UMIA Insurance, Inc.
curi.com

Healthcare Facility General Application for Liability Insurance
New Business

Requested Effective Date _____

Instructions:

- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this application is completed and all required documents are provided.
- A supplemental application may be required as instructed under section L.

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. ☐ Latest annual financial statements
4. ☐ Organizational chart
5. ☐ Marketing or advertising materials
6. ☐ Quality Improvement or Risk Management Plan
7. ☐ Most recent state survey reports, licensure reports and accreditation survey reports as applicable
8. ☐ Supplemental Application as required under Section L
9. ☐ Healthcare Umbrella Application if limits above $1,000,000/$3,000,000 are being requested
10. ☐ For Long Term Care Facilities, current CMS forms 671 Facility Staffing, 672 Resident Census, CMS 2567 and Quality Indicator Report for the past two six-month periods
11. ☐ Roles and responsibilities for volunteer workers as applicable

A. Agent (Do not complete this section if you are insured directly with MMIC.)				
Agent Name:	Agency Name:		Address:	
City:	State:	Zip:	Telephone Number:	Fax Number:

B. Applicant Information (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)		
Legal Name of Applicant:	Website:	Tax ID Number:
Address (Street, City, State, Zip Code):		County:
Telephone Number:	Fax Number:	E-mail Address:

Legal structure (Check all that apply):
☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ For Profit ☐ Not for Profit
☐ Government ☐ Other (Specify):

Accreditations/Certifications (Check all that apply):
☐ JCAHO Accredited ☐ CCAC Accredited ☐ CCRC Accredited ☐ AAAHC ☐ Medicare/Medicaid Certified
☐ Other (Specify):

Is the Applicant currently enrolled in a Patients' Compensation Fund or other state insurance fund? ☐ Yes ☐ No
☐ Kansas Health Care Stabilization Fund ☐ Nebraska Excess Liability Fund ☐ Wisconsin Patients' Compensation Fund
☐ Other (Specify):

Description of services provided:

Who may our Risk Management representative contact for a telephone or on-site review of your facility:
Name/Title:

Telephone Number:	Fax Number:	E-mail Address:

C. General Information

1. Indicate the number of years the Applicant has been:
Operating: _____ Owned by present owners: _____ Managed by present management: _____

2. Is the Applicant managed by a management company? ☐ Yes ☐ No
If yes, provide the name of the management company: _____
How many years in place with this management company? _____

3. Within the next 12 months, does the Applicant plan to:
a. Obtain another operation/entity? ☐ Yes ☐ No
b. Add or reduce the number of employees? ☐ Yes ☐ No
c. Add or reduce the number of locations? ☐ Yes ☐ No
d. Add or reduce current services? ☐ Yes ☐ No
e. Operate in other states? ☐ Yes ☐ No
Explain all "yes" answers in the Comments section.

4. Within the past 5 years, has the Applicant acquired, sold or discontinued any operations? ☐ Yes ☐ No
If yes, use the Comments section to explain.

5. Gross Revenue
Provide gross revenue for the years indicated:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Gross Revenue	$	$	$	$	$

6. Financial Interest
List the following details for each medical professional that has a financial interest in the Applicant's business. Use the Comments section if more space is needed.

Name	Profession	Policy No.	Interest (Owner/director/etc)	Patient Care	
				For the Facility	Outside Practice
				%	%
				%	%
				%	%
				%	%
				%	%

7. Subsidiaries and Affiliates
List all subsidiaries and affiliates of the Applicant.

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Insurance Carrier	Retroactive Date if Claims-Made	Coverage Desired? Y/N
		%				
		%				
		%				
		%				

8. Licensing
List all licenses held by the Applicant including type and expiration dates.

Has the Applicant's license been suspended, revoked or placed under probation? ☐ Yes ☐ No
If yes, provide a detailed explanation in the Comments section, including the date the license was reinstated.

9. Has the Applicant ever filed for bankruptcy? ☐ Yes ☐ No

If yes, please give name of the corporation and details of the arrangement in the Comments section.

