HEALTHCARE FACILITY
PROFESSIONAL LIABILITY APPLICATION

MMIC Insurance, Inc.

curi.com

Application Instructions **Requested Effective Date:** _____

- Please print or type all responses clearly and answer all questions as instructed.
- If you need more space than is given, continue in the Comments section at the end of the application or attach a separate document.
- Coverage will not be bound until this application is completed and signed and all required documents are provided.

Required Documents

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

- Prior carrier Loss Runs covering the past ten (10) years, dated within sixty (60) days of the application submission date for all coverages being applied for
- Declarations Page from current medical professional and general liability insurance carrier(s). If Excess coverage is requested, please include the declarations for each of the underlying policies.
- Roster of current Employed and Contracted Providers as specified in F3 and include COI for any provider not requesting coverage
- Listing of Locations (or Statement of Values) with description of use
- Audited Consolidated Financial Statements for the past two (2) years
- Organizational Ownership Chart reflecting all legal entities and DBAs
- Roles and Responsibilities for volunteer workers as applicable

A. BROKER INFORMATION	
Broker Office:	Producer:
Mailing Address:	
Producer Email Address:	Phone:

B. APPLICANT INFORMATION (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)		
Applicant (Legal Name):		
Mailing c/o or Attn, if applicable:		
Mailing Address:		County:
Billing Address:		Tax ID:
Physical Address:		NPI:
License #:	Website:	
Risk Manager:	Phone:	Email:

1. Specify type of legal entity (check all that apply):

☐ Sole Proprietorship ☐ Partnership ☐ Joint Venture ☐ For Profit ☐ Not For Profit
☐ Limited Liability Co. ☐ Corporation ☐ Government ☐ Other-specify:

2. Specify current accreditations and/or certifications (check all that apply):

☐ JCAHO Accredited ☐ CCAC Accredited ☐ CCRC Accredited ☐ AAAHC Medicare/Medicaid Certified
☐ Other (specify):

3. Is Applicant currently enrolled in a Patients' Compensation Fund (PCF) or similar state fund? ☐ Yes ☐ No
If yes, specify name of fund:

4. Provide a description of services offered:

5. List all states the Applicant operates in:

6. What patient populations are served:

☐ Children (birth through age 12) _____% ☐ Adults (ages 19 through 64) _____%

☐ Adolescents (ages 13 through 18) _____% ☐ Geriatrics (age 65 and older) _____%

7. Is overnight care provided? ☐ Yes ☐ No

8. Specify where services are provided below. Check all boxes that apply.

Acute and Inpatient Facilities	Outpatient and Ambulatory Settings
☐ Hospital	☐ Physician / Provider Office
☐ Nursing Homes/Extended Care Facility	☐ Ambulatory Surgical Center
☐ Rehabilitation Center	☐ Urgent Care Center
☐ Hospice	☐ Retail Clinic
☐ Mental Health/Substance Abuse Facility	☐ Mental Health/Substance Abuse Clinic
	☐ Dialysis Center
Home and Community Based Care	☐ Laboratory
☐ Community Health Center	☐ Pharmacy
☐ Patient's Home	☐ Diagnostic Imaging Center
☐ Day Care Center	☐ Free Standing Facility

C. CURRENT COVERAGE

1. Professional Liability Carrier Information

Carrier: _____

Limits of Coverage: _____

Deductible/Retention: _____

Policy Period: _____

Policy Premium: _____

Claims-Made or Occurrence: _____

If claims-made, prior acts date is: _____

2. General Liability Carrier Information

Carrier: _____

Limits of Coverage: _____

Deductible/Retention: _____

Policy Period: _____

Policy Premium: _____

Claims-Made or Occurrence: _____

If claims-made, prior acts date is: _____

3. Has any insurer canceled or declined to issue any of the coverages being applied for under this application?* If yes, explain below. *Missouri Applicants do not answer this question.

☐ Yes ☐ No

D. REQUESTED COVERAGE

1. Policy Period: **2.** Prior Acts Date:

3. Primary Limits of Liability (limits are expressed as per claim/aggregate):

Medical 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 Shared Excess Liability coverage is desired, please answer the following questions. If not, proceed to Section E.

4. Shared Excess Liability Limit: $

5. Select the following policies that should be included in the Shared Excess coverage and provide details for each.

In addition, please attach a current policy declarations page and loss history for each selected coverage.

