ADMIRALPRO DELTA® MED

Miscellaneous Medical Application

Admiral's comprehensive coverage was developed exclusively for the unique needs of Healthcare Facilities and Medical Organizations. Our modular policy form allows us to tailor to your client's needs.

INTRODUCTION

The purpose of this application form is to gather information relevant to the party applying for coverage through Admiral Insurance. In order to be able to best evaluate the party applying for coverage, this form needs to be completed fully and accurately without the use of any misleading information.

Additionally, it is important that the Applicant disclose any factors that may be relevant to the consideration of the application for coverage, even if they are not directly requested on this application form. If the applying party and Admiral Insurance enter into a contract of insurance, this application form will serve as the foundation of that contract.

HOW TO COMPLETE THIS FORM

This form should be completed by a principal, partner or director of the applying party. The individual completing this form should make all necessary enquiries of their fellow partners, directors and employees to ensure that all application questions are answered fully and accurately.

Once this application form has been completed, it should be returned directly to the Applicant's insurance broker for review.

ADMIRAL INSURANCE GROUP
a Berkley Company

SECTION 1 GENERAL INFORMATION

1. Full Name of Applicant:

(Include all DBAs and subsidiaries seeking coverage under the policy for which you are applying)

2. Mailing & Location Address:

(If multiple locations please include an attachment with a complete list of locations)

Mailing Address:

Location(s):

3. Website Address(es): *(if applicable)*

4. Date Established: *(mm/dd/yy)*

5. Type of Entity:

☐ Corporation ☐ Partnership ☐ Professional Association ☐ Sole Proprietor

☐ Governmental Entity ☐ Other *(please describe):*

6. Description of Operations:

7. Is this entity owned by, associated with or controlled by any other entity or are you part of a franchise? ☐ Yes ☐ No

***If Yes**, please explain:*

8. Are any of your services provided in, or under contract to a facility or entity that you own, operate or are somehow affiliated with? ☐ Yes ☐ No

***If Yes**, please explain:*

9. Does the Applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? ☐ Yes ☐ No

***If Yes**, please provide complete details, including name of entity, your ownership interest or contractual relationship, and information on their insurance program(s):*

10. Within the next 12 month period, does the Applicant plan to:

a. Obtain another operation or entity?	☐ Yes	☐ No
b. Add to the number of employees?	☐ Yes	☐ No
c. Expand the number of locations?	☐ Yes	☐ No
d. Eliminate current services or add new services?	☐ Yes	☐ No
e. Operate in other states?	☐ Yes	☐ No

***If Yes** to any of the above questions, please explain:*

11. Organization Accreditations/Certifications/Licensures:

a. Accredited	
b. Certified	
c. Licensed	

d. Has the Applicant's accreditation, certification or license been suspended or revoked? ☐ Yes ☐ No

***If Yes**, please explain:*

SECTION 2 EXPOSURES [PROFESSIONAL ACTIVITIES & SPECIALTIES]

12. Describe in detail all of your professional services and indicate the percentage of gross receipts/ revenues derived from each activity:

Description of Professional Services	% of Revenue

13. Please complete all sections that apply:

	Revenue	# of Outpatient Visits	# Inpatient Beds	# of Non-Emergency Transports	# of Emergency Transports	# of Students
Next 12 Months						
Last 12 Months						
Two Years Ago						

14. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of the Applicant:

	Employee or Volunteer	Independant Contractors	Insured on Own Med Mal Policy	Current Carrier & Limits of Liability
Physicians (no surgery)			☐ Yes ☐ No	
Physicians (surgical)			☐ Yes ☐ No	
Physician Assistants			☐ Yes ☐ No	
Surgical Technicians			☐ Yes ☐ No	
Certified Nurse Anesthetists			☐ Yes ☐ No	
Nurse Practitioners			☐ Yes ☐ No	
Registered Nurses			☐ Yes ☐ No	
LPNs or Nurse Aides			☐ Yes ☐ No	