10. Medicare/Medicaid

a. Is the Applicant approved for Medicare or Medicaid? ☐ Yes ☐ No

b. Has the Applicant been denied a Medicare or Medicaid certification? ☐ Yes ☐ No

c. Has the Applicant had its Medicare or Medicaid certification limited, suspended or revoked? ☐ Yes ☐ No

If yes, please explain in the Comments section.

d. Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations or paid any fines or penalties? ☐ Yes ☐ No

If yes, please explain in the Comments section.

11. Inspection/Surveys

a. When was the last inspection/survey of the Applicant by an outside entity? _____

b. Who performed the inspection? _____

c. Indicate total number of deficiencies: _____

For long term care applicants, indicate the following: D,E,F,G deficiencies: _____ F,H,I,J,K,L deficiencies: _____

d. Was a Corrective Action Plan accepted? ☐ Yes ☐ No

e. How many patient/family complaints were investigated in the past three (3) years? _____

f. How many complaints were substantiated? _____

D. Premises and Operations

1. List all premises owned, rented, leased, occupied or used by the Applicant. Attach a separate schedule if more space is needed.

Address	Use	Year Built	Constr. Type Number*	Fire Class	Number of Stories	Sprinkler System Y/N	Total Area

**Construction Type Number: 1 = Frame, 2 = Joisted Masonry, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive*

2. Does each location meet applicable NFPA building codes? ☐ Yes ☐ No

3. Does the Applicant have a written emergency evacuation plan? If yes, please attach a copy of the plan. ☐ Yes ☐ No

4. If an inpatient care facility location is more than 15 years old, when was the last qualified inspection of electric, heating and plumbing? _____

5. List any planned major fund-raising activities or sporting events which will be sponsored by the Applicant during the next year:

6. Are there any construction projects planned for the next year? ☐ Yes ☐ No

If yes, provide a description of the project in the Comments section, including estimated cost and duration of the project.

7. Does the Applicant operate a child daycare facility? ☐ Yes ☐ No If yes, specify the following:

Total licensed:_____ Average Participants:_____ Hours of Operation:_____ Number of Employees:_____

Does the Applicant provide transportation of children? ☐ Yes ☐ No

If yes, describe:

8. Does the Applicant operate an adult daycare facility? ☐ Yes ☐ No

If yes, specify the following:

Total licensed: _____ Average Participants: _____ Hours of Operation: _____ Number of Employees: _____

Does the Applicant provide transportation? ☐ Yes ☐ No

If yes, describe:

Are medical services provided? ☐ Yes ☐ No

If yes, describe:

9. Does the Applicant operate a fitness center? ☐ Yes ☐ No

If yes, what are the hours of operation? _____

Is there an attendant on duty during hours of operation? ☐ Yes ☐ No Annual Receipts: $_____

E. Current Coverage

Professional Liability Carrier Information:

Limit of Coverage:

Deductible/Retention:

Policy Period:

Policy Premium:

Coverage Type: ☐ Occurrence ☐ Claims-Made

If Claims-Made, retroactive date is:_____

General Liability Carrier Information:

Limit of Coverage:

Deductible/Retention:

Policy Period:

Policy Premium:

Coverage Type: ☐ Occurrence ☐ Claims-Made

If Claims-Made, retroactive date is:_____

Has any insurer canceled or declined to issue any of the coverages being applied for under this application?* ☐ Yes ☐ No

If yes, include an explanation in the Comments section.