Coverage Desired	Coverage Type	Carrier	Policy Number	Policy Period	Limits of Liability
☐	Auto Liability				
☐	Employers Liability				
☐	Other Liability:				

If Excess Automobile Liability coverage is desired, please answer the following. If not, proceed to Section E.

6. Current automobile liability premium: $

7. Current number of owned and leased company vehicles by type:

Private Passenger: _____ Light Service: _____ Medium Service: _____ Heavy Service: _____

Ambulance: _____ Passenger Vans: _____ Other (describe): _____

8. Indicate the number of employees driving:

a. Company vehicles: _____ b. Personal vehicles on behalf of the Applicant: _____

9. If the Applicant provides transportation services, please answer the following questions or specify NA. ☐ NA

a. Are transportation services provided to the public? ☐ Yes ☐ No

b. Are passengers carried for a fee? ☐ Yes ☐ No

c. Describe the transportation services offered by the Applicant:

E. GENERAL OPERATIONS

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? If yes, answer the following questions. ☐ Yes ☐ No

a. What is the name of the management company:

b. Who is the professional liability carrier for the management company:

c. Do you require proof of coverage? ☐ Yes ☐ No

d. Describe management services being provided:

3. Within the next 12 months, does the Applicant plan to:

a. Obtain another operating entity?	☐ Yes ☐ No
b. Add or reduce the number of employees (by over 10%)?	☐ 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? If yes, use the Comments section to explain. ☐ Yes ☐ No

5. Are there any construction projects underway or planned for the next twelve months? If yes, provide a description of the project in the Comments section, including cost and duration of the project. ☐ Yes ☐ No

6. Provide Gross Revenue for the years indicated below:

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

7. List all owners, including owners that are not medical professionals. Attach a separate document if necessary.

Individual/Entity Owner Full Name	% of Ownership	Medical Specialty or Professional Occupation	Professional Liability Carrier	If medical professional, list % of practice for Applicant.
				%
				%
				%
				%

8. List all Subsidiaries and Affiliates of the Applicant below or specify NA: ☐ NA

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Ins. Carrier	Prior Acts Date if Claims-Made	Coverage Desired Y/N
		%				
		%				
		%				
		%				

9. List all licenses held by the Applicant below, including type and expiration date.

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

11. Has the Applicant ever filed for bankruptcy? If yes, please give name of the legal entity and details of the arrangement:	☐ Yes ☐ No
12. Is the Applicant involved in any research activities? If yes, describe in the Comments section.	☐ Yes ☐ No
13. Are management services performed for other facilities? If yes, describe in the Comments section.	☐ Yes ☐ No

F. ADMINISTRATION AND STAFF

1. Provide the total number of employees, including non-medical staff:

2. Specify number of employed and contracted medical professionals listed below working on behalf of the Applicant.

Type	Employed	Contracted	Type	Employed	Contracted
Physicians (MDs & DOs)			Dentists		
Residents			Chiropractors		
Interns & Externs			Oral Surgeons		
CRNA's			Heart/Lung Perfusionists		
Certified Nurse Midwives			Nurse Practitioners		
Podiatrists			Physician Assistants		

3. Please complete a Curi Corporate Healthcare Provider Roster (spreadsheet) for all providers listed above. Or provide your own roster and include the following information.

- Full Name (First, Middle Initial, Last), Designation, Gender, Date of Birth, Email, Home Address
- Social Security Number, NPI Number, State Medical License Number(s)
- Medical Specialty and Surgical Category (No Surgical Procedures, Minor Surgical Procedures or Surgery)
- Employment Status (employed, contracted, owner). If owner, % of ownership.
- Hours worked for any part-time providers, including date when part-time work began
- Prior Acts Date (if claims-made)
- Specify if coverage is desired and limits. If coverage is not desired, specify carrier, limits and include COI.

