidentiality agreements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a chaperone policy for the treatment of female patients by male providers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Incident Reporting</u>		
Does the Incident Reporting procedure include:		
A statement that it is a non-punitive process?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Documenting only objective information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The reporting of near misses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Investigation procedures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Methods for tracking and trending incident/claim reports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Follow-up with all providers in the clinic so they learn from the incident/claim?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Follow Up

Does the Patient Follow-up/Call-back Procedure Include:

- Criteria to make the call/follow up (Diagnosis based?) _____
- Who is responsible for making the calls? _____
- Time frames for making the call? _____
- Documentation requirements? Yes No
- Parameters for physician communication? Yes No
- Tracking and trending of data? Yes No

Do you have a formal patient satisfaction survey system in place? Yes No

If Yes, how often for each one? _____

If Yes, do you use an Interactive Electronic System as the patient is leaving your care? Yes No

General Questions

Any "yes" answers require a separate written explanation and documentation.

- Does the Medi-Spa Facility or any of its subsidiaries participate in any experimental, investigational or other unconventional therapies including any alternative medicine activities? Yes No
- Does the Medi-Spa Facility or any of its subsidiaries participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? Yes No
- Does the Medi-Spa Facility or any of its subsidiaries contract to provide services to any federal or non-federal prisons? Yes No
- Does the Medi-Spa Facility or any of its subsidiaries contract to provide services to any nursing home or long term care facility? Yes No
- Does the Medi-Spa Facility or any of its subsidiaries contract to provide teaching services or the supervision of residents? Yes No
- Do you endorse any products or participate in offering professional advice to the public? (i.e. newspaper columns, broadcasts, etc.) Yes No

Please complete the following as it relates to the location of your facility:

Location	Area	Age	Type of Construction	# of Floors	Sprinkler Protection	Type of Fire Protection (City, State)	Monitored Alarm System?	Distance to nearest Fire Station
Patient Care Buildings								

If you have more than 1 location, please complete the attached Additional Locations form. (Page 14)

a. Are there elevators or escalators on any premises owned, leased, or occupied by the insured? Yes No

If yes, how many? _____

b. List the number and type of owned or leased vehicles (Attach a separate sheet if necessary):

c. Do you sell or lease any medical equipment or products to patients or others in connection with your operation? Yes No

d. Has the applicant sold, acquired, or discontinued any operations in the past ten (10) years? Yes No

If yes, please explain on a separate sheet.

e. Is the applicant considering any changes in operations or products over the next twelve (12) months? *If yes, please attach a separate sheet.* Yes No

Section IV – Coverage History

Provide insurance history for a minimum of the last ten years. Start with the most recent and attach an additional sheet if necessary.

Insurer	Policy Period	Limits of Liability	Coverage Type	Claims Trigger	Retroactive Date	Deductible Amount	Tail Purchased	Policy Premium	
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Incident Driven <input type="checkbox"/> Written Demand			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Has any insurance company ever declined, failed to renew, restricted or canceled your insurance?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, please complete the following:</i>									
Insurer			Date			Reason			
Has this Medi-Spa Facility ever operated without insurance?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have any of the facilities operations ever changed in the past 10 years?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If Yes, please explain on a separate sheet what services/procedures have been added or deleted and the date these changes were effective.</i>									

Section V – Claims History

Are you or have you ever been involved, directly or indirectly in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? Yes No

If yes, how many? _____

Please complete the attached Claim History Questionnaire (Addendum E) for each claim.

If yes, have these been reported to your insurer? Yes No

Please provide a copy of currently valued Insurance Company loss runs.

Do you have knowledge of any incident, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim? Yes No

If yes, how many? _____

If yes, have these been reported to your current insurer, or any prior insurer?

Please provide details.

Has an allegation or claim ever been made against the Corporation/Partnership, any of its subsidiaries, owners, shareholders, employees, employed or contracted physicians, regarding sexual harassment, sexual intimacy, exploitation or sexual assault in the performance of services for the Corporation/Partnership or otherwise? Yes No *(If yes, please attach an explanation)*

Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in Questions 1 and 2 is excluded from the proposed coverage.

