Corporate Healthcare (Entity) Professional Liability Application

Requested Effective Date _____

Required Documents
In addition to this application, the following information is required:

1. ☐ Loss runs, dated within 60 days of submission, covering the past ten years
2. ☐ Declarations page from current insurance carrier including retroactive date if claims-made coverage
3. ☐ Reporting endorsement from current insurance carrier if recently purchased
4. ☐ Corporate Healthcare Professional Liability Application for each organization
5. ☐ Certificates of Insurance for all medical professionals listed in section E and not insured with UMIA.

Renewal applicants are not required to provide items 1 through 3.

A. Applicant Information

Agency Name (if applicable)	UMIA Policy Number (if applicable)
Legal Entity Name	Tax ID Number

Principle Business Address (Street, City, State, Zip Code)	County

Business phone	Fax	E-mail	Web Site

Office Location #2 (Street, City, State, Zip Code) Use Comments section for additional locations.	County

Business Manager/Administrator	Telephone	E-mail
Risk Manager	Telephone	E-mail

Mailing/Billing Address (If different from principle business address listed above)	County

Type of Legal Entity:
☐ Solo Incorporated
☐ Multi-shareholder Corporation, Partnership, Limited Liability Company
☐ Joint Venture (indicate parties in venture and percentage ownership in Comments section)
☐ Other (specify):

Is Applicant currently enrolled in a Patient's Compensation Fund (PCF)? ☐Yes ☐No
If yes, answer the following question and indicate the fund name.

Has Applicant, at all times subsequent to the retroactive date, been continually qualified/covered by the state fund? ☐Yes ☐No

☐ Kansas Healthcare Stabilization Fund ☐ Nebraska Excess Liability Fund ☐ Wisconsin Patients' Compensation Fund
☐ Indiana Patients' Compensation Fund ☐ Other (specify):

B. Current Coverage *(Renewal applicants are not required to complete this section)*

Existing Form of Insurance: ☐ Occurrence ☐Claims-made If Claims-made, what is your retroactive date? _____

Specify below insurance coverage for the past 5 years:

Carrier name	Policy #	Coverage Dates	Limits	Retroactive Date

C. Requested Coverage *(Renewal applicants are not required to complete this section)*

Limits of Liability (Limits are expressed as per claim and annual aggregate)

☐ $1,000,000/$3,000,000 ☐ $2,000,000/$4,000,000 ☐ $3,000,000/$5,000,000 ☐ $4,000,000/$6,000,000

☐ $5,000,000/$7,000,000 ☐ $500,000/$1,000,000 (NE only) ☐ $200,000/$600,000 (KS PCF Members Only)

☐ $250,000/$750,000 (IN PCF Members Only) ☐ Other(specify):

For Kansas PCF members only, indicate PCF limits: ☐ $100,000/$300,000 ☐ $300,000/$900,000 ☐ $800,000/$2,400,000

Requested Retroactive Date: _____

If current coverage is claims-made and Applicant is **not** requesting prior acts coverage from UMIA, was a reporting endorsement purchased from the current carrier? ☐ Yes ☐ No

If yes, attach a copy of the reporting endorsement. If no, explain:

D. Practice Information

1. Specify description of operations:

☐ Private Doctor's Office ☐ Urgent Care Facility ☐ Community Clinic - Not for Profit

☐ Abortion Clinic ☐ Birthing Center ☐ Family Planning Clinic

☐ Physician-owned and operated lab used for other than doctor/owner patients ☐ Other (describe):

The definition of "owners" includes shareholders, partners and members.

2. Specify the number of owners of the Applicant: _____

3. Are all owners insured with UMIA or applying for coverage (if new business applicant)? ☐ Yes ☐ No

4. Are there any subsidiaries of the Applicant? ☐ Yes ☐ No If yes, specify the following:

Subsidiary	Description of Operations	% of Ownership	Date Acquired	Current Carrier	Coverage Desired?

If a subsidiary is not 100% owned by the Applicant, specify owners and percentage of ownership in the Comments section.

5. List all states in which the Applicant provides professional services, including the percentage of practice for each state:

6. Does the Applicant or any of its owners or employed or contracted physicians supervise any residents or interns? ☐ Yes ☐ No

If yes, specify facility, specialty and number supervised:

7. Does the Applicant or any of its owners or employed or contracted physicians supervise any healthcare providers other than those employed or contracted at the Applicant's practice? ☐ Yes ☐ No

If yes, specify facility, specialty and number supervised:

8. Specify total number of employees for each of the following:

Total number of employees: _____ Total number of non-medical employees: _____

Total number of physician employees: _____ Total number of non-physician medical professional employees: _____

9. Specify total number of contractors for each of the following:

Total number of contractors: _____ Total number of non-medical contractors: _____

Total number of physician contractors: _____ Total number of non-physician medical professional contractors: _____

10. Does Applicant employ or contract with any of the following healthcare providers? ☐ Yes ☐ No

If yes, indicate the number of employed/contracted providers for each occupation:

_____ Medical/Lab Technician _____ Occupational Therapist _____ Physician/Surgeon Assistant _____ Surgical Assistant

_____ Nurse _____ Optometrist _____ Psychologist

Nurse Practitioner Physical Therapist Respiratory Therapist

E. Owners / Physicians / Specified Healthcare Professionals

1. List ALL current owners, including owners that are not medical professionals.
2. List of ALL physicians (employed and contracted) who have practiced on behalf of the Applicant during the past five years. If a physician is no longer associated with the Applicant, indicate whether a reporting endorsement "tail" was purchased.
3. List all actively employed or contracted healthcare professionals for the following occupations: chiropractors, dentists, nurse midwives, perfusionists, podiatrists and nurse anesthetists.

