HUNTERSURE LLC

ALLIED HEALTH GENERAL APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE (Edition 04.01.24)

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____

Website: _____

5. a.) Date Established: _____

b.) Entity Type: Corp. _____ Partnership_____ Prof. Assoc. _____ Individual_____

c.) For Profit _____ Non-Profit _____

6. Funding is: Medicare _____% Medicaid _____% Private Pay _____%

7. a.) Desired Effective Date: _____

b.) Desired Limits of Liability: $ _____ / $ _____

c.) Desired Deductible: $ _____

8. a.) Gross Receipts for the Past 12 Months: $ _____

b.) Estimated Gross Receipts for the Next 12 Months: $ _____

c.) Payroll for the Past 12 Months: $ _____

d.) Estimated Payroll for the Next 12 Months: $ _____

9. Applicant's Service is licensed as: _____

10. Full description of services provided: _____

11. Does the applicant have any ancillary operations not stated above? Yes: _____ No: _____

If Yes, please provide details: _____

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12. Is the applicant engaged in, owned by, associated with, or controlled by any other business? If Yes, please provide details:

_____

_____

13. a.) What was your total number of outpatient visits last year? _____

b.) Estimated next year? _____

14. Breakdown of patient services:

AIDS _____ %	Alcoholic _____ %	Bariatric _____ %
Communicable _____ %	Dental _____ %	Disability _____ %
Drug Addiction _____ %	Emergency Medical _____ %	Family Planning _____ %
General Exams _____ %	Gynecological _____ %	Hemodialysis _____ %
Holistic Medicine _____ %	Major Surgery _____ %	Minor Surgery _____ %
Nutritional (Diet) _____ %	Obstetric _____ %	Occupational Medical _____ %
Optometry/Ophthalmology _____ %	Orthopedic _____ %	Pediatric _____ %
Psychiatric _____ %	Rehab Therapy _____ %	Research/Experimental _____ %
Stress Testing _____ %	Substance Abuse _____ %	Other; Describe: _____

15. Does the applicant provide weight loss services? Yes: _____ No: _____

If Yes, please confirm all methods used and if medications are prescribed, please confirm all medications prescribed:

_____

_____

16. Is the applicant involved in the use of Hormone Therapy? Yes: _____ No: _____

If Yes, please provide details on the type of hormones prescribed and what percent of this is their total operation:

_____

_____

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17. Are any of the following performed:

Administer anesthesia (general or local)?	Yes: _____	No: _____
Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)?	Yes: _____	No: _____
Cardiac Catheterization?	Yes: _____	No: _____
Diagnostic tests?	Yes: _____	No: _____
Chemotherapy?	Yes: _____	No: _____
X-Rays?	Yes: _____	No: _____
Radiation Therapy?	Yes: _____	No: _____
Reduction of Fracture?	Yes: _____	No: _____
Shock Therapy?	Yes: _____	No: _____
Prescribe medication?	Yes: _____	No: _____
Obstetric procedures?	Yes: _____	No: _____

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

18. a.) List the number and type of **EMPLOYEES**: (If none, state none)
(If Owner Operated, please provide details on backup plan if the owner is unavailable)

	# Part-time	# Full-time		# Part-time	# Full-time
Registered Nurse	_____	_____	Physician (patient contact)	_____	_____
Licensed Practical Nurse	_____	_____	Physician (no patient contact)	_____	_____
Certified Nurse Assistant	_____	_____	Physician (Medical Director Only)	_____	_____
Aide / Homemaker	_____	_____	Psychologist	_____	_____
Nurse Practitioner	_____	_____	Psychiatrist	_____	_____
Physician Assistant	_____	_____	Social Worker	_____	_____
Medical Assistant	_____	_____	Laser Technician	_____	_____
Physical Therapist	_____	_____	Massage Therapist	_____	_____
Speech Therapist	_____	_____	Aesthetician	_____	_____
Occupational Therapist	_____	_____	CRNA / Surgical Technician	_____	_____
Respiratory Therapist	_____	_____	Chiropractor	_____	_____
Paramedic / EMT	_____	_____	Pharmacist	_____	_____
			Other (please describe)	_____	_____
			_____		

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b.) List the number and type of INDEPENDENT CONTRACTORS estimated over the next 12 months. (If none, state none.)

	# Part-time	# Full-time		# Part-time	# Full-time
Registered Nurse	_____	_____	Physician (patient contact)	_____	_____
Licensed Practical Nurse	_____	_____	Physician (no patient contact)	_____	_____
Certified Nurse Assistant	_____	_____	Physician (Medical Director Only)	_____	_____
Aide / Homemaker	_____	_____	Psychologist	_____	_____
Nurse Practitioner	_____	_____	Psychiatrist	_____	_____
Physician Assistant	_____	_____	Social Worker	_____	_____
Medical Assistant	_____	_____	Laser Technician	_____	_____
Physical Therapist	_____	_____	Massage Therapist	_____	_____
Speech Therapist	_____	_____	Aesthetician	_____	_____
Occupational Therapist	_____	_____	CRNA / Surgical Technician	_____	_____
Respiratory Therapist	_____	_____	Chiropractor	_____	_____
Paramedic / EMT	_____	_____	Pharmacist	_____	_____
			Other (please describe) _____	_____	_____

c.) Are all individuals shown in response to questions 18a and b who are subject to state or federal licensing requirements so licensed? Yes: _____ No: _____ If No, attach explanation.

19. Do you require contracted staff (if any) to carry their own Professional Liability Insurance and secure certificates of Insurance as evidence of such coverage? Yes: _____ No: _____

If Yes, what is the minimum limit required? $_____ / $_____

If No, is coverage desired with shared limits on this policy? Yes: _____ No: _____

20. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists, or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

Yes: _____ No: _____ If Yes, at what limits? $_____ / $_____

21. Are all services provided at the applicant's location address(s)? Yes: _____ No: _____
If No, please provide details of any off-site exposure including what procedures are performed, at what types of locations, by whom and what percent this is of total procedures are performed off-site:_____
_____
_____

22. Does the applicant provide any beds for overnight stays? Yes: _____ No: _____
If Yes, give details: _____

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23. Do you sell, rent, or otherwise provide any equipment to products or others? Yes: _____ No: _____
If Yes, give details including types of products and gross receipts from each:
_____
_____

24. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?

Yes: _____ No: _____ If No, give details: _____

25. a.) Do you conduct pre-employment screening and investigation? Yes _____ No _____

b.) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

26. Check all the following that apply if obtained, verified, and kept on file as part of the employee hiring and screening process:

Applications/Resumes	_____	Criminal Background Checks	_____
Drug Testing	_____	Education/Training/Competence	_____
Licenses Held	_____		

27. Is the applicant a member of any association or certified or accredited by any governing body?

Yes: _____ No: _____ If Yes, give details: _____

28. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a.) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?	_____	_____
b.) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c.) Ever been treated for alcoholism or drug addiction?	_____	_____
d.) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____

29. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes: _____ No: _____

If Yes, give details, including name, location size and number of beds:

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_____

_____

30. Give Professional Liability coverage for last 5 years for the firm (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

31. Give General Liability coverage for last 5 years for the firm (if none, state none):

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

32. Is the applicant aware of any circumstances which may result in any claim against the proposed insured entity or any individual who would be covered by this policy?

Yes: _____ No: _____ If Yes, please give details _____

33. Has any insurer cancelled or refused to renew any similar insurance during the past 5 years?

Yes: _____ No: _____ If Yes, please give details _____

34. Has any claim been made against the proposed insured or any of its employees in the last 5 years?
Yes: _____ No: _____
If Yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

35. Is the applicant aware of any circumstances which may result in any claim against the insured or any of its employees that would be covered by this policy?
Yes: _____ No: _____ If Yes, please give full details.

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Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: 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 act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)