



**6822 Delmar Boulevard
St. Louis, Missouri 63130
Telephone: (314) 721-2366
Facsimile: (314) 721-2377**

**APPLICATION FOR
MEDICAL FACILITY
MEDICAL LIABILITY POLICY
CLAIMS MADE COVERAGE**

IMPORTANT INFORMATION

THIS DOCUMENT IS NOT A BINDER OR ACCEPTANCE OF INSURANCE.

Insurance coverage will not be considered until this application is completed, signed, and dated. Failure to provide complete information and attachments as requested will cause delay. Completion of this form, with or without payment of premium, does not bind Galen Insurance Company (“Company”, “we”, or “us”) to issue insurance.

Processing Time

Please be advised that a minimum of 30 business days is required to process this application once it is received in our office. After this application has gone through our underwriting process, we will inform the applicant (called “Applicant” or “the Facility” in this document) of our response to this application.

Completion of Application

This application is for facilities, other than hospitals and nursing homes, where medical procedures are performed. Medical groups, individual doctors, and allied medical professionals who do medical procedures at the Facility seeking insurance through this application should complete the applications intended for them if they seek separate coverage. This application must be signed and dated by an owner, partner, or officer of the Facility seeking insurance.

All questions must be answered. For questions that do not apply to the Applicant’s operation, please write “N/A” in the answer space provided. If the person completing this application does not know the answer to a particular question, please note that. All questions should be answered based on the knowledge of the Applicant’s employees, officers, directors, members, shareholders, partners, affiliates, or representatives. All questions should be answered based on the information applicable to and regarding the Applicant and all affiliates, physicians, and allied professionals for whom coverage is being sought.

Please make certain that all required information and attachments are provided in order to assist us in processing this application promptly and efficiently.

If an explanation or additional space is required for any answer, please use extra pages. If a question arises about the application process, call the Company at: 314-721-2366.

This document is an application for a claims-made policy of professional liability insurance. If issued, coverage under the policy is limited to liability for those claims that: (a) arise from incidents or events that happen while coverage under the policy is in force and that involve a named insured’s professional services; and (b) are first made against a named insured and are reported to the Company during the policy period, including any extended reporting period, or during any optional extended reporting period provided through an endorsement.

INSURANCE COVERAGE IS SUBJECT TO UNDERWRITING APPROVAL AND FULL PAYMENT OF THE PREMIUM. NO COVERAGE EXISTS UNTIL THE PREMIUM IS FULLY PAID AND RECEIVED AND A DECLARATION PAGE, TOGETHER WITH ANY ENDORSEMENTS THAT MAY APPLY, HAS BEEN ISSUED TO THE POLICYHOLDER.

Galen Insurance Company
6822 Delmar Boulevard
St. Louis, Missouri 63130
Telephone: (314) 721-2366
Fax: (314) 721-2377

**APPLICATION FOR
MEDICAL FACILITY
LIABILITY INSURANCE**

Please answer all questions fully and completely. If you do not have enough space to provide a complete answer, use separate pages, identifying the question and providing the additional information necessary for a complete answer. PLEASE TYPE OR PRINT LEGIBLY.

PART I: APPLICANT INFORMATION

a. Facility Name: _____

b. Principal business premise address: _____
(Street)

(City) (County) (State) (Zip)

c. Professional Corporation (for profit) Partnership
Professional Corporation (not for profit) Professional Association
Other (describe) _____

d. Date established: _____

e. Number of employees: Full time Part time Seasonal Total

f. Facility owner's name: _____

g. List of all employees or partners of owner who provide professional services in the Facility.

h. Please attach a copy of letterhead or other business stationery.

Part II. OPERATIONS

a. Is the Facility registered and licensed to operate? Yes No

If not, please explain _____

b. Professional specialty of the Facility (can be more than one):

- Cardiac Rehabilitation []
- Cardiology Testing Center []
- Medical Laboratory []
- Mental Health Counseling Services []
- Pharmacy []
- Physical/Occupational Rehab []
- Routine Clinical Pathology Lab []
- Surgicenter []
- Urgent Care Center []
- X-Ray/Imaging Lab []

c. Does the Facility maintain any beds for overnight occupancy? [] Yes [] No

If yes, how many? _____

What staffing does the Facility provide to care for overnight patients? _____

Is a physician available for overnight patients? [] Yes [] No

If yes, please describe: _____

d. Total square feet occupied (all locations): _____

e. Are clients treated for medical problems other than those normally addressed by the specialties checked above? [] Yes [] No

What sort of other treatments are given? _____

What percentage of the Facility's services is devoted to treatments outside of the checked specialty?
_____ %

f. Does the Facility use a collection agency?