Full Name (First, MI, Last)	Medical Specialty or Professional Occupation	O=Owner E=Employee C=Contractor	% Owner-ship	Average # Hours Per Week	Employment Date		Tail Purchased?		
					Start Date	End Date	Yes	No	N/A

Note: If any physicians or specified healthcare professionals are not insured by UMIA, you must attach a current certificate of insurance from their insurance carrier. In order to be considered for coverage with UMIA, an individual physician or ancillary application must be completed.

F. Underwriting Questions

Explain any "yes" answers to the following questions in the Comments section.

1.	Does the Applicant provide diagnostic, consulting or other professional services to patients (including telemedicine) in states other than those listed under question D5? If yes, include states, type of service and annual number of encounters in your explanation.	☐ Yes ☐ No
2.	Does the Applicant currently under contract to supervise, manage or administrate any departments within a hospital or other facility, for an HMO or PPO or any government agency or program?	☐ Yes ☐ No
3.	Has the Applicant agreed to hold harmless or indemnify others under contract?	☐ Yes ☐ No
4.	Does the Applicant own or operate a hospital, sanitarium or clinic with regular bed and board facilities?	☐ Yes ☐ No
5.	Has the Applicant's license ever been suspended, restricted, revoked or surrendered or has probation ever been invoked?	☐ Yes ☐ No

G. Claim Information

Explain any "yes" answers to the following questions in the Comments section.

For New Business Applicants Only:

1.	Have any claims or suits ever been made against the Applicant, the Applicant's owners, employees or contractors arising out of the performance of professional services rendered or which should have been rendered by any person for whose acts or omissions the Applicant is legally responsible for? If yes, indicate the number of previous and/or pending claims or suits: _____	☐ Yes ☐ No
2.	Are you aware of any potential claims including alleged injury, incidents, or circumstances that might reasonably lead to a claim or suit being brought against the Applicant even if the claim or suit would be without merit? This includes knowledge of any facts that could reasonably lead to a claim or suit? If yes, please attach copies of your claim notification letters sent to your current or prior professional liability carrier for each potential claim.	☐ Yes ☐ No
3.	Are you aware of any claims, suits or potential claims that have not been reported to your current or prior professional liability carrier?	☐ Yes ☐ No

For Renewal Applicants Only:

1.	Are you aware of any claims, suits or potential claims that have **not** been reported to UMIA? If yes, provide a brief description of each claim(s) in the Comments section and answer the following: Will claim(s) be reported to UMIA Claim Department? ☐ Yes ☐ No If no, explain (e.g. is this claim covered by a different insurance carrier?):	☐ Yes ☐ No

Please complete the Prior Claim/Suit Information Addendum for each claim, suit, or potential claim identified in Question 32. Make additional copies as needed. Do not include losses insured by UMIA.

H. Comments

Section & Question	Explanation

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another 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 and subjects the person to criminal and civil penalties.

UMIA FRAUD STATEMENT: Signing this application does not bind UMIA Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If UMIA Insurance, Inc. agrees to be bound under the terms of this application, the policy is void if the Applicant hides any important information, misleads or attempts to defraud or lie about any matter contained in this application.

CLAIMS-MADE DISCLOSURE: If this policy is issued on a claims-made basis, the policy will apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to UMIA Insurance, Inc. during the policy period or under a reporting endorsement.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: The Applicant authorizes access by and release to UMIA Insurance, Inc. of any and all information pertaining to underwriting the undersigned Applicant and relating to medical claims or any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organizations; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimburser, including State Departments of Welfare.

PRIVACY STATEMENT: UMIA Insurance, Inc. agrees to hold in confidence, use only for its proper business purposes and, unless otherwise constrained by law, not to re-release to third parties any and all information concerning Applicant which comes into its possession. Applicant acknowledges that it is within the proper business purposes of UMIA Insurance, Inc. to discuss any such information within its committees and boards.

APPLICANT ACKNOWLEDGEMENT: The Applicant hereby certifies the foregoing information is true and correct and that any and all claims or potential claims have been reported to the current carrier. The Applicant understands that, if granted prior acts coverage by UMIA Insurance, Inc., no insurance will be provided for any claim, suit or potential claim known at the effective date that has or has not been reported to another insurance carrier.

Signature	Title	Date