	Employee or Volunteer	Independant Contractors	Insured on Own Med Mal Policy	Current Carrier & Limits of Liability
X-Ray Technicians			☐ Yes ☐ No	
Medical Assistants			☐ Yes ☐ No	
Optometrists			☐ Yes ☐ No	
Opticians			☐ Yes ☐ No	
Pharmacists			☐ Yes ☐ No	
Pharmacy Technicians			☐ Yes ☐ No	
Chiropractors			☐ Yes ☐ No	
Massage Therapists			☐ Yes ☐ No	
Laboratory Technicians			☐ Yes ☐ No	
Paramedics			☐ Yes ☐ No	
EMTs			☐ Yes ☐ No	
Social Workers			☐ Yes ☐ No	
Aestheticians			☐ Yes ☐ No	
Other: _____			☐ Yes ☐ No	

15. Do you require all of your independent contractors to carry professional liability? ☐ Yes ☐ No

***If No**, please explain:*

16. Are all of the above noted employees and independent contractors licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

***If No**, please explain:*

17. Do you have a Medical Director? ☐ Yes ☐ No

***If Yes**, please provide the following details:*

a. What is the specialty of your Medical Director?

b. Does the Medical Director have direct patient care? ☐ Yes ☐ No

- ***If Yes***, does the Medical Director carry a medical malpractice policy? ☐ Yes ☐ No
- What limits of liability are carried and what is the name of the insurance carrier?

c. Does the Medical Director have supervisory duties over allied healthcare professionals? ☐ Yes ☐ No

- ***If Yes***, please explain:

d. Are you seeking coverage for the Medical Director's direct patient care under this policy? ☐ Yes ☐ No

- ***If yes***, please provide a physician's application.

18. Has the Applicant or any of the above employees and/or independent contractors:

a. Ever been the subject of a disciplinary or investigative proceeding or been reprimanded by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

b. Ever been convicted of a criminal act other than traffic offenses? ☐ Yes ☐ No

c. Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

d. Ever had any professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered such license? ☐ Yes ☐ No

***If Yes** to any of the above questions, please explain:*

19. Does the Applicant administer any of the following?

a. Methadone treatment? ☐ Yes ☐ No ***If Yes**, how many slots?*

b. Suboxone treatment? ☐ Yes ☐ No ***If Yes**, how many slots?*

c. Vivitrol treatment? ☐ Yes ☐ No ***If Yes**, how many slots?*

20. Does the Applicant administer detoxification treatment? ☐ Yes ☐ No

***If Yes**, how many patients annually?*

21. Do you offer rapid detoxification under anesthesia? ☐ Yes ☐ No

***If Yes**, how many patients annually?*

22. Is anesthesia (other than topical or by means of local infiltration) administered by, for or at the Applicant's facility? ☐ Yes ☐ No

***If Yes**, what percentage of procedures require general anesthesia?*

What procedures require general anesthesia?

Who administers the general anesthesia?

23. Does the Applicant sell any products? ☐ Yes ☐ No

***If Yes**, please answer the following questions and include product brochures.*

What kind of products?

Do any of these products require a physician's prescription? ☐ Yes ☐ No

Do you label any of these products in your own name? ☐ Yes ☐ No

24. Does the Applicant have a training school or provide internships? ☐ Yes ☐ No

***If Yes**, please answer the following questions:*

a. What profession or topic are the students being trained on?

b. How many students are trained per year?

c. Does their training include clinical training involving direct patient care? ☐ Yes ☐ No

***If Yes**, are you requesting coverage for students under this policy?* ☐ Yes ☐ No

d. What are the qualifications of the faculty providing the training?

25. Does the Applicant participate in any clinical trials? ☐ Yes ☐ No

***If Yes**, please explain:*

SECTION 3 RISK MANAGEMENT

26. Please Explain your Quality Assurance and Risk Management Program:

27. Are background checks performed on all employees, independent contractors and volunteers? ☐ Yes ☐ No

***If Yes**, what level or type of criminal background checks?*

☐ County ☐ State ☐ Federal ☐ Sexual Offender Registry

***If No**, please explain:*

28. Are all employees, independent contractors and volunteers screened for drugs and alcohol? ☐ Yes ☐ No

***If Yes**, how often are screens performed?*

29. How are patients referred to the Applicant?

30. Do you have a policy to prevent sexual abuse or allegations of sexual abuse? ☐ Yes ☐ No

***If Yes**, please explain and advise how often it is reviewed:*

SECTION 4 NETWORK SECURITY AND DATA PRIVACY PROCEDURES

31. Please describe security measures and procedures used to protect private data:

32. Do you have a formal documented security policy? ☐ Yes ☐ No

If Yes, are all employees required to read, receive and understand the security policy? ☐ Yes ☐ No