If yes, name of agency: _____

Does the agency have authority to file a collection suit on the Facility's behalf? [] Yes [] No

g. Do the owners, partners, or directors, (wholly or in part), operate or administer any hospital, nursing home, or other institution where medical services are customarily rendered? Yes No
If yes, give details including name, location, size, and number of beds. _____

h. Do the owners, partners, or directors own or operate any business other than the Facility? Yes No

If yes, please attach detailed explanations of such ownership or operation.

i. Does the Applicant advertise its services in any manner (other than a simple listing in a telephone directory)? Yes No

If yes, please attach a copy of ALL of the advertisements for past five years.

j. List the names and locations of any hospitals or institutions the Facility uses in its operations.

k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No

If yes,

(i) Has the Applicant implemented procedures to ensure compliance with the HIPAA Privacy Rules? Yes No

(ii) Provide the name and title of the Applicant's Privacy Officer. _____

Part III. PROFESSIONAL SERVICES

a. Do practitioners at the Facility perform:

(i) Acupuncture or acupuncture anesthesia? Yes No

Explain: _____

(ii) Angiography/arteriography/venography? Yes No

Describe: _____

(iii) Catheterization (other than urinary or umbilical)? Yes No

Describe: _____

(iv) Closed reduction of compound fractures and/or normal deliveries or dermabrasion? Yes No

(v) Injection of radioisotopes or use of irradiated substances? Yes No

Describe: _____

- (vi) Radiation therapy and/or chemotherapy? Yes No
Describe: _____
- (vii) Psychiatric shock therapy? Yes No
Describe: _____
- (viii) Silicone injections? Yes No
Describe: _____
- (ix) Spinal anesthesia (other than saddle blocks or caudals)? Yes No
Describe: _____
- (x) Laser treatment? Yes No
Describe: _____
- (xi) Experimental procedures or research testing? Yes No
Describe in detail on separate sheet
- (xii) Hypnosis? Yes No
Describe: _____

b. Are the following performed at the Facility:

- (i) Norplant insertion/removals? Yes No
If yes, yearly number? _____
- (ii) Surgery other than incision of superficial boils or suturing superficial fascia? Yes No
- (iii) Circumcisions, dilation and curettage, or insertion of temporary pacemaker? Yes No
- (iv) Tonsillectomies, adenoidectomies, or caesarean sections? Yes No
- (v) Cosmetic plastic surgery? Yes No
Describe: _____
- (vi) Excision of large cysts or I&D of deep-seated boils or carbuncles? Yes No
- (vii) Hysterectomies? Yes No
- (viii) Open reduction of fractures? Yes No
Describe: _____
- (ix) Surgery for weight reduction of patients? Yes No
- (x) Abortions or menstrual extractions? Yes No
Describe (include trimester, method, and number of abortions performed per month): _____
- (xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Yes No
Describe: _____
- (xii) Silicone implants? Yes No
Describe: _____
- (xiii) Sterilization procedures? Yes No
Describe: _____
- (xiv) Biopsies or endoscopies? Yes No
List types performed: _____
- (xv) Sex change operations? Yes No
Describe and advise number yearly: _____
- (xvi) Experimental surgery or surgical research? Yes No
Describe in detail on separate sheet.

(xvii) Other surgery? [] Yes [] No
Describe: _____

c. If any surgical procedure(s) are performed in the Facility answer (i) and (ii) below.

(i) List ALL surgical procedures performed (including minor surgery):

(ii) Is anesthesia (other than topical or local infiltration) administered at the Facility? [] Yes [] No

If yes, please attach a detailed explanation, including who administers the anesthesia, the training of such persons, and under what circumstances anesthesia is used.

d. Do the doctors and allied medical professionals using the Facility perform hospital emergency room care for patients who are not their own? [] Yes [] No

If yes, please attach an explanation and also advise the number "patient contact" hours at the Facility MONTHLY by :

(i) Emergency Room Physicians _____ hrs (iii) Nurses _____ hrs
(ii) Paramedics _____ hrs (iv) Other _____ hrs

e. Do the doctors and allied medical professionals using the Facility use drugs for weight reduction of patients? [] Yes [] No

If yes, attach list of drugs used and percentage of the Facility devoted to weight reduction, frequency and duration of prescriptions of weight reduction drugs, and average quantity dispensed per patient.

f. Do you administer any methadone treatment? [] Yes [] No

If yes, please attach a description of treatment and controls used and indicate number of treatments during: Last 12 months _____; next 12 months (anticipated) _____

g. Number of annual x-ray exposures: for diagnosis _____ for treatment _____

h. If x-ray treatment is given, what qualifications are required of the staff?

i. Do the doctors or allied medical professionals using the Facility participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? [] Yes [] No

If yes, please attach detailed explanation of this activity

j. Attach a detailed description of any additional activities or procedures which the doctors and allied medical professionals using the Facility perform there or on its behalf.

