

HEALTH CARE PROVIDER & HEALTH CARE FACILITY SUPPLEMENT

(Complete in addition to ACORD Application)

Proposed First Named Insured & Other Named Insured(s):

Lo	cation Address Street		City	County	State	ZIP Code	
BU	ISINESS INFORMATION						
1.	Interest of Named Insured in pre-	mises:	Owner	General Lessee	Tenant		
	Other:						
2.	Check your specific professiona	l occupatio	n:				
	Aide/Homemaker						
	Artificial Limb Fitter						
	Audiologist	Do you op	perate a mobile	unit?	Yes	No	
	Counselor Psychia	atrist	Psychologis	t Social Work	ker		
	Dental Hygienist						
	Dietitian/Nutritionist	Do you m	arket products	under your own labe	el? Yes	No	
	Druggist/Pharmacist	Do you pr	escribe medica	ntions?	Yes	No	
	Hearing Aid Specialist						
	Massage Therapist						
	Nurse - <i>Type:</i>		Check if	appropriate:	Midwife	Nurse Anesthetist	
	Occupational Therapist	R	espiratory Ther	apist			
	Optician	S	peech Therapis	it			
	Optometrist	Х	-Ray Technicia	n/X-Ray Specialist			
	Physical Therapist	0	ther:				
3.	Indicate type of services perform	ed and pe	rcentage:				
	Abortion/Family Planning		%	Occupational			%
	Alcohol/Drug		%	Optician			%
	Child Abuse/Sexual Offende	ers	%	Optometrist			%
	Criminal		%	Physical Thera	apist		%
	Crisis Intervention	. <u> </u>	%	Respiratory Th	nerapist		%
	Family/Marital		%	School/Youth			%
	General Guidance	. <u> </u>	%	Speech Thera	pist		%
	Hot Line/Referral	. <u> </u>	%	X-Ray Technic	cian		%
	Nurse - <i>Type:</i>		%				
	Check if appropriate:	X-Ray Spe	ecialist	Midwife Nu	rse Anesthetist		
	Counseling Agency:		%				
	Type: Drug/Alcohol Re	ehab. Cent	er Half	way House Me	ntally Handicapp	ed Facility	
	Other:			%			
	<i>Type:</i> Group Home	Menta	al Health Center	Physical/Od	ccup. Rehab. Ce	nter Shelter	

 Do you perform shock therapy, use restraints, heavy sedation or offer any experimental treatments? Yes No If yes, describe:

OP	ERATIONS - Health Care Provide	er								
1.	Do you treat children exclusively	? Yes	No							
2.	Indicate percentage of time spen	t in the follo	wing work loca	ations:						
	Administrative Office	%	Hospice		%	Pro	fessional Offic	ce	%	, D
	Classroom	%	Outpatient C	linic	%	Nur	sing Home		%	
	Emergency Dept. of Hospital	%	Laboratory		%	Oth	er:		%	
	Hospital Ward (Specify):				%	Pat	ient's Home		%	, D
3.	Are you engaged in, associated v	vith, or invol	ved in any oth	er enterp	rises?	Yes	No			
	If yes, explain:									
								Yes	No	N/A
4.	Does your employer carry insural		-	ual to or	greater thar	n the lim	nit of this			
		neral Liability								
_		fessional Lia	2							
5.	Are you an owner, operator, office	•		or have a	a similar cap	bacity fo	r any other			
	health care or related services or									
	If yes, is there separate insurance	e in place wi	th limits equal	to or gre	ater than the	e limits o	of this			
_	policy?									
6.	Have you entered into any contra	•								
	If yes, is legal advise sought to w									
_	Does the agreement require you		third party har	mless?						
7.	Do you have recordkeeping proc			_						
8.		ne (30+ hou			Time (30 ho					
9.	Do you have independent contractors working for you? Yes No If yes, describe:									
4.0	Number of Contractors including Type:									
10.	Do you use the services of volunt	teers or stud	lents?	Yes	No If ye	s, desci	ribe:			
	Duties:									
	Training:									
							0		Yes	No
11.	Do you comply with all applicable	e laws and c	ordinances per	taining to	licensing c	or codes	57			
40	If no, describe:									
12.	Do you diagnose or prescribe me	edications?								
10	If yes, describe:		and any profe		who are full	time on				
13.	Are any of the psychiatrists, welfa	are workers	and any profes	ssionais	who are ruil-	-ume en	npioyees			
11	of a hospital?									
14.	Are overnight facilities provided?									
15	If yes, describe: Are you affiliated with, owned by,	or attached	l to a hospital	or ricke o	f a govorpr	ont not	uro?			
	Is Additional Insured status requi				•	ient nati				
	Do you specialize in Family Plan			uicai sia	11					
17.	If yes, describe:	ing Service	5!							
	ERATIONS - Health Care Facility	,								
		·							Yes	No
1.	Does your facility: Diagnos	se patients/r	esidents?						163	NO
••			t or medication	ns to nati	ents/resider	nts?				
2.	Describe all services provided. A			•			d by the facilit	V. Also	attack	ז
	audited financial statement or an				g mater			,. ,	41401	-

3.	Are outpatient services provided?	Yes	No	Number of outpatie	nt visits annually:
4.	Number of beds:	Average O	ccupanc	y:	Licensed # of beds:

Under 18 Years: [6] 9 Years & Over: 6. Patient admission is: Forced Voluntary 7. Are patients/residents accepted on a court order? No 8. Are there procedures in place for patient screening and acceptance? No 9. Are current records and files maintained on each patient? All other stages: 11. Have any patients/residents been given a probable diagnosis of having Alzheimer's? If yes, how many at the following stages: Stage 1: All other stages: 12. Average length of stay for patients/residents: Interview any patients/residents allowed to leave premises unattended? 14. Number of non-ambulatory residents: Interview any patients/residents allowed to leave premises unattended? 14. Number of non-ambulatory residents: Interview any patients/residents above the second floor? 16. Describe management's/administrator's education and experience: Interview any patients/residents adove the second floor? 17. Do you train new paraprofessionals (e.g. aides, homemakers)? If yes, explain: 18. De you provide ongoing training for paraprofessionals? If yes, describe, indicating who is responsible for maintenance and submit a copy of contract. 21. Do you allo relaxe any modical equipment from doffs? If yes, describe, indicating who is responsible for maintenance? 22. Do you require lessees to provide certificates of insurance? If yes, describe.	5.	Resident age groups (# for each):						
Yes No 7. Are patients/residents accepted on a court order? Are current records and files maintained on each patient? 8. Are there procedures in place for patient screening and acceptance? Are current records and files maintained on each patient? 10. Have any patients/residents been digenosed with a mental illness (e.g. schizophrenia, psychopathic, sociopathic diagnosis)? All other stages: 11. Have any patients/residents been dignosed with a mental illness (e.g. schizophrenia, psychopathic, sociopathic diagnosis)? Are residents/patients? 12. Average length of stay for patients/residents:		Under 18 Years:	18 - 59 Years:	60 Years & Over:				
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		c. Have your privileges ever been restricted, suspended, or revoked by any health care facility?						
If yes, describe:		d. Have you had any licensing or code violations in the past three years?						
		If yes, describe:						

6.	Check all procedures you use when hiring professionals, paraprofessionals, or any other			
	employee providing patient care services at your facility:	None	Written	Verbal

- a. Educational background or residency program check, when applicable.
- b. Previous employers check.
- c. Personal references check.
- d. Criminal background check.
- e. Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals.

EMPLOYEE PROCEDURES & STAFFING - Health Care Facility

- 1. Do you have employees? Yes No
- Do any of the medical professionals, to be insured under this policy, operate a separate practice and/or have ownership in a medical institution?
 Yes
 No

Staff	Total Number	Staff	Total Number
Nurse Anesthetists		RN/LPN/LVNs	
Nurse Practitioners		Technicians	
Nurse Midwives		Social Workers	
Psychologists		Aides/Homemakers	
Physical Therapists		Counselors	
Occupational Therapists		Other:	

Yes No

- 4. Do you comply with minimum required staff standards for each shift?
- 5. Is any staff working on a contract basis?

If yes, do you require proof of separate professional liability insurance?

- 6. Do you have a written requirement that physicians, oral surgeons, and dentists providing services at your facility(ies) carry professional liability insurance and provide proof of this coverage?
- 7. Do you have: a. Written job descriptions
 - b. Policies and/or procedures manual
 - c. Full-time administrator or medical director on staff
 - d. Emergency shelter arrangements for participants
- 8. Have you or any partner, officer, director, or employee ever been the subject of disciplinary

action by a regulatory authority as a result of their professional activities?

If yes, explain:

IMPORTANT NOTICE

DECLARATION

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.

SIGNATURES

Applicant Signature	Title	Date			
Producer Signature		Date			
Producer Name and Address					