ALLIED HEALTH PROFESSIONAL LIABILITY *INSURANCE APPLICATION*

This is an application for claims-made insurance. It is important that you report any currently known facts, incidents, situations or circumstances that could result in a claim to your current insurer or purchase an extended reporting period endorsement to cover such known facts, incidents, situations or circumstances. Protective Specialty Insurance Company will not provide coverage for known facts, incidents, situations, circumstances or claims of which you are aware prior to the inception date of this coverage.

Instructions for completing this application:

1. Please answer all the questions. This information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.

2. If a question is not applicable, state "N/A". If more space is required to answer a question, please attach an exhibit with the question number.

3. The application must be signed and dated by a named insured or authorized person.

4. PLEASE ATTACH THE FOLLOWING:
   - Brochures or other descriptive literature about the applicant's services or operations.
   - Resume of principals or officers and key professional staff.
   - A copy of your letterhead.
   - Supplemental application(s) if applicable.

5. Return this and all supplemental applications to the insurer at:
   sales@rockwoodinsurance.com
   OR
   Rockwood Programs, Inc.
   4001 Miller Road
   Wilmington, DE 19802

Proposed Effective Date: From _____ to _____

GENERAL INFORMATION

1. Applicant, including all named insureds, DBAs, subsidiaries or professional degree (if an individual):

   _____

   _____

   _____

2. Address: _____

   City: _____ State: _____ ZIP: _____ County: _____

   Additional locations should be listed on a separate exhibit.

3. Phone: _____ Fax: _____

4. Website: _____ Email Address: _____

5. Applicant is a(n): ☐ Individual/solo practitioner ☐ Partnership ☐ Corporation ☐ Association

   ☐ Employee of (name of corporation): _____ ☐ Other: _____

6. Date your entity was established: _____

7. In what state(s) is the applicant/individual licensed/registered to practice? _____

8. During the past five years, has the name changed? ☐ Yes ☐ No

   Has any other business been purchased, merged or consolidated with this applicant? ☐ Yes ☐ No

   If yes to either question, please provide details: _____

   _____

9. Is the applicant controlled, owned, affiliated or associated with any other firm, corporation or entity? ☐ Yes ☐ No

   Are any services provided by the applicant to such business enterprises? ☐ Yes ☐ No

   If yes to either question, please provide details: _____

   _____

10. Total number of employees, including full-time, part-time, volunteers and independents: _____

EDUCATION/EXPERIENCE

This section to be completed by individuals or solo practitioners only.

Degree/Certification Attained	**Years of Training**	**Institution Name & Location**
_____	_____	_____
_____	_____	_____

11. Where have you practiced during the last 10 years?

    a. Location: _____ From _____ to _____

    b. Location: _____ From _____ to _____

    c. Location: _____ From _____ to _____

12. Have you ever failed any professional licensing examination? ☐ Yes ☐ No

13. Has your license ever been suspended, revoked, renewal refused or voluntarily surrendered? ☐ Yes ☐ No

14. Have you ever been investigated for or convicted of a felony? ☐ Yes ☐ No

15. Have you ever been the subject of any disciplinary action or investigative proceedings or reprimand by any government body, administrative agency or professional association within the last five years? ☐ Yes ☐ No

16. Have you ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

If yes to 12, 13, 14, 15 or 16, please provide a detailed explanation, including dates and location.

PROFESSIONAL SERVICES

17. Please describe all the services you provide: _____

    _____

    _____

    _____

18. Please state approximate percent of gross revenue derived from the following specialties. The total should equal 100%.