**Missouri applicants do not answer this question.*

F. Coverage Requested

1. Limits of Liability (Limits are expressed as per claim/aggregate)

Professional Liability Limit:	☐ $1,000,000/$3,000,000*	☐ Other: _____
General Liability Limit:	☐ $1,000,000/$3,000,000*	☐ Other: _____
Employee Benefits Liability Limit:	☐ $1,000,000/$3,000,000*	☐ Other: _____

If Employee Benefits Liability coverage is desired, please specify total number of employees: _____

**For limits above $1,000,000/$3,000,000, please complete a Healthcare Umbrella Application.*

2. Deductibles

☐ No Deductible ☐ $5,000/$25,000 ☐ $10,000/$50,000 ☐ $25,000/$125,000 ☐ Other-Specify: _____

3. Form of Insurance

Is retroactive coverage being applied for? ☐ Yes ☐ No Retroactive Date: _____

G. Medical Equipment/Products

1. Does the Applicant sell, rent, lease or distribute any of the following? ☐ Yes ☐ No

☐ Durable Medical Equipment/Supplies ☐ Expendable Medical Equipment/Supplies ☐ Medical Products

If yes, check the appropriate category and answer the following questions:

a. Does the Applicant provide service or maintenance for the equipment/products? ☐ Yes ☐ No

b. If an outside vendor provides maintenance, what limits of liability insurance are required? $_____

c. Does the Applicant repackage or redesign the equipment/products? ☐ Yes ☐ No

Describe the type of equipment/products sold or leased in the Comments section.

2. Does the Applicant manufacture any type of medical equipment and/or products? ☐ Yes ☐ No

If yes, describe type of equipment and/or products in the Comments section.

H. Administration and Staff

1. Medical Director

a. Does the Applicant employ or contract a medical director? ☐ Yes ☐ No

If yes, please answer the following questions.

b. What is the name of the medical director? _____

c. What is the employment status of the medical director? ☐ Employee ☐ Contractor

d. What is the medical specialty of the medical director? _____

e. How many hours per month, on average, is the medical director on-site at the facility? _____

f. Does the medical director have direct patient contact? ☐ Yes ☐ No

If yes, indicate the insurance carrier and limits of liability carried.

Insurance Carrier: Limits of Liability:

Is the medical director involved in credentialing facility medical staff? ☐ Yes ☐ No

g. Is the medical director an active participant in the facility's quality improvement program? ☐ Yes ☐ No

h. Is the medical director responsible for hiring and firing? ☐ Yes ☐ No

i. Is the medical director involved with peer review of physicians? ☐ Yes ☐ No

2. Physicians and Surgeons

Physicians and Surgeons	Specialty	Insurance Carrier and Policy Number	Check one:	Hours/ Month*
			☐ Employee ☐ Contractor ☐ Volunteer	
			☐ Employee ☐ Contractor ☐ Volunteer	
			☐ Employee ☐ Contractor ☐ Volunteer	
			☐ Employee ☐ Contractor ☐ Volunteer	
			☐ Employee ☐ Contractor ☐ Volunteer	
			☐ Employee ☐ Contractor ☐ Volunteer	
			☐ Employee ☐ Contractor ☐ Volunteer	
			☐ Employee ☐ Contractor ☐ Volunteer	

***Hours/Month –** *Indicate the total number of hours per month, on average, that each individual works for the Applicant.*

3. Allied Health Care Professionals – Indicate the number of personnel in each applicable category:

	Employees		Contractors		Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Dentists						
Chiropractors						
Podiatrists						
Oral Surgeons						
Nurse Anesthetists/CRNAs						
Nurse Midwives						
Nurse Practitioners						
Phys Assist/Surgical First Assist.						
EMTs/Paramedics						
Occupation Therapists						
Therapists						
RNs/LPNs/LVNs						
Social Workers						
Psychologists						
Lab Technicians						
Optometrists						
Pharmacists						
Estheticians						
Other (describe)						

4. Insurance Requirements – Please explain any "No" answers in the Comments section.

Does the Applicant require the following health care professionals to carry professional liability insurance?

