NORTHFIELD
EXCESS & SURPLUS LINES | A TRAVELERS COMPANY

HEALTH CARE PROVIDER & HEALTH CARE FACILITY SUPPLEMENT

(Complete in addition to ACORD Application)

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

Location Address | Street | City | County | State | ZIP Code

BUSINESS INFORMATION

1. Interest of Named Insured in premises: ☐ Owner ☐ General Lessee ☐ Tenant
   ☐ Other:
2. Check your specific professional occupation:
   - ☐ Aide/Homemaker
   - ☐ Artificial Limb Fitter
   - ☐ Audiologist — *Do you operate a mobile unit?* ☐ Yes ☐ No
   - ☐ Counselor ☐ Psychiatrist ☐ Psychologist ☐ Social Worker
   - ☐ Dental Hygienist
   - ☐ Dietitian/Nutritionist — *Do you market products under your own label?* ☐ Yes ☐ No
   - ☐ Druggist/Pharmacist — *Do you prescribe medications?* ☐ Yes ☐ No
   - ☐ Hearing Aid Specialist
   - ☐ Massage Therapist
   - ☐ Nurse - *Type:*_____ *Check if appropriate:* ☐ Midwife ☐ Nurse Anesthetist
   - ☐ Occupational Therapist ☐ Respiratory Therapist
   - ☐ Optician ☐ Speech Therapist
   - ☐ Optometrist ☐ X-Ray Technician/X-Ray Specialist
   - ☐ Physical Therapist ☐ Other:
3. Indicate type of services performed and percentage:

☐ Abortion/Family Planning	_____ %	☐ Occupational	_____ %
☐ Alcohol/Drug	_____ %	☐ Optician	_____ %
☐ Child Abuse/Sexual Offenders	_____ %	☐ Optometrist	_____ %
☐ Criminal	_____ %	☐ Physical Therapist	_____ %
☐ Crisis Intervention	_____ %	☐ Respiratory Therapist	_____ %
☐ Family/Marital	_____ %	☐ School/Youth	_____ %
☐ General Guidance	_____ %	☐ Speech Therapist	_____ %
☐ Hot Line/Referral	_____ %	☐ X-Ray Technician	_____ %
☐ Nurse - *Type:* _____	_____ %		

   Check if appropriate: ☐ X-Ray Specialist ☐ Midwife ☐ Nurse Anesthetist
   ☐ Counseling Agency: _____ %
   Type: ☐ Drug/Alcohol Rehab. Center ☐ Halfway House ☐ Mentally Handicapped Facility
   ☐ Other: _____ _____ %
   Type: ☐ Group Home ☐ Mental Health Center ☐ Physical/Occup. Rehab. Center ☐ Shelter
4. Do you perform shock therapy, use restraints, heavy sedation or offer any experimental treatments?
   ☐ Yes ☐ No If yes, describe:

OPERATIONS - Health Care Provider

1. Do you treat children exclusively? ☐ Yes ☐ No
2. Indicate percentage of time spent in the following work locations:

Administrative Office	%	Hospice	%	Professional Office	%
Classroom	%	Outpatient Clinic	%	Nursing Home	%
Emergency Dept. of Hospital	%	Laboratory	%	Other:	%
Hospital Ward (Specify):			%	Patient's Home	%

3. Are you engaged in, associated with, or involved in any other enterprises? ☐ Yes ☐ No
   If yes, explain:

		Yes	No	N/A
4. Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following:	General Liability	☐	☐	☐
	Professional Liability	☐	☐	☐
5. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?		☐	☐	
If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?		☐	☐	
6. Have you entered into any contractual agreements?		☐	☐	
If yes, is legal advise sought to write and approve?		☐	☐	
Does the agreement require you to hold any third party harmless?		☐	☐	
7. Do you have recordkeeping procedures?		☐	☐	