Section VI - APPLICANT AUTHORIZATION and REPRESENTATION

Please initial the statements below:

_____ For the purposes of this application, the undersigned applicant declares that to the best of their knowledge the statements herein are true and complete. The Wood Insurance Group (WIG) is authorized to make any inquiry in connection with this application. WIG's acceptance of this application or making subsequent inquiries does not bind the applicant or WIG to complete the insurance or issue a policy.

_____ The applicant understands that the information in this application is material to the acceptance of the risk assumed by WIG. If a policy is issued, it will be in reliance by WIG upon the application, and the application will be the basis of the policy.

_____ The applicant understands that the information contained in and submitted with this application is on file with WIG and along with this application will be considered physically attached to, part of and incorporated into the policy if issued.

_____ The applicant understands if the information in this application materially changes prior to the effective date of the policy, the applicant or their agent must immediately notify WIG, who may modify or withdraw its quotation or any agreement to bind insurance.

_____ The applicant understands that this information will be kept confidential and that their authorization is required to release any of this information, except for the obtaining of the insurance being applied for with this application.

_____ The applicant understands that any miss-statement, incorrect information, or false information will void coverage

_____ The applicant understands that this application is will become part of their insurance policy if coverage is offered and bound. The applicant also acknowledges that they have read and understand the following Fraud Notice.

FRAUD NOTICE: 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 FACTS MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, INCLUDING BUT NOT LIMITED TO FINES, DENIAL OF INSURANCE BENEFITS, CIVIL DAMAGES, CRIMINAL PROSECUTION, AND CONFINEMENT IN STATE PRISON.

Prior Acts Coverage Certification

The applicant hereby certifies that if Prior Acts Coverage is being requested, they have no knowledge of any professional liability claims which have been asserted against any insured, or any affiliated professional association, corporation, or subsidiary to which this insurance may apply, or of any occurrence, incident, or circumstance likely to result in a claim on or after the requested initial effective date of the Prior Acts Coverage, except as described on the attached separate page.

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

I hereby certify that all of the information provided in this application, including any supplemental information requested and provided, is true and correct. I authorize the release and exchange of all information considered relevant by the company to the underwriting of this application and authorize any exchange of information between agents, government licensing agencies, any professional society or association of which I am a member, hospitals, health insurers, managed care organizations. I agree to indemnify and hold harmless from liability or expense any organization or individual supplying information to the company in good faith.

I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. Any information supplied that is found to be intentionally false and misleading may result in the voiding of coverage.

Signature: _____

Date: ____/____/____

Printed Name: _____

Title: _____

Insurance is not effective until application is approved by us; a premium quotation with policy terms is issued by us and accepted by you.

Additional Location Information

Location #2: _____
Address

Location	Area	Age	Type of Construction	# of Floors	Sprinkler Protection	Type of Fire Protection (City, State)	Monitored Alarm System?	Distance to nearest Fire Station
Patient Care Buildings								

Location #3: _____
Address

Location	Area	Age	Type of Construction	# of Floors	Sprinkler Protection	Type of Fire Protection (City, State)	Monitored Alarm System?	Distance to nearest Fire Station
Patient Care Buildings								

Location #4: _____
Address

Location	Area	Age	Type of Construction	# of Floors	Sprinkler Protection	Type of Fire Protection (City, State)	Monitored Alarm System?	Distance to nearest Fire Station
Patient Care Buildings								

Location #5: _____
Address

Location	Area	Age	Type of Construction	# of Floors	Sprinkler Protection	Type of Fire Protection (City, State)	Monitored Alarm System?	Distance to nearest Fire Station
Patient Care Buildings								

Business Information Application

Name: _____

Sole Proprietorship/dba: Name Partnership Corporation Other

Owner(s): _____ % of ownership: _____ %

_____ % of ownership: _____ %

_____ % of ownership: _____ %

Main Contact: _____

Renewal Contact: _____

Accounting Contact: _____

Risk Management Contact: _____

Mailing Address: _____

City, State, Zip: _____

Physical Address: _____

(If different then mailing address)

City, State, Zip: _____

Phone: _____ Fax: _____

Mobile: _____ Pager: _____

E-Mail Address: _____

X _____
Signature of authorized personnel

X _____
Date

This page must be completed in full and returned with your application.