Adoption/foster care services	_____%	Medical student	_____%
Adult day care	_____%	Medical training: see “Schools” below	
Alcohol & drug abuse services	_____%	Mental health clinic/counseling	_____%
Ambulance (air)	_____%	Midwife/obstetric services	_____%
Ambulance (ground)	_____%	Nurse registry	_____%
Blood bank/blood services*	_____%	Nursing home/assisted living	_____%
Cancer treatment center	_____%	Organ/tissue services	_____%
Case management/utilization review	_____%	Orthotics/prosthetics	_____%
Chiropractic services	_____%	Pain management center	_____%
Clinical trials*	_____%	Pharmacy services	_____%
Cosmetic surgery	_____%	Plastic surgery	_____%
Counseling services	_____%	Psychiatric facilities	_____%
CRNA (group)	_____%	Psychologist	_____%
CRNA (individual)	_____%	Referral agency/services	_____%
Dental services	_____%	Rehabilitation center (inpatient)	_____%
Dialysis center/services	_____%	Schools	_____%
Durable medical equipment	_____%	Dental	_____%
Emergency call center/crisis hotline	_____%	Medical	_____%
EMT/paramedic	_____%	Nursing	_____%
Exams/physical assessments	_____%	Optometry	_____%
Eye care services	_____%	Other healthcare providers	_____%
Fertility services	_____%	Residential detox facility	_____%
Group homes	_____%	Residential healthcare facility	_____%
Healthcare center	_____%	Sleep apnea center/services	_____%
College/university	_____%	Social services	_____%
Community	_____%	Staffing services	_____%
Correctional/jail/prison	_____%	Surgical center	_____%
Home healthcare services/agency*	_____%	Teleradiology	_____%
Hospice services	_____%	Therapy services*	_____%
Hospital	_____%	Physical	_____%
Hyperbaric services	_____%	Occupational	_____%
Imaging services	_____%	Speech	_____%
Laboratory services	_____%	Veterinarian	_____%
Laser treatments	_____%	Visiting nurse association*	_____%
Lithotripsy	_____%	Wound care/hyperbaric services	_____%
Medical clinic/urgent care (outpatient)*	_____%	Other (specify): _____	_____%
Medical spa/anti-aging services*	_____%	Other (specify): _____	_____%

*Supplemental information may be needed

19. Please indicate sources of gross revenue.

Source	Revenues last year	Projected this year
Fees for services	$_____	$_____
Government funding	$_____	$_____
Charitable contributions	$_____	$_____
Other: _____	$_____	$_____
Total Gross Revenues	$_____	$_____

Estimate of total projected revenue for next year: $_____

20. Indicate the total number of all professional employees, including volunteers and independent contractors.

	Full-time/Part-time		Full-time/Part-time
Athletic trainer	_____/_____	Optometrist	_____/_____
Chiropractor	_____/_____	Orthotist	_____/_____
Clerical/administration	_____/_____	Perfusionist	_____/_____
Counselor	_____/_____	Pharmacist	_____/_____
CRNA	_____/_____	Phlebotomist	_____/_____
Dental hygienist	_____/_____	Physician assistant	_____/_____
EKG/EEG tech	_____/_____	Physicians, surgeons, dentists	_____/_____
Home health aides	_____/_____	Physiotherapist	_____/_____
Imaging technician	_____/_____	Psychologist/psychotherapist	_____/_____
Lab tech	_____/_____	Social workers	_____/_____
Medical assistant	_____/_____	Therapist: Occupational	_____/_____
Medical tech	_____/_____	Therapist: Physical	_____/_____
Naprapath	_____/_____	Therapist: Inhalation	_____/_____
Nurses aides	_____/_____	Therapist: Radiation	_____/_____
Nurses, LPN	_____/_____	Therapist: Rehab	_____/_____
Nurses, RN	_____/_____	Therapist: Speech	_____/_____
Nurse practitioner	_____/_____	Therapist: Sports Medicine	_____/_____
Optician	_____/_____	Other: _____	_____/_____

a. Are all individuals listed above licensed in accordance with all applicable local, state and federal regulations?

☐ Yes ☐ No If no, please explain: _____

b. Do you require any above individuals to maintain their own professional liability coverage?

☐ Yes ☐ No If yes, please explain: _____

c. Do all individuals listed above maintain professional liability coverage equal to or greater than the applicant?

☐ Yes ☐ No If no, please explain: _____

21. Please provide the annual number of patient encounters.

Type of visit	Last year	Projected this year
Clinic (# of visits)	_____	_____
Laboratory (# of procedures)	_____	_____
Other (specify)	_____	_____

22. Is the applicant a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No

If yes:

a. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No

If no, please explain: _____

b. Please provide the name and title of the applicant's Privacy Officer: _____

_____

23. Please list any professional associations or societies of which you are a member: _____

_____

24. Are you associated with or do you work for a physician or surgeon? (Individuals/solo practitioners only)

☐ Yes ☐ No If yes, please provide the name and specialty of the physician: _____

_____

PROCEDURES

If yes to any of the below, please attach an exhibit.

