LEXINGTON INSURANCE COMPANY

Administrative Office: 100 Summer Street

Boston, Massachusetts 02110

APPLICATION FOR HEALTHCARE FACILITY PROFESSIONAL & COMMERCIAL GENERAL LIABILITY INSURANCE

Instructions:

1. Please use Microsoft Word to type text directly onto the application. Answer **ALL** questions which are appropriate to your operation completely, leaving no blanks. If any questions, or part thereof, do not apply, state "N/A." If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number. When necessary, check all boxes that apply. This form must be completed, dated, and signed by a principal or an officer of the applicant.

2. Please include the following information with the completed application:
   - Previous insurance company loss runs for the past ten (10) years including current year**,** ground-up and unlimited, including all self insured, insured, and uninsured losses. Full details of allegations on all losses paid or outstanding in excess of $50,000.
   - Current audited financial statement.
   - Brochures, pamphlets or other advertising material utilized by your facility.
   - Copies of any inspection reports/surveys conducted by outside organizations within the past 3 years.
   - For Excess coverage (when a Chartis Company is not primary carrier) please provide copies of all underlying policies.
   - For Umbrella coverage please provide copies of Primary Declaration pages or COI for all applicable coverages (auto, Employers Liability, etc.). Copy of underlying automobile carrier's loss run for the past 5 years including the following information: carrier, date of loss, report date, total incurred, status (open or closed), and narrative of claim. Date of loss valuation must be within past ninety days.

2. If you exclusively perform any of the following, we have developed the following supplemental applications which should be completed as well and accompany this application.

- Ambulatory Surgery Center
- Allied Health School
- Blood bank
- Diagnostic Imaging Center
- Dialysis clinic
- EMS / Ambulance
- Hospice
- Medical Laboratory
- Medical Spa
- Mental Health and drug treatment facility
- Organ procurement and Tissue bank
- Pharmacy Benefit Managers (PBM)

I. GENERAL INFORMATION

Producer Name: ______________________________

Address: ______________________________
Street City State Zip

Telephone Number: ______________________________
(Area Code) Number

Applicant's Name: ______________________________

Business Address: ______________________________
Street City State Zip

Mailing Address: ______________________________

Website address (if available): ______________________________

Applicant key contact person: ________________ Telephone No: ________________

Nature of business: ____________________

State and date of incorporation: _________________ Date _______

Historical (past 5 years) annual gross revenues: *Gross Revenues* *Year*

	Gross Revenues	*Year*
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
Current year annual gross revenues:	_____	_____
Projected 12 months annual gross revenues:	_____	_____

Requested policy effective date: __________

Insurance Coverage Desired:

Primary	Effective Date	Occ. or Claims Made	Retro Date	Limits of Liability (Per Claim/Aggregate)*	Ded ☐ or SIR ☐
Professional Liab PL					
General Liab GL					
Employee Benefits					
Excess/Umbrella					
Underlying PL					
Underlying GL					
Auto Liab.					
Employers' Liab.					
Employee Benefits					
Other:					

**Professional Liability and General Liability Limits must be the same, but limits apply separately*.

Applicant is a:
- ☐ Corporation
- ☐ Partnership
- ☐ Partnership Association
- ☐ Sole Proprietorship
- ☐ Joint Venture
- ☐ Other (*Please Explain)* _____

Applicant operates: ☐ For Profit ☐ Not for Profit ☐ Governmental entity

Deductible (*applies separately to Professional Liability and General Liability*)
- ☐ None
- ☐ $5,000
- ☐ $10,000
- ☐ $25,000
- ☐ $50,000
- ☐ Other_____

Self-Insured Retention – SIR (if applicable please complete our SIR questionnaire)

List below all subsidiary, controlled entity or LLC that are desired to be added as additional named insured. For each facility/entity, provide date acquired, description of operations, ownership in percentages and retroactive date.

Subsidiaries	Date Acquired	Description of Operations	% Ownership	Retroactive date

II. PROFESSIONAL LIABILITY INFORMATION

1. Services Provided: Indicate all services provided by your facility, giving requested information for each classification. Information given should include projected numbers for the next 12 months. "Visits" are defined as the number of times each patient enters your facility for healthcare related services. "Beds" are defined as the average number of occupied beds. "Revenue" is the amount generated from sale of goods and services.

Facility	Current Year Annual Gross Revenues	Projected 12 Months Annual Gross Revenues
Drug Wholesaler		
Laboratory *		
Optical Establishments (Eye Care)		
Organ/Tissue Banks		
Pharmacy – retail		
Pharmacy – institutional/LTC		
Pharmacy Benefit Manager (PBM)*		
Weight Loss Centers		
X- Ray/Imaging/MRI *		
Other (*please describe*)		

Facility	Current Year # of Visits	Projected 12 Months # of Visits	Number of overnight Beds
Abortion Clinic			
Birthing Center			
College/University Health Center			
Community Health Center			
Emergicenter			
Hospice Care *			
Mental Health – Counseling *			
Mental Health – Crisis Management *			
Mental Health – Substance Abuse *			
Rehabilitation – Cardiac			
Rehabilitation – Physical/Occupational			
Rehabilitation – Trauma – Therapy			
Rehabilitation – Trauma – Transitional Living			
Rehabilitation – Trauma – Skilled Medical			
Retail Clinic			
Surgical Center - Single Specialty* Please specify:			
Surgical Center – Multi-Specialty*			
Urgent Care Center			
Other (*please describe*)			

* If major part of the operation, please complete an available exposure specific supplemental application.

PROFESSIONAL LIABILITY INFORMATION (Continued)

Facility	Current Year Outpatient Visits	Projected 12 Months Outpatient Visits
Cancer Research		
Correctional Health		
Home Care		
Kidney Dialysis *		
Medical Spa *		
Reproduction Facility (IVF)		
Other (*please describe*)		

Facility	Current Year number of donations	Projected 12 months - number of donations
Blood/Plasma Banks *		
Other (*please describe*)		

Facility	Current Year Annual Gross Revenue	Projected 12 Months Gross Revenue	Current Year Annual Payroll	Projected 12 Months Annual Payroll	Current Year Number of Runs	Projected 12 Months Number of Runs
EMT/Ambulance*						
Other (*please describe*)						

2. A proposed physician/surgeon would only be covered under the policy in his/her capacity as a medical director for activities relating to administration of the facility. If a more comprehensive physician/surgeon professional liability coverage is desired, please complete individual physician/ surgeon application.

Medical Director Name	Specialty	Current Insurance Carrier & Policy Number	Limits of liability	Effective date of the policy	Employee/ Contractor	Hours/Month

* If major part of the operation, please complete an available exposure specific supplemental application.

3. Other Health Care Professionals. Indicate the number in each category, full-time and part-time

	Employees Full Time – Part Time	Contractors Full Time – Part Time	Volunteers Full Time – Part Time
Dentists			
Emergency Medical Technicians			
Nurse Anesthetists			
Nurse Midwives			
Nurse Practitioners			
Occupational Therapists			
Oral Surgeons			
Pharmacists			
Physical Therapists			
Physician Assistants			
Psychologists			
RNs/LPNs/LVNs			
Social Workers			
Technicians			
Other (define)			

4. Are there any state licensing requirements for your facility? ☐ Yes ☐ No
5. If yes, has the state conducted an inspection of your facility? ☐ Yes ☐ No

6. Is the facility accredited by any of the following:

Joint Commission ☐ Yes ☐ No
AAAHC ☐ Yes ☐ No
AAAASF ☐ Yes ☐ No
CARF ☐ Yes ☐ No

If yes, please describe and include a copy of the accreditation report. ____________________
____

Have ever been denied accreditation by any of the above organizations? ☐ Yes ☐ No
If yes, please explain. ____
____

7. Do you have written requirements that the following providers carry Professional Liability Insurance? Please indicate the limits required.

	Yes	No	Limits
Physicians			
Surgeons			
Oral Surgeons			
Dentists			
Pharmacists			
Nurse Anesthetists			
Nurse Midwives			
Nurse Practitioners			
Physician Assistants			
Other (define)			

III. COMMERCIAL GENERAL LIABILITY INFORMATION

1. Please provide physical facility information as requested:

Address/Occupancy	Square Footage	Age	Type of Construction	# of Floors	Type of Fire Protection*

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

2. Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

3. Do you sell or lease any durable medical equipment or products to patients or others in connection with your operation? ☐ Yes ☐ No

   If yes, please complete the following information:

   Total Annual Sales: $ ____________________

   Total Annual Lease/Rental Receipts: $ ______________

   Please provide product brochures and a list of items and their total annual sales and leases.

   ____

   Have any of the products that you distribute ever been recalled? ☐ Yes ☐ No

4. Do you provide preventive maintenance or repairs on medical equipment leased to others? ☐ Yes ☐ No
   If yes, please provide details: _________

IV. EXCESS AUTOMOBILE LIABILITY INFORMATION

Vehicle Type	Service Radius (in miles per vehicle)	Number of Urban Use Vehicles	Number of Non Urban Use Vehicles	Used for Patient Transport?
Private Passenger Delivery				☐ Yes ☐ No
Private Passenger Service				☐ Yes ☐ No
Private Passenger Other				☐ Yes ☐ No
Emergency Ambulance				☐ Yes ☐ No
Non Emergency Van (< 8 passengers)				☐ Yes ☐ No
Non Emergency Van (8-15 passengers)				☐ Yes ☐ No
Light Truck Delivery				☐ Yes ☐ No
Light Truck Service				☐ Yes ☐ No
Light Truck Other				☐ Yes ☐ No
Medium Truck				☐ Yes ☐ No
Bus (15-30 passengers)				☐ Yes ☐ No
Bus (> 30 passengers)				☐ Yes ☐ No
Hired & non-Owned Autos				☐ Yes ☐ No
Other:				☐ Yes ☐ No

Do you have autos garaged in any of these states?