Physicians or Surgeons ☐ Yes ☐ No Limits $_____

Allied Healthcare professionals ☐ Yes ☐ No Limits $_____

5. Hiring/Screening Procedures

a. Are hiring/screening procedures in place for all workers providing patient care services? ☐ Yes ☐ No

b. Do the procedures apply to: ☐ Employees ☐ Contractors ☐ Volunteers

c. Please indicate if the following procedures are included in the hiring and screening process:

1) Verification of educational background, including licensure and/or certification? ☐ Yes ☐ No

2) Confirm hospital privileges for physicians, oral surgeons and dentists? ☐ Yes ☐ No

How often is the list of specific privileges updated? _____

3) Check for any license suspensions, revocations or any disciplinary actions? ☐ Yes ☐ No

4) Check criminal history? ☐ Yes ☐ No

5) Require information regarding medical professional claims history? ☐ Yes ☐ No

d. Does the Applicant have a formal/documented orientation program in place? ☐ Yes ☐ No

e. Does the Applicant have a formal/documented credentialing program in place? ☐ Yes ☐ No

f. Are workers transporting patients? ☐ Yes ☐ No

If yes, are driving records (MVRs) verified? ☐ Yes ☐ No How often? _____

6. Risk Management

Is the overall responsibility for Quality Improvement/Risk Management designated to one individual? ☐ Yes ☐ No

If no, please describe how these functions are monitored:

I. Contractual Agreements

1. Does the Applicant have an attorney review all contracts before signing? ☐ Yes ☐ No

If no, who reviews the contracts? _____

2. Has the Applicant signed any contractual agreements to provide services to others? ☐ Yes ☐ No

If yes, describe the types of services:

3. Has the Applicant signed any contractual agreements where others are providing healthcare services on behalf of the Applicant? ☐ Yes ☐ No

If yes, describe the types of service:

Specify the minimum limits of liability that are required: $_____

Is proof of this coverage verified? ☐ Yes ☐ No

Does the contract contain an indemnification (hold harmless) clause? ☐ Yes ☐ No

J. Professional Services

DIRECTIONS: Check each box that applies, giving the requested information for each classification using the most recent 12 months. Use the Comments section for additional classifications not listed or for further explanation.

Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed. Include visits made to a client's home when home health care is provided.
Annual Receipts	Use annual gross revenues resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Beds	Use the average number of occupied beds by dividing the total annual inpatient days by 365.
FTE	Use the full-time equivalent based upon 2080 annual hours.
Donations	Rate for each unit received from a donor.
Sub-Acute Care	Applicable to facilities offering ventilator care, wound management, post-operative care/trauma recovery, intravenous/antibiotic/hydration therapy, spinal cord/head injury care, oncology, total parenteral nutrition (TPN), blood/plasma transfusion, central line care, tracheostomy and dialysis.
Skilled Care	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings.
Intermediate Care	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living - bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation.
Assisted Living	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self administration and/or assistance with medication.
Independent Living	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication.

Behavioral Health	**Visits**	**Beds**
☐ Mental Health Counseling	_____	_____
☐ Substance Abuse Counseling	_____	_____
☐ Developmental Disability	_____	_____
☐ Crisis Center	_____	_____

Rehabilitation	**Visits**	**Beds**
☐ Cardiac Rehabilitation	_____	_____
☐ Physical or Occupational Rehab	_____	_____
☐ Trauma Rehabilitation Therapy	_____	_____
☐ Trauma Rehab/Transitional Living	_____	_____

Surgical/Specialized Services	**Visits**	**Beds**
☐ Birthing Center	_____	_____
☐ Endoscopy	_____	
☐ Lithotripsy	_____	_____
☐ Surgicenter	_____	
☐ X-Ray/Imaging	_____ Receipts	

Home Care/Hospice/Medical Registry	**Visits**	**Beds**
☐ Hospice Care	_____	_____
☐ Intravenous Therapy	_____	
☐ Personal/Companion Care	_____	
☐ Rehabilitation Therapy	_____	
☐ Respiration Therapy	_____	
☐ Skilled Care	_____	
☐ Durable Medical Equipment	_____ Receipts	
☐ Pharmacy	_____ Receipts	
☐ Medical Registry	Refer to supplemental application.	

Ambulance Companies	**FTE**
☐ Ambulance Service Company	_____ EMT
	_____ Paramedical

Schools for Healthcare Professionals

☐ Chiropractic ☐ Dental ☐ Medical ☐ Optometry
☐ CRNA ☐ EMT ☐ Nursing ☐ Other

Non-Direct Healthcare Services	**Number**
☐ Dental Laboratory	_____ Receipts
☐ Medical Laboratory	_____ Receipts
☐ Ocular Laboratory	_____ Receipts
☐ Pathology Laboratory	_____ Receipts
☐ Pharmacy	_____ Receipts
☐ Durable Medical Equipment	_____ Receipts
☐ Blood/Plasma Bank	_____ Donations
☐ Organ Bank - direct processing	_____ Donations
☐ Organ Bank - no direct processing	_____ Donations

Treatment Centers	
☐ College/University Health Center	_____ Visits
☐ Community Health Center	_____ Visits
☐ Convenience Care/Retail Clinic	_____ Visits
☐ Dialysis Center	_____ Visits
☐ Medi-Spa	_____ Visits
☐ Municipal Health Department	_____ Visits
☐ Oncology Services	_____ Visits
☐ Optical Establishment	_____ Receipts
☐ Sleep Lab	_____ Beds
☐ UrgiCenter	_____ Visits
☐ Weight Loss Center	_____ Visits

Long Term Care	**Total Licensed Beds**	**Average Occupancy**
☐ Sub Acute Care	_____	_____
☐ Skilled Care	_____	_____
☐ Intermediate Care	_____	_____
☐ Assisted Living	_____	_____
☐ Home Health Care	_____ Visits	
☐ Independent Living	_____ Units	_____ Total Number of Residents at Full Occupancy

K. Loss History

1. Have there been any liability claims or suits made against the Applicant, including any individual or entity proposed for coverage? ☐ Yes ☐ No

If yes, provide the following information:

a. If a current loss summary is available from the present or previous carrier, please attach a copy.

b. If a summary is not available, attach a separate page showing the following information for each claim:

1) Date of the event and date the claim was reported to the insurance company.
2) Description (cause) of the loss or claim.
3) Location of the loss.
4) Current status (open or closed).
5) Paid amount and current reserve amount.

2. Does the Applicant, including any individual or entity proposed for coverage, have knowledge of any claims that may be made in the future? If yes, attach a description of each claim. ☐ Yes ☐ No

3. Does the Applicant, including any individual or entity proposed for coverage, have knowledge of any activities that might give rise to a claim or suit in the future? ☐ Yes ☐ No

If yes, attach a description of each activity. Include any non-billing or non-record transfer-related requests for medical records.

L. Supplemental Application Requirements

A supplemental application will need to be completed based upon the information indicated in the Professional Services Section. More than one supplemental application may need to be completed based upon the services provided.

For all **Behavioral Health** facilities:	Complete the Behavioral Health Supplemental Application
For all **Rehabilitation** facilities:	Complete the Rehabilitation Supplemental Application
For all **Surgical/Specialized Care** facilities:	Complete the Surgical/Specialized Care Supplemental Application
For all **Home Care/Hospice/Medical Registry** facilities:	Complete the Home Care/Hospice/Medical Registry Supplemental Application
For all **Ambulance Companies:**	A supplemental application is NOT required.
For all **Schools for Healthcare Professionals:**	Complete the Schools for Healthcare Professionals Supplemental Application
For all **Non-Direct Healthcare Services** facilities:	Complete the Non-Direct Healthcare Services Supplemental Application
For all **Treatment** facilities	Complete the Treatment Supplemental Application
For all **Long Term Care** facilities:	Complete the Long Term Care Supplemental Application

M. Comments

Section and Question	Comments

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.

MMIC FRAUD STATEMENT: Signing this application does not bind MMIC Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If MMIC 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 any portion of the policy to be issued is on a claims-made basis, such portions shall apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services or caused by an occurrence or offense occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to MMIC 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 MMIC 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: MMIC 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 MMIC 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 MMIC 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.

Applicant Signature	Title	Date