

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): <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> For Profit <input type="checkbox"/> Not For Profit <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Corporation <input type="checkbox"/> Government <input type="checkbox"/> Other-specify:			
2. Specify current accreditations and/or certifications (check all that apply): <input type="checkbox"/> JCAHO Accredited <input type="checkbox"/> CCAC Accredited <input type="checkbox"/> CCRC Accredited <input type="checkbox"/> AAAHC Medicare/Medicaid Certified <input type="checkbox"/> Other (specify):			
3. Is Applicant currently enrolled in a Patients' Compensation Fund (PCF) or similar state fund? If yes, specify name of fund:			<input type="checkbox"/> Yes <input type="checkbox"/> No
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
<input type="checkbox"/> Hospital	<input type="checkbox"/> Physician / Provider Office
<input type="checkbox"/> Nursing Homes/Extended Care Facility	<input type="checkbox"/> Ambulatory Surgical Center
<input type="checkbox"/> Rehabilitation Center	<input type="checkbox"/> Urgent Care Center
<input type="checkbox"/> Hospice	<input type="checkbox"/> Retail Clinic
<input type="checkbox"/> Mental Health/Substance Abuse Facility	<input type="checkbox"/> Mental Health/Substance Abuse Clinic
	<input type="checkbox"/> Dialysis Center
	<input type="checkbox"/> Laboratory
	<input type="checkbox"/> Pharmacy
	<input type="checkbox"/> Diagnostic Imaging Center
	<input type="checkbox"/> Free Standing Facility

Home and Community Based Care

Community Health Center

Patient's Home

Day Care Center

C. CURRENT COVERAGE

<p>1. Professional Liability Carrier Information</p> <p>Carrier: _____</p> <p>Limits of Coverage: _____</p> <p>Deductible/Retention: _____</p> <p>Policy Period: _____</p> <p>Policy Premium: _____</p> <p>Claims-Made or Occurrence: _____</p> <p>If claims-made, prior acts date is: _____</p>	<p>2. General Liability Carrier Information</p> <p>Carrier: _____</p> <p>Limits of Coverage: _____</p> <p>Deductible/Retention: _____</p> <p>Policy Period: _____</p> <p>Policy Premium: _____</p> <p>Claims-Made or Occurrence: _____</p> <p>If claims-made, prior acts date is: _____</p>
<p>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.</p>	
<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

D. REQUESTED COVERAGE

1. Policy Period: _____	2. Prior Acts Date: _____
<p>3. Primary Limits of Liability (limits are expressed as per claim/aggregate):</p> <p>Medical Professional Liability Limit <input type="checkbox"/> \$1,000,000/\$3,000,000 Other: _____</p> <p>General Liability Limit <input type="checkbox"/> \$1,000,000/\$3,000,000 Other: _____</p> <p>Employee Benefits Liability Limit <input type="checkbox"/> \$1,000,000/\$3,000,000 Other: _____</p>	

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
<input type="checkbox"/>	Auto Liability				
<input type="checkbox"/>	Employers Liability				
<input type="checkbox"/>	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? Yes No
 If yes, use the Comments section to explain.

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

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? Yes No
 If yes, provide a detailed explanation including the date the license was reinstated.

11. Has the Applicant ever filed for bankruptcy? If yes, please give name of the legal entity and details of the arrangement:	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is the Applicant involved in any research activities? If yes, describe in the Comments section.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are management services performed for other facilities? If yes, describe in the Comments section.	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Employees <input type="checkbox"/> Contractors <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Confirm hospital privileges for physicians, oral surgeons and dentists?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Check for any license suspensions, revocations or any disciplinary actions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Conduct criminal background checks, including screenings for sexual offenses, for all providers at both the state and national levels?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Require information regarding medical professional claims history?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does the Applicant have a formal/documented orientation program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the Applicant have a formal/documented credentialing program in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do all practitioners responsible for patient care have an educational concentration, licensure or certification specific to the services they are providing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are assessments and/or evaluations of staff performed? If yes, answer the following questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often are they performed?	
Are assessments/evaluations documented in writing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Are workers transporting patients? If yes, answer the following questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are driving records (MVRs) verified? <input type="checkbox"/> Yes <input type="checkbox"/> No How often?	
How are they transported? <input type="checkbox"/> Employee vehicle <input type="checkbox"/> Company vehicle <input type="checkbox"/> Other(describe):	