☐Florida ☐Georgia ☐Louisiana ☐New Hampshire ☐Vermont ☐West Virginia

V. EMPLOYER'S LIABILITY AND EMPLOYEE BENEFIT LIABILITY INFORMATION

1. Number of employees:
2. Are employee benefits self-administered? ☐ Yes ☐ No
   If not, are they administered by an outside vendor? ☐ Yes ☐ No
   If yes, what is the name of the vendor:

VI. OTHER EXPOSURES

Are there any current or past professional or general liability exposures that are not listed under sections II and III of this application? ☐ Yes ☐ No
If yes, please explain: _____

VII. RISK MANAGEMENT/LOSS CONTROL

1. Does your facility have a written Risk Management or a Patient Safety Program? ☐ Yes ☐ No

2. Do you have a system to document and report incidents, adverse events and complaints? ☐ Yes ☐ No

3. Who coordinates your Risk Management Program?

   Name: _____

   Title: _____

   Phone Number: _____

4. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility – check all that apply:

☐ Verification of educational background, or residency program, when applicable.

☐ Verification of previous employers

☐ Verification of personal references

☐ Verification on hospital privileges for physicians, oral surgeons and dentists

How often do you update your list of specific privileges? _____

☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.

☐ Require information on any professional liability or work-related claim that has previously been made against any individual.

☐ Criminal background checks

VIII. POLICY AND LOSS INFORMATION

1. Please provide past policy information as requested. (expand the table with additional rows as needed, or attach separate page)

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	Ded ☐ or SIR ☐	Premium
Professional Liab PL							
General Liab GL							
Employee Benefits							
Excess/Umbrella							
Underlying PL							
Underlying GL							
Auto Liab.							
Employers' Liab.							
Employee Benefits							
Other:							

If claims-made, indicate retroactive date.

2. Are you aware of any circumstance, accident or loss which has occurred after the retroactive date, which may result in a claim under this insurance coverage that has not been reported to your current or prior insurer? ☐ Yes ☐ No
If yes, provide complete details. _____

3. Have any claims ever been made against the applicant or any person proposed for this insurance?
☐ Yes ☐ No

If yes, please give dates, allegations and disposition of each claim or suit in the comments section below:
____

IX. FACILITY SPECIFIC INFORMATION

REHABILITATION FACILITIES

. Are patients referred to you by a physician? ☐ Yes ☐ No

If no, please describe referral procedures: _____

What is the length of the orientation and training period for new employees and volunteers? _____

Does it include training for the proper use of equipment and special training for high tech areas?
☐ Yes ☐ No

INPATIENT FACILITIES

1. Was the facility designed or built for this occupancy? ☐ Yes ☐ No

   If no, what was the original occupancy? _____

2. What is the construction? _____ Fire Protection Class? _____ Number of Stories? _____

3. How many exits per floor?

4. Are the electrical, heating and plumbing systems up to code and regularly inspected? ☐ Yes ☐ No

FIRE PROTECTION

1. Are there smoke detectors and fire extinguishers? ☐ Yes ☐ No

   Number and Location: _____

2. Is the building completely sprinklered? ☐ Yes ☐ No

   If partially sprinklered, identify those areas that are sprinklered: _____

3. Are there fire alarms? ☐ Yes ☐ No

   Number and type (local, central station, etc.): _____

4. Are there evacuation plans posted and drills held regularly? ☐ Yes ☐ No

5. Are there non-slip surfaces in bathing areas and handrails? ☐ Yes ☐ No

6. How are the beds licensed? (nursing home, ambulatory facility, etc.) _____

7. What is the minimum number of staff on duty at night? _____

8. What level of care is provided for the beds maintained?

   Is skilled nursing care provided including medication administration, injections, catherizations or other procedures ordered by physicians? ☐ Yes ☐ No

   Is assistance with daily living activities and some medication administration provided but no skilled nursing care? ☐ Yes ☐ No

   Are patients responsible for their own medication but some daily living activities planned, such as meals and social activities? ☐ Yes ☐ No

9. Do you provide residential care to children or adolescents? ☐ Yes ☐ No

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS:IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS:ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS:: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS:: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

APPLICANT

Name of Applicant:____

Title: ____

Signature: ____

Date: ____