25. Do you perform any:

a.	Surgery, other than incision of superficial boils or suturing of superficial fascia?	☐ Yes	☐ No
b.	Circumcision, dilation and curettage, or insertion of temporary pacemakers?	☐ Yes	☐ No
c.	Radiation or chemo therapy?	☐ Yes	☐ No
d.	Psychiatric shock therapy?	☐ Yes	☐ No
e.	Invasive medical procedures or surgery?	☐ Yes	☐ No
f.	Plastic surgery?	☐ Yes	☐ No
g.	Open reduction of fractures?	☐ Yes	☐ No
h.	Surgery for weight loss?	☐ Yes	☐ No
i.	Abortions, sterilization procedures or sex change operations?	☐ Yes	☐ No
j.	Silicone implants?	☐ Yes	☐ No
k.	Endoscopies?	☐ Yes	☐ No
l.	Hospital room emergency care?	☐ Yes	☐ No

m. Methadone treatment? ☐ Yes ☐ No

n. Anesthesia other than topical? ☐ Yes ☐ No

o. Injection of radioisotopes or use of any irradiated substances? ☐ Yes ☐ No

26. Do you:

a. Maintain any beds for overnight occupancy? ☐ Yes ☐ No

b. Own, operate or administer a hospital or nursing home? ☐ Yes ☐ No

c. Own or operate any business other than shown in this application? ☐ Yes ☐ No

d. Advertise your professional services in any manner other than a telephone directory? ☐ Yes ☐ No

e. Compound in bulk, manufacture or wholesale medicines, including pharmaceuticals? ☐ Yes ☐ No

27. Are you under contract to any individual other than the named insured? ☐ Yes ☐ No

If your contract contains a hold harmless agreement, please attach a copy of the contract.

28. Are you:

a. Employed by any individual or entity other than that shown in this application? ☐ Yes ☐ No

b. Under contract to any individual or entity other than that shown in this application? ☐ Yes ☐ No

c. Employed by or under contract to any governmental entity? ☐ Yes ☐ No

d. Associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? ☐ Yes ☐ No

29. If the applicant has a training school, complete the following:

a. Professions for which students are being trained: _____

b. Maximum number of students per session: _____

c. Number of sessions per year: _____

d. Percent of time in clinical setting: _____

e. Qualifications of faculty (MD, RN, PhD): _____

PRIOR INSURANCE INFORMATION

☐ Check here if no prior insurance.

PROFESSIONAL LIABILITY

30. List the professional liability insurance carried for each of the past five (5) years, including periods of no coverage.

Insurance Carrier	Policy Period	Limit of Liability per Claim/Aggregate	Coverage Type	Deductible (if any)	Policy Premium
	From: To:		☐ Claims-made ☐ Occurrence		
	From: To:		☐ Claims-made ☐ Occurrence		

Question 30 continued

Insurance Carrier	Policy Period	Limit of Liability per Claim/Aggregate	Coverage Type	Deductible (if any)	Policy Premium
	From: To:		☐ Claims-made ☐ Occurrence		
	From: To:		☐ Claims-made ☐ Occurrence		

31. Does your current policy contain a prior acts limitation or a retroactive date? ☐ Yes ☐ No

    If yes, indicate the date: _____

    Please attach a copy of your current policy's prior acts endorsement and/or declarations retroactive date.

32. Has any application for similar insurance made on behalf of the applicant or any of its predecessors in business been declined or has any such insurance ever been rescinded, canceled or has renewal been refused?

    ☐ Yes ☐ No If yes, please provide details: _____

    _____

GENERAL LIABILITY

Please indicate the expiring information, if coverage is requested.