8. Do you practice: ☐ Full Time (30+ hours/week) ☐ Part Time (30 hours or less/week)
9. Do you have independent contractors working for you? ☐ Yes ☐ No If yes, describe:
   Number of Contractors including Type:
10. Do you use the services of volunteers or students? ☐ Yes ☐ No If yes, describe:
    Duties:
    Training:

	Yes	No
11. Do you comply with all applicable laws and ordinances pertaining to licensing or codes?	☐	☐
If no, describe:		
12. Do you diagnose or prescribe medications?	☐	☐
If yes, describe:		
13. Are any of the psychiatrists, welfare workers and any professionals who are full-time employees of a hospital?	☐	☐
14. Are overnight facilities provided?	☐	☐
If yes, describe:		
15. Are you affiliated with, owned by, or attached to a hospital or risks of a government nature?	☐	☐
16. Is Additional Insured status required for hospital staff or medical staff?	☐	☐
17. Do you specialize in Family Planning Services?	☐	☐
If yes, describe:		

OPERATIONS - Health Care Facility

		Yes	No
1. Does your facility:	Diagnose patients/residents?	☐	☐
	Prescribe treatment or medications to patients/residents?	☐	☐

2. Describe all services provided. *Attach any brochures or other advertising material used by the facility. Also attach audited financial statement or annual report.*
3. Are outpatient services provided? ☐ Yes ☐ No Number of outpatient visits annually:
4. Number of beds: | Average Occupancy: | Licensed # of beds:

5. Resident age groups (# for each):

Under 18 Years:	18 - 59 Years:	60 Years & Over:

6. Patient admission is: ☐ Forced ☐ Voluntary

	Yes	No
7. Are patients/residents accepted on a court order?	☐	☐
8. Are there procedures in place for patient screening and acceptance?	☐	☐
9. Are current records and files maintained on each patient?	☐	☐
10. 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:		
11. Have any patients/residents been diagnosed with a mental illness (e.g. schizophrenia, psychopathic, sociopathic diagnosis)?	☐	☐
12. Average length of stay for patients/residents:		
13. Are residents/patients allowed to leave premises unattended?	☐	☐
14. Number of non-ambulatory residents:		
15. Any non-ambulatory patients above the second floor?	☐	☐
16. Describe management's/administrator's education and experience:		
17. Do you train new paraprofessionals (e.g. aides, homemakers)?	☐	☐
If yes, explain:		
18. Do you provide ongoing training for paraprofessionals?	☐	☐
19. Are sleeping facilities separated by gender?	☐	☐
20. Are facilities affiliated with, owned by, or attached to a hospital or risks of a government nature?	☐	☐
21. Do you sell or lease any medical equipment or other products **to others**?	☐	☐
If yes, describe, indicating who is responsible for maintenance and submit a copy of contract.		
Receipts: $		
22. Do you require lessees to provide certificates of insurance?	☐	☐
23. Do you lease or rent any equipment **from others**?	☐	☐

EMPLOYEE PROCEDURES & STAFFING - Health Care Provider

1. Check the highest level of education you have completed relating to practice in your field:

☐ None required ☐ Bachelor's Degree ☐ Other: _____

☐ Associate Degree ☐ Doctorate Degree *School where degree was obtained:*

☐ Master's Degree ☐ Post-Doctorate Degree _____

For multiple employees, attach list with names, degree(s) and school(s).

2. Describe any professional training, licensing, or certification needed for this operation:

3. Are you certified/licensed? ☐ Yes ☐ No

If yes, name of board/licensing body:

		Yes	No	N/A
4. Has your license ever been:	Restricted?	☐	☐	☐
	Suspended?	☐	☐	☐
	Revoked?	☐	☐	☐
a. Have you ever been denied a license or board certification?		☐	☐	☐
b. Have you ever been a patient in any chemical dependency program?		☐	☐	☐
c. Have your privileges ever been restricted, suspended, or revoked by any health care facility?		☐	☐	☐
d. Have you had any licensing or code violations in the past three years?		☐	☐	☐

If yes, describe:

5. List any professional association or organization of which you are a member. Show complete name. ☐NONE

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
2. 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
3.

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