4. Specify number of employed and contracted medical professionals listed below working on behalf of the Applicant.

Type	Employed	Contracted	Type	Employed	Contracted
Anesthesia Assistants			Psychologists		
EMTs/Paramedics			RN/LPN/LVN		
Estheticians			Speech Therapists		
Laboratory Technicians			Social Workers		
Occupational/Physical Therapists			Surgical Assistants		
Optometrists			X-Ray Technicians		
Pharmacists			Other:		

Medical Director

5. Does the Applicant employ or contract a medical director? If yes, answer the following questions.	☐ Yes ☐ No
6. What is the name of the medical director:	
7. What is the employment status of the medical director? ☐ Employee ☐ Contractor	
8. What is the medical specialty of the medical director?	
9. How many hours per month, on average, is the medical director on-site at the facility?	
10. Does the medical director have direct patient contact? If yes, specify insurance carrier and limits of liability carried below:	☐ Yes ☐ No
11. Is the medical director involved in credentialing Applicant's medical staff?	☐ Yes ☐ No
12. Is the medical director an active participant in the Applicant's quality improvement program?	☐ Yes ☐ No
13. Is the medical director responsible for hiring and firing?	☐ Yes ☐ No
14. Is the medical director involved with peer review of physicians?	☐ Yes ☐ No

G. HIRING AND SCREENING

1. Are hiring/screening procedures in place for all workers?	☐ Yes ☐ No

2.	Do the procedures apply to: ☐ Employees ☐ Contractors ☐ Volunteers	
3.	Please specify if the following procedures are included in the hiring and screening process:	
a.	Verification of educational background, including licensure and/or certification?	☐ Yes ☐ No
b.	Confirm hospital privileges for physicians, oral surgeons and dentists?	☐ Yes ☐ No
c.	Check for any license suspensions, revocations or any disciplinary actions?	☐ Yes ☐ No
d.	Conduct criminal background checks, including screenings for sexual offenses, for all providers at both the state and national levels?	☐ Yes ☐ No
e.	Require information regarding medical professional claims history?	☐ Yes ☐ No
4.	Does the Applicant have a formal/documented orientation program in place?	☐ Yes ☐ No
5.	Does the Applicant have a formal/documented credentialing program in place?	☐ Yes ☐ No
6.	Do all practitioners responsible for patient care have an educational concentration, licensure or certification specific to the services they are providing?	☐ Yes ☐ No
7.	Are assessments and/or evaluations of staff performed? If yes, answer the following questions.	☐ Yes ☐ No
	How often are they performed?	
	Are assessments/evaluations documented in writing? ☐ Yes ☐ No	
8.	Are workers transporting patients? If yes, answer the following questions.	☐ Yes ☐ No
	Are driving records (MVRs) verified? ☐ Yes ☐ No How often?	
	How are they transported? ☐ Employee vehicle ☐ Company vehicle ☐ Other(describe):	

H. MEDICAL EQUIPMENT / PRODUCTS

1. Does the Applicant sell, rent/lease or distribute medical equipment or products **to others**? ☐ Yes ☐ No

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

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

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

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

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

5. Describe the type of equipment/products below and include whether they are sold, rented, leased or distributed.

I. CONTRACTUAL AGREEMENTS

1.	Does the Applicant have an attorney review all contracts before signing? If no, who reviews the contracts?	☐ Yes ☐ No
2.	Has the Applicant signed any contractual agreements to provide services to others? If yes, describe the types of services:	☐ Yes ☐ No
3.	Has the Applicant signed any contractual agreements where others are providing healthcare services on behalf of the Applicant? If yes, answer the following questions. a. Describe the types of services: b. What are the minimum limits of liability insurance required? c. If proof of coverage required? ☐ Yes ☐ No d. Does the contract contain an indemnification (hold harmless) clause? ☐ Yes ☐ No	☐ 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 healthcare is provided.
Annual Revenue	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.

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		
☐ Surgery Center		
☐ X-Ray / Imaging		Revenue

Hospice / Home Healthcare	Visits	Beds
☐ Hospice Care		
☐ Intravenous Therapy		
☐ Personal/Companion Care		
☐ Rehabilitation Therapy		
☐ Respiration Therapy		
☐ Skilled Care		
☐ Durable Medical Equipment		Revenue
☐ Pharmacy		Revenue

Staffing Agency

Specify Provider Type and FTE Below

☐ _____ FTE
☐ _____ FTE
☐ _____ FTE
☐ _____ FTE

Non-Direct Healthcare Services		
☐ Dental Laboratory		Revenue
☐ Medical Laboratory		Revenue
☐ Ocular Laboratory		Revenue
☐ Pathology Laboratory		Revenue
☐ Pharmacy		Revenue
☐ Durable Medical Equipment		Revenue
☐ 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		Revenue
☐ Sleep Lab		Beds
☐ Sleep Lab		Visits
☐ Urgent Care Center		Visits
☐ Weight Loss Center		Visits
☐ Family Practice Clinic		Visits

Ambulance Companies		
☐ Emergency Medical Technician		FTE
☐ Paramedic		FTE
☐ Other provider type:		FTE

Other		
☐ Child Day Care		Enrollees
☐ Adult Day Care		Enrollees
☐ Fitness Center (open to public)		Revenue

K. SURIGICAL PROCEDURES

Anesthesia

1.	Is anesthesia provided? If yes, answer the following questions. If no, proceed to question 5.	☐ Yes ☐ No
2.	What level of anesthesia is provided?	
☐ Level A	Local or topical anesthesia	
☐ Level B	Local or topical anesthesia and/or IV or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia (including nitrous oxide)	
☐ Level C	Levels listed above and/or surgical procedures with epidural anesthesia, endotracheal or laryngeal mask intubation or inhalation anesthesia, spinal or epidural	
3.	Is a physician, CRNA or RN with Advanced Cardiac Life Support certification immediately available on the premises until all patients have met documented discharge criteria?	☐ Yes ☐ No
4.	Is Level C anesthesia administered by an anesthesiologist or CRNA? If no, explain the qualifications of professionals administering general anesthesia:	☐ Yes ☐ No

Sterilization of Instruments and In-House Medical Emergencies for Surgical Procedures	
5. Are surgical procedures provided? If yes, answer the following questions. If no, proceed to section L.	☐ Yes ☐ No
6. Are instruments sterilized on site? If yes, specify which method.	☐ Yes ☐ No
☐ Steam Sterilization ☐ Gas Sterilization ☐ Chemical Soak ☐ Routine Flash Sterilization	
7. Are written protocols in place for daily autoclave testing?	☐ Yes ☐ No
8. Is each sterilized pack marked with the date of sterilization and expiration date?	☐ Yes ☐ No
9. Are all clinical staff CPR trained or higher?	☐ Yes ☐ No
10. Is there documented protocol for handling in-house medical emergencies?	☐ Yes ☐ No
11. Is there an agreement with a local hospital for emergency transfers? If yes, what is the distance and length of travel time between your facility and this hospital?	☐ Yes ☐ No
12. Is there an agreement in place with an ambulance company for transportation of emergency cases?	☐ Yes ☐ No
13. Is emergency equipment tested routinely with documentation?	☐ Yes ☐ No
Questions 14, 15 and 16 should be answered if anesthesia is administered.	
14. Are all medications in the ACLS Algorithm available on the emergency cart?	☐ Yes ☐ No
15. Are malignant hypothermia drugs available?	☐ Yes ☐ No
16. Is a copy of the ACLS Malignant Hypothermia Algorithm maintained on the cart?	☐ Yes ☐ No

FOR SECTIONS L THROUGH W, COMPLETE THE SECTIONS THAT APPLY. SPECIFY NA IF NOT APPLICABLE.

L. BARIATRIC SURGERY	☐ NA
1. Specify the number of procedures performed annually:	
2. What is the age range of patients undergoing bariatric surgery?	
3. How long has the Applicant been performing bariatric procedures?	
4. On average, what percentage of procedures have complications?	
5. What percentage of procedures are laparoscopic?	
6. Check those organizations whose guidelines you follow:	
☐ American Society for Metabolic and Bariatric Surgery	
☐ Society of American Gastrointestinal and Endoscopic Surgeons	
☐ American College of Surgeons	
☐ Other (specify):	
7. Are the credentialing guidelines of the American Society for Metabolic and Bariatric Surgery and the Society of American Gastrointestinal and Endoscopic Surgeons being followed? If no, explain the in the Comments section.	☐ Yes ☐ No

M. BEHAVIORAL HEALTH			☐ NA
1. Check all services provided:			
☐ Acupuncture	☐ Psychodrama Therapy	☐ Massage Therapy	
☐ Addiction/Dependency Treatment	☐ Criminal/Domestic Violence	☐ Nutritional/Eating Disorders	
☐ Aversion Therapy	☐ Electroconvulsive Therapy (ECT)	☐ Psychotherapy/Psychoanalysis	
☐ Biofeedback/Neurofeedback	☐ Genetic Counseling	☐ Recreation Therapy	
☐ Boot Camp/Wilderness Survival Trng	☐ Hippotherapy	☐ Sexual Therapy	
☐ Case Management/Social Services	☐ Learning/Developmental Disabilities	☐ Spiritual/Religious Counseling	
☐ Counseling	☐ Life Coaching	☐ Grief Counseling	
☐ Art/Dance/Drama/Music Therapy	☐ Marriage/Family Therapy	☐ Trauma Counseling	
☐ Grief Counseling	☐ Vocational Counseling	☐ Rehabilitation Counseling	
☐ Medication Management	☐ Other(describe):		
2. Does the Applicant treat high-risk patients, including suicidal ideation, substance abuse, severe mental illness? If yes, describe in the Comments section.			☐ Yes ☐ No

N. COLLEGE/UNIVERSITY HEALTH CENTER, COMMUNITY HEALTH CENTER, CONVENIENCE CARE/RETAIL CLINIC, MUNICIPAL HEALTH CENTER, URGENT CARE CENTER ☐ NA

1. Check all services provided:

☐ Emergency Care	☐ Surgery	☐ Obstetrical Deliveries
☐ X-Ray/Imaging Services	☐ Pediatric Primary Health Care	☐ Nutritional/Eating Disorders
☐ Invasive Procedures/Minor Surgery	☐ Prenatal Care	☐ Abortions
☐ Laboratory	☐ Genetic Counseling	☐ Pharmacy

2. Does the Applicant have a referral network for patients who are in need of further treatment? ☐ Yes ☐ No

3. Does the Applicant provide follow-up patient status calls? ☐ Yes ☐ No

4. Does the Applicant provide instructions for after-hours care? ☐ Yes ☐ No

5. Does the Applicant dispense controlled narcotics? ☐ Yes ☐ No

O. HOME HEALTH CARE ☐ NA

1. Specify the current number of patients:

2. Are services provided under the direction and supervision of a physician based on physician orders and plan of care? ☐ Yes ☐ No

3. How often are status reports given to the ordering physicians?

4. Describe back-up procedures if assigned staff is not available to make a scheduled visit (include how absence is detected, who is assigned to cover and timeliness):

5. What is the typical daily visit load for a full-time nurse (include number of patients seen per day):

6. Is annual in-service training documented for all healthcare staff? ☐ Yes ☐ No

If yes, indicate which training areas are included:

☐ High-technology equipment areas	☐ Safe client lifting, transferring and ambulating techniques
☐ Proper use of equipment	☐ Infection control and safety
☐ Managing emergencies	☐ Other (explain):

P. LABORATORY ☐ NA

1. What types and complexity of testing are performed?

2. Does the Applicant provide any of the following services?

☐ Cytology ☐ Paternity Testing ☐ Assisted Reproductive Treatment/Techniques

3. Is sperm or embryo storage provided? ☐ Yes ☐ No

4. Is the Applicant certified by CLIA (Clinical Laboratory Improvement Amendments)? ☐ Yes ☐ No

5. What is the process for reporting and communicating critical or abnormal results?

Q. LITHOTRIPSY ☐ NA

1. Does the Applicant provide any of the following types of services? If yes, indicate the annualized number.

Ureterolithotomy (Open surgery)	☐ Yes	☐ No	Annualized Visits:
Nephrolithotomy (Open surgery)	☐ Yes	☐ No	Annualized Visits:
Pyelolithotomy (Open surgery)	☐ Yes	☐ No	Annualized Visits:
Any other type of open surgery (Describe in Comments section.)	☐ Yes	☐ No	Annualized Visits:

2. Is lithotripsy performed on children (under age 18)? If yes, please answer the following questions. ☐ Yes ☐ No

a. How many children are treated on an annual basis?

b. Is treatment modified to consider the age of the patient? ☐ Yes ☐ No

R. PHARMACY ☐ NA

1. Does the Applicant manufacture any drugs or drug products? ☐ Yes ☐ No

2. Are any of the following services provided? Specify if not applicable. ☐ NA

☐ Administration of medication	☐ Case management	☐ Compounding
☐ Pain management	☐ Patient monitoring	

If any of these services are provided, further describe the service in the Comments section and include the percentage these services represent in comparison to all services provided.

S. REHABILITATION ☐ NA

1. Check all services provided:

- ☐ Aquatic Therapy
- ☐ Athletic Training
- ☐ Cardiac Rehabilitation
- ☐ Cognitive Therapy
- ☐ Driving, Adaptive
- ☐ Hippotherapy
- ☐ Occupational Therapy
- ☐ Orthotics/Prosthetics
- ☐ Physical Therapy
- ☐ Recreational Therapy
- ☐ Sexuality Therapy
- ☐ Other (describe):
- ☐ Social Services
- ☐ Speech/Language/Audiology
- ☐ Sports Medicine
- ☐ Trauma Rehabilitation
- ☐ Vocational Training

2.	Are diagnostic services provided? If yes, indicate the type of diagnostic services provided and the percentage of total patients being diagnosed:	☐ Yes ☐ No
3.	Do any patients require skilled medical care and/or life support apparatus? If yes, indicate the type of patients and the percentage of total patients requiring this type of care:	☐ Yes ☐ No
4.	Are cardiac rehabilitation services provided? If yes, answer the following questions.	☐ Yes ☐ No
a.	Are AACVPR guidelines followed?	☐ Yes ☐ No
b.	Is a physician available on the premises when the program is in operation?	☐ Yes ☐ No
c.	Are patients screened with a stress test?	☐ Yes ☐ No
d.	Are all exercises prescribed by a physician or exercise physiologist?	☐ Yes ☐ No
e.	Is staff certified in BLS and ACLS?	☐ Yes ☐ No
f.	Is emergency equipment (defibrillator, O2, emergency medications) available?	☐ Yes ☐ No
g.	How often is emergency equipment checked?	
h.	Are there written emergency protocols?	☐ Yes ☐ No
i.	Are mock code drills conducted?	☐ Yes ☐ No
Explain all “no” answers in the Comments section.		

T. SLEEP LAB ☐ NA

1. Indicate the percentage of sleep studies administered in each setting:

In lab:

At home:

Other (specify):

2.	Do all professionals have a valid CPR certification?	☐ Yes ☐ No
3.	What is the patient to staff ratio?	
4.	How many technicians are certified by the Board of Registered Polysomnographic Technologists?	
5.	Is there a mechanism to visually monitor and record patients during testing?	☐ Yes ☐ No
6.	Do medically unstable patients have a nurse in attendance during the sleep study?	☐ Yes ☐ No
7.	Do pediatric patients and patients who need assistance with daily living activities have a guardian or caregiver in attendance during the sleep study?	☐ Yes ☐ No
8.	Are patients referred by a physician?	☐ Yes ☐ No
9.	Who performs the screening prior to admitting a patient for a sleep study?	
10.	Does the Applicant have written policies and procedures for all technical procedures?	☐ Yes ☐ No

U. SURGERY CENTER (INCLUDES ENDOSCOPY SERVICES) ☐ NA

1.	Are patients screened to determine they are low-risk and are able to withstand having a surgical procedure performed on an outpatient basis? If yes, who performs the screening?	☐ Yes ☐ No

2. Does the Applicant provide any of the following types of services? If yes, indicate the annualized number of visits.

Abortion	☐ Yes	☐ No	Annualized Visits:
Bariatrics	☐ Yes	☐ No	Annualized Visits:
Cardiac Catheterization	☐ Yes	☐ No	Annualized Visits:

3.	Specify annual percent of patients for each patient classification:	
	ASA Physical Status Classification	**Annual Percent of Patients**
	P1–Normal healthy patient	%
	P2–Patient with mild systemic disease	%
	P3–Patient with severe systemic disease	%
	P4–Patient with severe systemic disease that is a constant threat to life	%
	P5–Moribund patient who is not expected to survive without the operation	%
	P6–Declared brain-dead patient whose organs are being removed for donor purposes	%
4.	Is the surgeon required to discuss the procedure and consent with the patient prior to the procedure?	☐ Yes ☐ No