Part IV. STAFF

a. Please indicate the number of professional employees, volunteers, and independent contractors. IF NONE, STATE NONE.

	Employees and Volunteers	Independent Contractors		Employees and Volunteers	Independent Contractors
(i) Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	_____	_____	(xi) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons and Orthopedic Surgeons	_____	_____
(ii) Physicians: Minor surgery or obstetrical procedures not constituting major surgery	_____	_____	(xii) Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet)	_____	_____
(iii) Proctologists, Ophthalmologists and Urologists	_____	_____	(xiii) Unlicensed Interns	_____	_____
(iv) General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____	(xiv) Dentists (no oral surgery)	_____	_____
(v) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	_____	_____	(xv) Orthodontists	_____	_____
(vi) Oral Surgeons	_____	_____	(xvi) Podiatrists	_____	_____
(vii) Nurse Anesthetists	_____	_____	(xvii) Chiropractors	_____	_____
(viii) Perfusionists	_____	_____	(xviii) RN, LPNs	_____	_____
(ix) Pharmacists	_____	_____	(xix) Other	_____	_____
(x) Optometrists, Opticians	_____	_____			

NOTE: If any of the above practitioners seeks professional liability insurance, a separate application designed for the situation should be submitted.

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation?
 If no, please attach explanation. [] Yes [] No

c. Please attach certificates of liability insurance for each employee, independent contractor, and volunteer (the staff). If a staff member does not have insurance, state that.

c. PLEASE ATTACH A DETAILED EXPLANATION FOR ANY "YES" ANSWERS ON THE FOLLOWING:

(i) Has the Facility ever been the subject of disciplinary or investigatory proceedings by a governmental or an administrative agency, hospital, or professional association? [] Yes [] No

(ii) Has the Facility ever had any state license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, or accepted only on special terms or ever voluntarily surrendered same? [] Yes [] No

Part V. REVENUES

a. Please state sources and amounts of total revenue:

<u>Source</u>	<u>This Fiscal Year</u>	<u>Next Fiscal Year</u> (anticipated)
(i) Charitable Contributions	\$ _____	\$ _____
(ii) Government Funding	\$ _____	\$ _____
(iii) Fee for Service	\$ _____	\$ _____
(iv) Other _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

b. Please provide number of outpatient visits:

<u>Type of Visit</u>	<u>Last 12 Months</u>	<u>Next 12 Months</u> (anticipated)
Clinics	_____	_____
Laboratory	_____	_____
Emergency Room	_____	_____
TOTAL NO. OF VISITS	_____	_____

c. If you have a training program please complete the following, using a separate sheet if necessary.

Specify Profession for Which Students Are Being Trained	Max # of students per session	# of Sessions per year	% of time in a clinical setting	Faculty Number	Faculty Qualifications (e.g. MD, RN, PhD)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Part VI. AFFILIATIONS

- a. Is the Facility associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? [] Yes [] No
 If yes, please attach detailed explanation and a copy of ALL of the advertisements for the past five years.
- b. Is the Facility under contract to any individual or other entity? [] Yes [] No
 If this contract contains a hold-harmless agreement, a copy of the contract must be attached.
- c. Is the Facility in the employ of or under contract to any governmental entity? [] Yes [] No

Part VII. HISTORY/CLAIMS

- a. Has any claim or suit been brought against the Facility or any of its employees? [] Yes [] No
 If yes, a supplemental claim information form must be completed for each claim or suit.

- b. Is the management of the Facility aware of any circumstances which may result in a malpractice claim or suit being made or brought against it or any of its employees? [] Yes [] No
 If yes, please give details on separate sheet.

- c. Please list general liability insurance carried for each of the past three years. IF NONE, STATE NONE

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo/Day/Yr.	Expiration Mo/Day/Yr.	Claims Made		Retro Date
							Yes	No	
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is chosen in accordance with the terms of the policy.

WARRANTY: I/We understand and accept, on behalf of the Applicant, the notice stated above and warrant to Galen Insurance Company that the information contained herein is true and that it shall be the basis of the policy of insurance sought and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Galen Insurance Company.

 Name of Applicant

 Date

 Signature of Applicant's Duly Authorized Representative

 Title of Signer (Officer, partner, etc.)

SIGNING this application does not bind the Applicant or the Insurer to complete the insurance, but one copy of this application will be attached to the policy if one is issued.