

Healthcare Facility Application Non-Hospital—Renewal



PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Expiring Policy No. _____

1. Introductory Information

Policyholder Name: _____

Address: _____

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

Telephone Number: _____ Fax Number: _____

Hospital Fiscal Year Begins: _____

Contact Name: _____ Contact Email: _____

Website Address: _____

Instructions:

1. Please review and complete this renewal application.
2. When necessary, check all boxes that apply.
3. If you need more space for your responses, continue on a separate sheet indicating question number.

2. General Information

A. Has there been a change in facility ownership or management? Yes No

If *yes*, please explain: _____

B. Provide details of any new start-up services or any services discontinued during the past fiscal year.

C. Has the facility's license been revoked, suspended or restricted during the past fiscal year? Yes No

If *yes*, please provide details: _____

D. Has any accreditation program revoked, suspended or restricted the facility's accreditation status? Yes No

If *yes*, please provide details: _____

E. Please provide a copy of the facility's latest fiscal year-end audited financial statement.

F. Please provide an updated schedule of locations and insured entities.

3. General Exposure Data

A. Are any procedures performed on persons rendered unconscious through anesthesia? Yes No

If *yes*, give detailed description of how anesthesia is provided, including minimum patient age and number of overnight beds on premises or affiliated.

B. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. Yes No

C. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. Yes No

For requested visit classifications, complete number of annual visits and *not* number of procedures. For example, if someone came in and had more than one type lab work done, or maybe lab work and then x-ray, that would be just one visit and *not* the total number of procedures. For requested procedure classifications, provide the actual number of annual procedures.

Description	Number	Description	Number
Abortion Clinic	_____ Occupied Beds _____ Annual Visits	Medical Lab	_____ Annual Receipts
*Bariatric Surgery	_____ Ann. Procedures	Mental Health Counseling	_____ Occupied Beds _____ Annual Visits
Birthing Center	_____ Occupied Beds _____ Annual Visits	Municipal Health Department	_____ Annual Visits
Blood or Plasma Bank	_____ Ann. Donations	Ocular Lab	_____ Annual Receipts
Cardiac Rehabilitation	_____ Occupied Beds _____ Annual Visits	Oncology Cancer Center	_____ Occupied Beds - Radiation _____ Ann. Procedures - Chemotherapy _____ Ann. Procedures
College/University Health Center	_____ Occupied Beds _____ Annual Visits	Optical Establishment	_____ Annual Receipts
Community Health Center	_____ Occupied Beds _____ Annual Visits	Organ Bank-Direct Processing	_____ Annual Receipts
Crises Stabilization Center	_____ Occupied Beds _____ Annual Visits	Organ Bank-No Direct Processing	_____ Annual Receipts
Dental Lab	_____ Annual Receipts	Pathology Lab	_____ Annual Receipts
Developmental Disability Rehab.	_____ Occupied Beds _____ Annual Visits	Pharmacy	_____ Annual Receipts
Developmental Health Counseling	_____ Annual Visits	Physical/Occup./Speech Rehab.	_____ Occupied Beds _____ Annual Visits
Dialysis Center	_____ Annual Visits	Quality Control/Reference Lab	_____ Annual Receipts
Emergicenter	_____ Occupied Beds _____ Annual Visits	Substance Abuse-Counseling	_____ Occupied Beds _____ Annual Visits
Fitness Center/Health Club	_____ Annual Members _____ Ann. Gross Sales	Substance Abuse-Skilled Medical	_____ Occupied Beds _____ Annual Visits
Home Care-Durable Equipment	_____ Annual Receipts	*Surgery Center	_____ Occupied Beds _____ Ann. Procedures
Home Care-Intravenous Therapy	_____ Annual Visits	Trauma Rehab.-Skilled Medical	_____ Occupied Beds _____ Annual Visits
Home Care-Personal Care	_____ Annual Visits	Trauma Rehab.-Therapy	_____ Occupied Beds _____ Annual Visits
Home Care-Rehabilitation	_____ Annual Visits	Trauma Rehab.-Transitional Living	_____ Occupied Beds _____ Annual Visits
Home Care-Respiratory Therapy	_____ Annual Visits	Urgent Care	_____ Occupied Beds _____ Annual Visits
Home Care-Skilled Care	_____ Annual Visits	Weight Loss Center	_____ Occupied Beds _____ Annual Visits
Hospice Care	_____ Occupied Beds _____ Annual Visits	X-ray/Imaging Center	_____ Annual Receipts
Medical/Hosp./Surg. Equip. Rental	_____ Ann. Gross Sales		
Medical/Hosp./Surg. Equip. Sales	_____ Ann. Gross Sales		

*Separate Application Required if new operation – Refer to Company

4. Personnel

A. Physicians providing health care services at this entity:

Name	Specialty	Board Certified	Limits	C=Contracted E=Employed O=Owner	Current Insurance Carrier

Please attach additional sheets if necessary.

Do you require certification of Professional Liability Coverage?

Yes No

If *yes*, how much? _____

B. Non-Physician Personnel

No. Employed

No. Contracted

	No. Employed	No. Contracted
Anesthesiology Assistant		
Audiologists		
*Chiropractors		
*Dentists		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
#Nurse Anesthetists - Are they supervised by an anesthesiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Nurse Midwives		
#Nurse Practitioners/Clinical Nurse Specialists		
Occupational/Physical Therapists		
Opticians		
#Optometrists		
*Oral Surgeons		
Paramedics or EMT's		
*Perfusionists		
Pharmacists		
Pharmacy Technicians		
#Physician Assistants		
Physiotherapists		
*Podiatrists		
#Psychologists/Psychotherapists		
RNs		
Social Workers		
Speech Therapists		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe)		

*Separate Application Required – Refer to Company

#Separate Application Required for New Personnel if not Previously Submitted

5. Premises and Operations

- A. Are there any construction plans for the next twelve months? Yes No
 If *yes*, please provide cost of project: _____
- B. Total square footage of parking lots or decks: _____
- C. Total number of swimming pools: _____
- D. Total number of lakes: _____
- E. Total number of fountains: _____
- F. Does the facility have a day care center? Child: Yes No Adult: Yes No
 Is it open to the public? Child: Yes No Adult: Yes No
 Number enrolled in the past 12 months: Child: _____ Adult: _____
- G. Does the facility have a fitness center/health club? Yes No
 Number of members enrolled in the past 12 months: _____
 Annual Gross Sales: _____
- H. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. Yes No
- I. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. Yes No

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____
 Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):	
Agent: _____	Phone: _____
Agency: _____	Fax: _____
Address: _____	Email: _____
_____	License No.: _____
Signature: _____	

**Insured Entities and D/B/A'S
Schedule A**

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Please attach additional sheets if necessary.