33. Current carrier: _____

34. Policy period: From _____ to _____

35. Limit per occurrence/claim: _____ Products/completed ops aggregate: _____

36. General aggregate: _____ Deductible: _____

37. ☐ Claims-made ☐ Occurrence If claims-made, please indicate the retroactive date: _____

38. Please provide a schedule of locations including square footage.

39. Please provide a fully completed ISO general liability application, if coverage is requested.

CLAIM ACTIVITY

IMPORTANT NOTICE: All KNOWN FACTS, INCIDENTS, CIRCUMSTANCES OR SITUATIONS that could result in a professional liability claim are specifically excluded from this coverage. Report all such KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATIONS OR CLAIMS to your current insurer. If any KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATION OR CLAIMS omission exists that could result in a professional liability claim, then such claim and/or any claim arising from such KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATIONS OR CLAIMS is excluded from coverage that may be provided under this proposed insurance. Further, failure to disclose such KNOWN FACTS, INCIDENTS, CIRCUMSTANCES, SITUATIONS OR CLAIM may result in the proposed insurance being void or subject to rescission.

40. Has any proposed named insured ever been investigated or convicted of a felony? ☐ Yes ☐ No

    If yes, please provide complete details on a separate sheet, including the present status of any individuals.

41. Has the applicant or any employee, principal, partner, officer or directory, past or present, ever been the subject of any disciplinary action or investigative proceedings or reprimand by any government body, administrative agency, or professional association within the last five years? ☐ Yes ☐ No

    If yes, please provide complete details on a separate sheet, including the present status.

42. Has any claim or suit been made against the applicant or its predecessor or any current or former member, principal, partner, officer, directory or employee? ☐ Yes ☐ No

If yes, please provide claim details and a currently valued loss run for a minimum of five years. Please describe procedures or training the applicant uses to avoid similar situations in the future: _____

_____

_____

43. Does the applicant know of any fact, incident, circumstance or situation that could result in a professional liability claim or suit against any current or former member, principal, partner, officer, director or employee or its predecessor entity(ies)? ☐ Yes ☐ No

If yes, has this been reported to your current carrier? ☐ Yes ☐ No

44. Has any local, state or federal professional license or license to prescribe or dispense narcotics been refused, suspended, revoked, renewal refused or accepted on special terms or ever voluntarily surrendered?

☐ Yes ☐ No If yes, please provide details on a separate sheet.

COVERAGE REQUESTED

45. Please indicate the limit of liability desired.

Per Claim/Annual Aggregate: ☐ $500,000/$1,000,000 ☐ $1,000,000/$3,000,000
☐ $2,000,000/$4,000,000 ☐ Other: _____

46. Please indicate the deductible desired. In selecting the deductible, please remember that claim expenses, including legal fees and costs of defense, are chargeable to the deductible.

Per Claim Deductible: ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ Other: $_____

Please provide additional comments that would further clarify the information above or address characteristics of your practice not specifically addressed herein.

_____

_____

_____

_____

_____

SIGNATURE

By signing this application, you represent and agree to each of the following four (4) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your company is aware of any actual or alleged fact, circumstance, situation, incident, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in the Claim Activity section of this application; and

2. Each of the statements and answers given in this application, and any supplemental applications, are:
    a. Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
    b. Representations you are making on behalf of all persons and entities proposed to be insured;
    c. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
3. This application, along with any supplemental applications, are hereby deemed to be attached to the policy and incorporated into the policy, whether or not any of the supplemental applications are physically attached to a particular copy of the policy, and regardless of whether any of the supplemental applications are signed or dated.
4. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this application, or in any supplemental application, that may occur or be discovered after the completion date of said application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

FRAUD WARNING: Any person who knowingly and with the 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 purposes of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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 AGENCIES.

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

NOTICE TO MARYLAND AND LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY 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, 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 MAY INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

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 ARKANSAS AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE 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 CIVIL FINES AND PENALTIES.

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.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage. Please see IMPORTANT NOTICE in the Claim Activity section above.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

An authorized representative who is an active owner, officer or partner of your firm must sign this application within thirty (30) days prior to the policy inception date.

If additional space is needed, please provide details on a separate attachment.

I understand the information submitted herein becomes a part of my professional liability insurance application and is subject to the same warranties and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

_____

Signature of Owner, Officer or Partner Date

_____

Printed or Typed Name and Title