33. Do you have a full time Chief Information Officer responsible for security of private information? ☐ Yes ☐ No

34. Do you utilize encryption for data stored and data transmitted? ☐ Yes ☐ No

35. Are your computer systems and networks actively monitored for security breaches? ☐ Yes ☐ No

***If Yes**, by whom?*

36. Have you ever experienced a security breach, data loss event or denial of service attack? ☐ Yes ☐ No

***If Yes**, please explain:*

SECTION 5 ADDITIONAL COVERAGES INFORMATION

37. Do you publish or broadcast any material other than for your own advertising activities? ☐ Yes ☐ No

***If Yes**, please describe:*

38. Do you develop or sell software to third parties for a fee? ☐ Yes ☐ No

***If Yes**, please describe:*

39. Do you do medical billing services for others for a fee? ☐ Yes ☐ No

***If Yes**, do you have a separate professional liability policy for these services?* ☐ Yes ☐ No

Please explain:

40. Do you do your own medical billing? ☐ Yes ☐ No

***If No**, who does your medical billing?*

41. What percentage of your revenues are from services that are private pay?

42. Are you subject to HIPAA regulation? ☐ Yes ☐ No

43. Are you HIPAA compliant? ☐ Yes ☐ No

SECTION 6 COVERAGE HISTORY

44. Please provide the following information as respects the last five years of PROFESSIONAL LIABILITY coverage beginning with the most current coverage: *(If none, state NONE)*

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

45. Please provide the following information as respects the last five years of GENERAL LIABILITY coverage beginning with the most current coverage: *(If none, state NONE)*

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date *(if applicable)*

46. Are you interested in a quote for General Liability? ☐ Yes ☐ No

***If Yes**, please complete the GL Section of this application.*

SECTION 7 CLAIMS HISTORY

47. Has any application for professional liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, cancelled or have any policies been non-renewed?

☐ Yes ☐ No

***If Yes**, please provide details including name of carrier and date:*

48. Has any claim ever been made against the Applicant or any of its employees? ☐ Yes ☐ No

***If Yes**, please complete a Supplement Claim Information Form for each and every claim [**FORM LINK**].*

49. Is the Applicant aware of any errors, omissions, circumstances or incidents which may result in a claim being made against them or their employees, or are there any claims that have not yet been reported?

☐ Yes ☐ No

***If Yes**, please provide complete details:*

50. Have any of the Applicant's employee(s) or independent contractors been the subject(s) of alleged or actual incidents regarding sexual abuse or molestation or child abuse/neglect?

☐ Yes ☐ No

***If Yes**, please provide details on a separate attachment.*

GL SECTION

A. Complete the following for each of the Applicant's facilities:

Location	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Y/N)	Is There an Adjacent Exposure? (Y/N)

B. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction *(frame, brick, concrete)*				
% of Building Occupied by Applicant				
Other Occupants? *(Yes/No)*				

**Include square footage of parking facilities if owned or rented by the Applicant.*

C. Are all of the Applicant's locations equipped with:

1. Complete sprinker system?	☐ Yes	☐ No
2. At least two clearly marked exits on each floor?	☐ Yes	☐ No
3. Self-closing fire doors on each floor?	☐ Yes	☐ No
4. Automatic fire alarm system connected to a local fire department?	☐ Yes	☐ No
5. Smoke detectors?	☐ Yes	☐ No
6. Emergency electrical system?	☐ Yes	☐ No
7. Heat sensors?	☐ Yes	☐ No
8. Fire escape(s)?	☐ Yes	☐ No
9. Posted emergency evacuation procedures?	☐ Yes	☐ No
10. Properly maintained fire extinguishers?	☐ Yes	☐ No

*If any of the above questions are answered **No**, please provide details on an attachment.*

Please attach the following information if applicable:

- 5 years of currently valued carrier loss runs.
- A complete roster of physicians that are contracted with your facility.
- Copies of informed consent documents.

☐ The Applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the Applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application. The Applicant understands that any subsequent contract issued by the Company may be issued on a claims made form.

Electronic signature of Applicant or authorized representative:

Title:

Current Date:

If you prefer not to return application with an electronic signature, please print and sign below.

Signature of Applicant or authorized representative:

Title:

Current Date: