Curi

Underwritten by a Curi company:

MMIC Insurance, Inc. | UMIA Insurance, Inc.
Arkansas Mutual Insurance Company
MMIC Risk Retention Group, Inc.

curi.com

Healthcare Facility Liability Protection Renewal Questionnaire

Name of Applicant: _____ **Policy Number:** _____
(Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

A. General Information

1. Please use the Comments section to advise us of any changes to the contact information we have for you including the following:

☐ Address ☐ Phone/Fax Number ☐ Email Address ☐ Contact Person

2. Please use the Comments section to advise us of any desired changes to your insurance program including the following:

☐ Deductible ☐ Limits ☐ Umbrella Coverage ☐ Physician Coverage ☐ Other

For the following questions, please explain all "yes" answers in the Comments section.

3. Have there been any changes to the Applicant's operation within the past 12 months related to the following?

- Obtaining another operation/entity? ☐ Yes ☐ No
- Selling or discontinuing any operation/entity? ☐ Yes ☐ No
- Adding or reducing the number of employees? ☐ Yes ☐ No
- Adding or reducing the number of locations? ☐ Yes ☐ No
- Adding or reducing current services? ☐ Yes ☐ No
- Operating in new states? ☐ Yes ☐ No
- Entering into any joint ventures or limited partnerships? ☐ Yes ☐ No
- New construction or renovation projects? ☐ Yes ☐ No

4. Are future operational changes anticipated related to the items listed in question #3? ☐ Yes ☐ No

5. Have there been any changes to the Applicant's additional named insureds? ☐ Yes ☐ No

6. Does the Applicant provide management services to other entities for a fee? ☐ Yes ☐ No

7. Does the Applicant sell or rent any equipment to others? ☐ Yes ☐ No

8. Has the Applicant employed any new physicians in the past 12 months that are not currently listed on the schedule? If yes, please complete an individual application for each person. ☐ Yes ☐ No

9. Please specify exposure information based upon the following:

Type	Number	Exposure
Total Number of Employees	_____	Employees
Adult or Child Care Center	_____	Individuals
HMO/PPO/IPA or other Managed Care Services	_____	Members
Vacant Land	_____	Acres
Pay Parking Areas	_____	Receipts
Fitness Center Open to the Public	_____	Receipts

***Please attach a listing of locations or a copy of your statement of values.**

B. 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 questionnaire.	

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

C. 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.

The Applicant hereby certifies the foregoing information is true and correct.

Applicant Signature	Title	Date