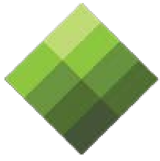


GREENHILL
INSURANCE SERVICES

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056
WWW.GRNHLL.COM

Professional Liability Application for Health Care Services

(TO BE COMPLETED ONLY IF A MORE SPECIFIC APPLICATION IS NOT APPLICABLE)
INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): ______________________________

Tax ID: ______________________________

1.2 Mailing Address: ______________________________

____

1.3 Location Address(es): ______________________________

____

1.4 County (parish) of each location: ______________________________

1.5 Telephone Number: Office (________)__________________ Fax (_________)____________

Email: ______________________________

Website: ______________________________

1.6 Person to contact for Survey: Name: ____________________Title: ____________________

Email: ____________________Telephone Number: (________)____________

1.7 Year entity established: ______________________________

1.8 The Applicant is (Please check and complete A) or B) below:

☐ A. The **APPLICANT** is an: ☐ INDIVIDUAL ☐ Employee ☐ Student ☐ Sole Practitioner

☐ B. The **APPLICANT** is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability

☐ Other –Please Describe ______________________________

1.9 Entity is: ☐ For Profit ☐ Non-Profit

Please describe source of funds: ______________________________

____

1.10 **Proposed Effective Date:** ______________________________

1.11 Requested Limits of Liability (if available): $ ______________________/$ ______________________

1.12 Annual Gross Receipts: Estimated next twelve months - $______________________

Last twelve months - $______________________

1.13 Annual Remuneration: Estimated next twelve months - $______________________

Last twelve months - $______________________

1.14 Total Premises Square Footage Occupied By Applicant:______________________

PART II. EXPOSURES

2.1 Service is licensed as ______________________

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted:

____

____

2.3 List all memberships in professional organizations. ______________________

____

2.4 Total number of all staff ______________________

2.5 Number of Professional Staff:

E = Employed
C = Contracted

E	C		E	C	
__	__	Aides or Orderlies	__	__	Optometrists
__	__	Acupuncturists	__	__	Opticians
__	__	Audiologists	__	__	Paramedics or EMT's
__	__	Chiropractors	__	__	Pharmacists
__	__	Dentists	__	__	Pharmacy Technicians
__	__	Dental Hygienists/Tech.	__	__	Physicians or Surgeons*
__	__	Dental Assistants	__	__	Physician Assistants
__	__	Dietitians/Nutritionists	__	__	Physiotherapists/Physical Therapists
__	__	EEG or EKG Operators	__	__	Podiatrists
__	__	Electrologists	__	__	Prosthetic Device Fitters
__	__	Hearing Aid Fitters	__	__	Psychologists/Psychotherapists
__	__	Inhalation/Resp. Therap.	__	__	RN's
__	__	Laboratory Technicians	__	__	Social Workers
__	__	LPN's	__	__	Speech Therapists
__	__	Massage Therapists	__	__	Veterinarians

__	__	Medical Technicians	__	__	X-Ray or Radiologist Technicians
__	__	Nurse Midwives	__	__	X-Ray or Radiologist Therapists
__	__	Nurse Practitioners	__	__	Other, describe ____________________
__	__	Occupational Therapists			

* Attach list and indicate specialty.

2.6 If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors and annual estimated Out Patient Visits by professional category. ____

____

2.7 Do you require:

A) Contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?____

B) Employed or contracted 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? ____

2.8 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ☐ Yes ☐ No

2.9 What minimum limits of Professional Liability are required? ____

2.10 What was your total number of patient/client visits last year? ____

Estimated next year? ____

2.11 **Adult Day Care** ☐ Yes ☐ No

If YES, please provide average occupancy:____

2.12 Breakdown of patient services:

__% Pediatric	__% Gynecological
__% Dental	__% Emergency Medical
__% Obstetric	__% General Exams
__% Psychiatric	__% Occupational Medical
__% Rehabilitative Therapy	__% Optometry/Ophthalmology
__% Minor Surgery	__% Nutrition (Diet)
__% Major Surgery	__% Other(describe) ____________________
__% Orthopedic	____________________

2.13 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

For all "yes" answers, please give detailed description on separate page or back of application.

PART III. RISK MANAGEMENT

3.1 Give name of Administrator/Supervisor and describe his/her training and experience. ______________________

____

____

3.2 Do you enter into contractual agreements? ☐ Yes ☐ No

IF **YES**, please enclose copies of all such contracts.

3.3 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? ☐ Yes ☐ No

If **NOT**, are you agreeable to instituting this procedure? ☐ Yes ☐ No

3.4 Enclose a copy of all brochures or advertising materials distributed by you.

3.5 Describe any "fund raising" or other special events activities conducted. ______________________

____

3.6 Describe any swimming pool, playground or amusement exposure. ______________________

____

3.7 Do you rent, sell, or otherwise provide any equipment or products to others? ☐ Yes ☐ No

IF **YES**, complete our Products Supplement.

3.8 Do you provide 24 hour bed and board care for any patients, or do you (wholly or in part) own, operate or administer any facility which does provide such services? ☐ Yes ☐ No

IF **YES**, complete our Residential Facilities Application.

3.9 Do you provide any of the following services?

A) Blood Bank/Plasma Centers ☐ Yes ☐ No

B) Cemeteries/Funeral Homes/Morticians ☐ Yes ☐ No

C) Medical Arts Schools and Colleges ☐ Yes ☐ No

D) Pharmacies ☐ Yes ☐ No

E) Nursing Homes ☐ Yes ☐ No

IF **YES**, please complete the appropriate supplement application.

3.10 Do you have any other premises or operations exposures not stated in this application? ☐ Yes ☐ No

IF **YES**, enclose complete description and underwriting/rating information.

PART IV. HISTORY

3.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date?____________________

3.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date?____________________

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐ Yes ☐ No

IF **YES**, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary).____________________

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? ☐ Yes ☐ No

IF **YES**, describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

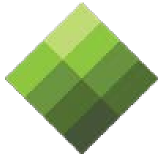
I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date	Applicant	Title



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Medical Products Sales or Equipment Rental Supplemental Application

A. LIST EACH PRODUCT OR EQUIPMENT LINE INDIVIDUALLY and provide receipts for each. Please attach COPY OF YOUR PRODUCTS / EQUIPMENT BROCHURES.

DESCRIBE PRODUCT / EQUIPMENT LINE	ANNUAL RECEIPTS From Rental	ANNUAL RECEIPTS From Sales
1.________________________	____________	
2.________________________	____________	
3.________________________	____________	
4.________________________	____________	
5.________________________	____________	

B. Describe clients applicant sells / rents to, and % each:

_____% Individuals using products in their home
_____% Individuals in nursing homes*
_____% Nursing Homes or similar residential facilities*
_____% Hospitals*
_____% Clinics / Labs*
_____% Physicians*
_____% Other*, Describe ______________________________

* If other than individuals in their home, is there a financial / ownership relationship between applicant and client or facility?

☐ Yes ☐ No If YES, please explain

____

C. Who does the servicing and repair of the products? ______________________________

Who does the servicing and repair of rental equipment? ______________________________

D. Are any products manufactured by others and sold under your entity's label? ☐ Yes ☐ No

If YES, which products? ______________________________

E. Are any additional products planned in the next twelve months? ☐ Yes ☐ No

If YES, include them under A. and estimate the receipts in the next 12 months.

F. How are products marketed? (Please attach ad copy or brochures)______________________________

____

G. Is a rental/lease agreement signed by customers prior to releasing any rental equipment? ☐ Yes ☐ No
If yes, please ENCLOSE A COPY OF THE RENTAL AGREEMENT.

H. Is formal written inspection program for rental equipment conducted prior to each rental? ☐ Yes ☐ No

I. Are manufacturer's labels/directions/instructions provided to customers for all rentals? ☐ Yes ☐ No

J. Do the MANUFACTURERS or distributors of any of the above listed items:
1) Name your entity as an additional insured under their products liability policies ☐ ☐ Yes ☐ No
2) Provide Certificates of Insurance for Products Liability to you? ☐ Yes ☐ No
3) Provide maintenance/service agreements for their product(s)? ☐ Yes ☐ No
4) Hold you harmless for loss arising from their products? ☐ Yes ☐ No
If the answer is YES for some products, please specify which product line and which answers: ____________
____

K. Are all manufacturers / suppliers well known U. S. firms? ☐ Yes ☐ No
If NO, please give details of which are not, and any foreign products. ______________________________

L. If sales of MEDICINES OR DRUGS are made by applicant, is a licensed pharmacist employed or contracted? ☐ Yes ☐ No
If YES, please indicate number: ________Employed (W-2) ________ Contracted (1099)
Does pharmacist carry his/her own professional liability insurance? ☐ Yes (Limits __________) ☐ No

____________________ ________________________________ ________________________
Date Signature Title