H. MEDICAL EQUIPMENT / PRODUCTS

1. Does the Applicant sell, rent/lease or distribute medical equipment or products to others ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check the appropriate category and answer the following questions: <input type="checkbox"/> Durable Medical Equipment/Supplies <input type="checkbox"/> Expendable Medical Equipment/Supplies <input type="checkbox"/> Medical Products
2. Does the Applicant provide service or maintenance for the equipment/products? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the Applicant signed any contractual agreements to provide services to others? If yes, describe the types of services:	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Does the contract contain an indemnification (hold harmless) clause? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/> Mental Health Counseling	_____	_____
<input type="checkbox"/> Substance Abuse Counseling	_____	_____
<input type="checkbox"/> Developmental Disability	_____	_____
<input type="checkbox"/> Crisis Center	_____	_____

Rehabilitation	Visits	Beds
<input type="checkbox"/> Cardiac Rehabilitation	_____	_____
<input type="checkbox"/> Physical or Occupational Rehab	_____	_____
<input type="checkbox"/> Trauma Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Trauma Rehab/Transitional Living	_____	_____

Surgical / Specialized Services	Visits	Beds
<input type="checkbox"/> Birthing Center	_____	_____
<input type="checkbox"/> Endoscopy	_____	_____
<input type="checkbox"/> Lithotripsy	_____	_____
<input type="checkbox"/> Surgery Center	_____	_____
<input type="checkbox"/> X-Ray / Imaging	_____	Revenue

Hospice / Home Healthcare	Visits	Beds
<input type="checkbox"/> Hospice Care	_____	_____
<input type="checkbox"/> Intravenous Therapy	_____	_____
<input type="checkbox"/> Personal/Companion Care	_____	_____
<input type="checkbox"/> Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Respiration Therapy	_____	_____
<input type="checkbox"/> Skilled Care	_____	_____
<input type="checkbox"/> Durable Medical Equipment	_____	Revenue
<input type="checkbox"/> Pharmacy	_____	Revenue

Staffing Agency	FTE
Specify Provider Type and FTE Below	
<input type="checkbox"/>	_____ FTE
<input type="checkbox"/>	_____ FTE
<input type="checkbox"/>	_____ FTE
<input type="checkbox"/>	_____ FTE

Non-Direct Healthcare Services	Revenue
<input type="checkbox"/> Dental Laboratory	_____ Revenue
<input type="checkbox"/> Medical Laboratory	_____ Revenue
<input type="checkbox"/> Ocular Laboratory	_____ Revenue
<input type="checkbox"/> Pathology Laboratory	_____ Revenue
<input type="checkbox"/> Pharmacy	_____ Revenue
<input type="checkbox"/> Durable Medical Equipment	_____ Revenue
<input type="checkbox"/> Blood/Plasma Bank	_____ Donations
<input type="checkbox"/> Organ Bank-direct processing	_____ Donations
<input type="checkbox"/> Organ Bank-no direct processing	_____ Donations

Treatment Centers	Visits
<input type="checkbox"/> College/University Health Center	_____ Visits
<input type="checkbox"/> Community Health Center	_____ Visits
<input type="checkbox"/> Convenience Care/Retail Clinic	_____ Visits
<input type="checkbox"/> Dialysis Center	_____ Visits
<input type="checkbox"/> Medi Spa	_____ Visits
<input type="checkbox"/> Municipal Health Department	_____ Visits
<input type="checkbox"/> Oncology Services	_____ Visits
<input type="checkbox"/> Optical Establishment	_____ Revenue
<input type="checkbox"/> Sleep Lab	_____ Beds
<input type="checkbox"/> Sleep Lab	_____ Visits
<input type="checkbox"/> Urgent Care Center	_____ Visits
<input type="checkbox"/> Weight Loss Center	_____ Visits
<input type="checkbox"/> Family Practice Clinic	_____ Visits

Ambulance Companies	FTE
<input type="checkbox"/> Emergency Medical Technician	_____ FTE
<input type="checkbox"/> Paramedic	_____ FTE
<input type="checkbox"/> Other provider type:	_____ FTE

Other	Revenue
<input type="checkbox"/> Child Day Care	_____ Enrollees
<input type="checkbox"/> Adult Day Care	_____ Enrollees
<input type="checkbox"/> Fitness Center (open to public)	_____ Revenue

K. SURGICAL PROCEDURES

Anesthesia	
1. Is anesthesia provided? If yes, answer the following questions. If no, proceed to question 5.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What level of anesthesia is provided?	
<input type="checkbox"/> Level A	Local or topical anesthesia
<input type="checkbox"/> 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)
<input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is Level C anesthesia administered by an anesthesiologist or CRNA? If no, explain the qualifications of professionals administering general anesthesia:	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are instruments sterilized on site? If yes, specify which method.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Steam Sterilization <input type="checkbox"/> Gas Sterilization <input type="checkbox"/> Chemical Soak <input type="checkbox"/> Routine Flash Sterilization	
7. Are written protocols in place for daily autoclave testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is each sterilized pack marked with the date of sterilization and expiration date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are all clinical staff CPR trained or higher?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is there documented protocol for handling in-house medical emergencies?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is there an agreement in place with an ambulance company for transportation of emergency cases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Is emergency equipment tested routinely with documentation?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are malignant hypothermia drugs available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Is a copy of the ACLS Malignant Hypothermia Algorithm maintained on the cart?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

L. BARIATRIC SURGERY		<input type="checkbox"/> 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:		
<input type="checkbox"/> American Society for Metabolic and Bariatric Surgery		
<input type="checkbox"/> Society of American Gastrointestinal and Endoscopic Surgeons		
<input type="checkbox"/> American College of Surgeons		
<input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No	

M. BEHAVIORAL HEALTH		<input type="checkbox"/> NA
1. Check all services provided:		
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Psychodrama Therapy	<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Addiction/Dependency Treatment	<input type="checkbox"/> Criminal/Domestic Violence	<input type="checkbox"/> Nutritional/Eating Disorders
<input type="checkbox"/> Aversion Therapy	<input type="checkbox"/> Electroconvulsive Therapy (ECT)	<input type="checkbox"/> Psychotherapy/Psychoanalysis
<input type="checkbox"/> Biofeedback/Neurofeedback	<input type="checkbox"/> Genetic Counseling	<input type="checkbox"/> Recreation Therapy
<input type="checkbox"/> Boot Camp/Wilderness Survival Trng	<input type="checkbox"/> Hippotherapy	<input type="checkbox"/> Sexual Therapy
<input type="checkbox"/> Case Management/Social Services	<input type="checkbox"/> Learning/Developmental Disabilities	<input type="checkbox"/> Spiritual/Religious Counseling
<input type="checkbox"/> Counseling	<input type="checkbox"/> Life Coaching	<input type="checkbox"/> Grief Counseling
<input type="checkbox"/> Art/Dance/Drama/Music Therapy	<input type="checkbox"/> Marriage/Family Therapy	<input type="checkbox"/> Trauma Counseling
<input type="checkbox"/> Grief Counseling	<input type="checkbox"/> Vocational Counseling	<input type="checkbox"/> Rehabilitation Counseling
<input type="checkbox"/> Medication Management	<input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

<input type="checkbox"/> Emergency Care	<input type="checkbox"/> Surgery	<input type="checkbox"/> Obstetrical Deliveries
<input type="checkbox"/> X-Ray/Imaging Services	<input type="checkbox"/> Pediatric Primary Health Care	<input type="checkbox"/> Nutritional/Eating Disorders
<input type="checkbox"/> Invasive Procedures/Minor Surgery	<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> Abortions
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Genetic Counseling	<input type="checkbox"/> 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:

<input type="checkbox"/> High-technology equipment areas	<input type="checkbox"/> Safe client lifting, transferring and ambulating techniques
<input type="checkbox"/> Proper use of equipment	<input type="checkbox"/> Infection control and safety
<input type="checkbox"/> Managing emergencies	<input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annualized Visits:
Nephrolithotomy (Open surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annualized Visits:
Pyelolithotomy (Open surgery)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annualized Visits:
Any other type of open surgery (Describe in Comments section.)	<input type="checkbox"/> Yes <input type="checkbox"/> 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

<input type="checkbox"/> Administration of medication	<input type="checkbox"/> Case management	<input type="checkbox"/> Compounding
<input type="checkbox"/> Pain management	<input type="checkbox"/> 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		<input type="checkbox"/> NA
1. Check all services provided: <input type="checkbox"/> Aquatic Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Social Services <input type="checkbox"/> Athletic Training <input type="checkbox"/> Orthotics/Prosthetics <input type="checkbox"/> Speech/Language/Audiology <input type="checkbox"/> Cardiac Rehabilitation <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Sports Medicine <input type="checkbox"/> Cognitive Therapy <input type="checkbox"/> Recreational Therapy <input type="checkbox"/> Trauma Rehabilitation <input type="checkbox"/> Driving, Adaptive <input type="checkbox"/> Sexuality Therapy <input type="checkbox"/> Vocational Training <input type="checkbox"/> Hippotherapy <input type="checkbox"/> Other (describe):		
2. Are diagnostic services provided? If yes, indicate the type of diagnostic services provided and the percentage of total patients being diagnosed:		<input type="checkbox"/> Yes <input type="checkbox"/> 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:		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are cardiac rehabilitation services provided? If yes, answer the following questions.		<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Are AACVPR guidelines followed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is a physician available on the premises when the program is in operation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Are patients screened with a stress test?		<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Are all exercises prescribed by a physician or exercise physiologist?		<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Is staff certified in BLS and ACLS?		<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Is emergency equipment (defibrillator, O2, emergency medications) available?		<input type="checkbox"/> Yes <input type="checkbox"/> No
g. How often is emergency equipment checked?		
h. Are there written emergency protocols?		<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Are mock code drills conducted?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain all "no" answers in the Comments section.		

T. SLEEP LAB		<input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do medically unstable patients have a nurse in attendance during the sleep study?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are patients referred by a physician?		<input type="checkbox"/> Yes <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No

U. SURGERY CENTER (INCLUDES ENDOSCOPY SERVICES)		<input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the Applicant provide any of the following types of services? If yes, indicate the annualized number of visits.		
Abortion	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annualized Visits:
Bariatrics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annualized Visits:
Cardiac Catheterization	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are services provided under the direction of a physician based on physician orders and plan of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is there a fitness center on site? If yes, is it open to the public? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, annual revenue: \$ Describe the exercise facility in the Comments section including equipment and classes offered.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No

W. X-RAY / IMAGING CENTERS NA

1. Does the Applicant provide any of the following services? Specify if not applicable: <input type="checkbox"/> NA <input type="checkbox"/> Interventional Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the Applicant provide: <input type="checkbox"/> initial read <input type="checkbox"/> over-read/second reads <input type="checkbox"/> external peer review services	
4. Does the Applicant provide teleradiology services? If yes, answer the following questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Does the Applicant offer these services to patients in states outside of your primary location? If yes, list each state:	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is the “reading” physician licensed in all states in the service area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Does the reading physician reside outside of the U.S. and its territories?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

Notice Concerning Policyholder Rights in an Insolvency Under the Minnesota Insurance Guaranty Association Law

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
4640 West 77th Street
Edina, Minnesota 55435
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY OR LIABILITY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE OR LIABILITY POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.