V. WEIGHT LOSS SERVICES ☐ NA

1.	Describe the services offered:	
2.	Are patients examined by a physician prior to starting any diet or exercise program?	☐ Yes ☐ No
3.	Are services provided under the direction of a physician based on physician orders and plan of care?	☐ Yes ☐ No
4.	Is there a fitness center on site? If yes, is it open to the public? ☐ Yes ☐ No If yes, annual revenue: $ Describe the exercise facility in the Comments section including equipment and classes offered.	☐ Yes ☐ No
5.	Does the Applicant sell vitamins, food supplements or beverages to patients? If yes, please describe in the Comments section including annual gross revenue.	☐ Yes ☐ No
6.	Does the Applicant advocate the use of weight loss drugs? If yes, use the Comments section to explain the type of screening performed on patients using drugs, the monitoring of patients and the types of drugs used.	☐ Yes ☐ No
7.	Does the Applicant sell or prescribe weight loss drugs? If yes, use the Comments section to explain the type of screening performed on patients using drugs, the monitoring of patients, the types of drugs used and annual gross revenue.	☐ Yes ☐ No

W. X-RAY / IMAGING CENTERS ☐ NA

1.	Does the Applicant provide any of the following services? Specify if not applicable: ☐ NA ☐ Interventional Therapy ☐ Radiation Therapy ☐ IV Contrast	
2.	Is there an external peer review program for high risk/high volume studies/images? If no, describe the peer review process in the Comments section.	☐ Yes ☐ No
3.	Does the Applicant provide: ☐ initial read ☐ over-read/second reads ☐ external peer review services	
4.	Does the Applicant provide teleradiology services? If yes, answer the following questions.	☐ Yes ☐ No
	a. Does the Applicant offer these services to patients in states outside of your primary location? If yes, list each state:	☐ Yes ☐ No
	b. Is the "reading" physician licensed in all states in the service area?	☐ Yes ☐ No
	c. Does the reading physician reside outside of the U.S. and its territories?	☐ Yes ☐ No

X. CLAIM HISTORY - ALL APPLICANTS ANSWER THIS SECTION

In answering these questions, consider all coverage being applied for:

1.	Have any claims or suits ever been made against the Applicant, the Applicant's owners, employees or contractors, including any person for whose acts or omissions the Applicant is legally responsible for? If yes, have all claims and suits been disclosed to us? ☐ Yes ☐ No	☐ Yes ☐ No
2.	Is the Applicant 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, the Applicant's owners, employees or contractors (including any person for whose acts or omissions the Applicant is legally responsible for) even if the claim or suit would be without merit? This includes any request for medical records related to an adverse outcome. If yes, have they all been reported to your current or prior professional liability carrier? ☐ Yes ☐ No	☐ Yes ☐ No
3.	Is the Applicant aware of any claims, suits or potential claims that have not been reported to the Applicant's current or prior professional liability carrier?	☐ Yes ☐ No

Y. COMMENTS SECTION

Please include section and question number.

APPLICATION: All application information is considered important. Signing this application does not bind insurance. We must review and formally approve or reject the application.

FRAUD WARNING/STATEMENT: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Any person who includes any false or misleading information on an application for an insurance policy may be guilty of a crime and subject to penalties that include imprisonment, fines and denial of insurance benefits. Refer to the State Fraud Warning Notices document for your state specific fraud warning notice which will replace this notice, if applicable.

CLAIMS-MADE AND REPORTED DISCLOSURE: If any portion of the policy is issued on a claims-made and reported basis, such portions will apply only to claims first made against you during the policy period arising out of the performance of professional services occurring on or after the prior acts date shown on the policy. Claims must be reported to us during the policy period or under an extended reporting period endorsement.

PRIVACY STATEMENT: We may communicate the results of the application to your authorized representative. To review detailed information on how we collect and use your personal information, visit the company website at curi.com.

APPLICANT ACKNOWLEDGEMENT: Applicant declares this information, including any provider roster, is complete and accurate. Applicant acknowledges a continuing duty to supplement any information that may materially affect this application. Applicant acknowledges the applicable state fraud warning notice as shown on the State Fraud Warning Notices document.

PRIOR ACTS ACKNOWLEDGEMENT: All claims or potential claims have been reported to the Applicant's current or prior carrier. The Applicant understands the company will not provide coverage for any claim, suit or potential claim known on the effective date.

Applicant Signature	Title	Date

Print Signature