GenStar

RENEWAL APPLICATION

PROFESSIONAL LIABILITY
MISCELLANEOUS HEALTHCARE FACILITIES

NOTE - Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

YOUR COVERAGE CANNOT BE RENEWED WITHOUT THIS APPLICATION COMPLETED IN ITS ENTIRETY.

INSTRUCTIONS TO THE APPLICANT:

- Please answer all questions on this application and on applicable supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
- To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The application must be signed and dated by an owner, partner, officer or director of your facility.
- Please attach the following to your completed application:
  - Brochures, pamphlets, advertisements or other descriptive literature of operations and services,
  - Copies of any surveys conducted by outside organizations within the past three years,
  - Copy of the current practice license(s),
  - Current audited financial statement.

I. GENERAL INFORMATION

1	Applicant/Entity Name:		Current General Star Policy No.:
2	Mailing Address:		
	City:		County:
	State:		ZIP:
3	Business Address:		
	City:		County:
	State:		ZIP:
4	Telephone:		Web Site:
5	Applicant Is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other (describe):		
	Applicant Type: ☐ For Profit ☐ Not for Profit		
6	Within the last twelve(12) months, has there been any change in any of the following:		
	a	Description of Operation?	☐ Yes ☐ No
	b	Services provided to other organizations (hospitals, nursing homes, etc.)?	☐ Yes ☐ No
	c	Ownership of any subsidiaries (including acquisition, discontinuation or selling of?	☐ Yes ☐ No
	d	Operation of any subsidiaries?	☐ Yes ☐ No
	e	Locations changed, added, or deleted?	☐ Yes ☐ No
	f	Changes to the current locations' operations?	☐ Yes ☐ No
	If **YES** to any of the above, please describe separately:		
7	Within the next 12 months, does the applicant plan to: (check all that apply and provide details)		
	☐ Purchase or acquire another operation or entity?	☐ Expand the number of locations?	
	☐ Add any services?	☐ Expand operation into other states?	
	Provide details:		

II. OPERATIONS

		Projected	Current Year
1	Provide applicant's total **gross** annual revenues:	$	$
2	If your operation is an outpatient facility, please provide the number of outpatient visits:	#	#
3	During the last twelve (12) months, has the applicant's status changed regarding its:		
	a	Accreditation?	☐ Yes ☐ No
	b	Membership in professional organization or association?	☐ Yes ☐ No
	c	State license?	☐ Yes ☐ No
	d	Medicare reimbursement?	☐ Yes ☐ No
	If **YES** to any of the above, please explain:		
4	During the last twelve (12) months, have any contractual arrangements changed:		

	a	With independent contractors?	☐ Yes ☐ No
	b	Regarding services by the applicant to others?	☐ Yes ☐ No
	If **YES** to any of the above, please explain:		
5	Does applicant provide any overnight bed facilities? If **YES**, advise number of beds:		☐ Yes ☐ No
6	During the last twelve (12) months, have your protocols or transfer agreements to transfer patients in the event of a life-threatening emergency changed? If so, please provide a copy of those documents and advise:		☐ Yes ☐ No
	Name of the facility:		
	Number of miles to the facility: Miles		
	Driving time to facility: Minutes		
7	During the last twelve (12) months, have you added or deleted any medical director providing services at the applicant's facility: If so, complete the information below.		☐ Yes ☐ No

Medical Director's Name	Specialty	Insurance Carrier & Policy Number	Limits	Employee/ Contractor	Hours per Month

Please note: Coverage for Medical Director is limited to administrative duties as described in the policy form.

8 Identify the number of other employed health care professionals providing services at the applicant's facility:

Type of Professional	# Full Time Employees	# Part Time Employees	# Full Time Contractors	# Part Time Contractors	Contractors Annual Hours
EMT					
Nurse					
Nurse Aid					
Nurse Practitioner					
Occupational Therapist					
Paramedic					
Pharmacist					
Phlebotomist					
Physical Therapist					
Physician Assistant					
Radiation Technician					
Respiratory Therapist					
Social Worker					
Speech Therapist					

III. RISK MANAGEMENT/LOSS CONTROL

1	During the last twelve (12) months, has there been any change in:		
	a	Formal written Risk Management Program?	☐ Yes ☐ No
	b	Who has the overall responsibility for Risk Management & Loss Control?	☐ Yes ☐ No
	c	Who is to be contacted for loss control survey?	☐ Yes ☐ No
	If **YES** to any of the above, please provide details:		
2	During the last twelve (12) months, has there been any change in:		
	a	Hiring/screening procedures are used for employees and contractors?	☐ Yes ☐ No
	b	The policies/procedures for employee training?	☐ Yes ☐ No
	c	The policies/procedures for incident reporting?	☐ Yes ☐ No
	d	The policies/procedures for medical equipment training?	☐ Yes ☐ No
	e	The policies/procedures for infection control?	☐ Yes ☐ No
	f	Written job descriptions for all professionals?	☐ Yes ☐ No
	g	Written job descriptions for all clinical support staff?	☐ Yes ☐ No
	If **YES** to any of the above, please describe changes:		

IV. BUILDING INFORMATION

1	During the last twelve (12) months, has there been any change to your building or location? Be sure to consider any changes to life safety measures including sprinklers, safety exits, etc. If **YES**, please describe:	☐ Yes ☐ No

V. PRIOR POLICY and LOSS INFORMATION UPDATES

1	During the last twelve (12) months, have any fee or professional relations complaints been alleged against you with your professional association(s) or any State licensing authority		☐ Yes ☐ No
2	During the last twelve (12) months, have any claims been made against you, suit papers served upon you, or any other demands for money resulting from a medical incident? If **YES**, answer questions below.		☐ Yes ☐ No
	a	Have these been reported to and acknowledged by **General Star**?	☐ Yes ☐ No
	b	Have these been reported to any other current or prior insurance carrier?	☐ Yes ☐ No

3	Does the applicant have knowledge of facts or circumstances that relate to a medical incident(s) that might reasonably result in a claim, that have **not** been reported to **General Star** or a prior insurance carrier? If **Yes**, a **Claim Information Supplemental Application** must be completed for each incident referenced. ► **When facts or circumstances that relate to a medical incident(s) that might reasonably result in a claim are disclosed in response to this question and any accompanying Claim Information Supplemental Application, there will not be coverage for any claims made against you arising from those facts or circumstances under any General Star policy that becomes effective on or after the date of the disclosure.** ► **The disclosure of facts or circumstances that relate to medical incident(s) that might reasonably result in a claim in response to this question or in any accompanying Claim Information Supplemental Application DOES NOT constitute notice to General Star for claim reporting purposes under your current General Star policy.** ► **In order to report a claim, the reporting requirements in your current General Star policy must be followed. Please review your current policy for claim or potential claim reporting requirements.**	☐ Yes ☐ No
4	During the last twelve (12) months, has any prior claim(s) been adjudicated, settled, closed, dismissed or otherwise changed in status? If **YES**, please provide details as to claimant, final disposition, amounts, etc.	☐ Yes ☐ No

VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.
By signing this Application, you represent and agree to each of the following five (5) items:

1	You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, 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 this Application; and	
2	This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):	
	☐ Ambulance Service Supplemental Application	☐ Durable Medical Equipment Supplemental Application
	☐ Out-Patient / Ambulatory Surgery Center Supplemental Application	☐ Home Health Care and Hospice Care Supplemental Application
	☐ Blood / Donor Banks Supplemental Application	☐ Laboratory & Imaging Supplemental Application
	☐ Birthing Center Supplemental Application	☐ Other (specify):
	☐ Claim Information Supplemental Application	
3	Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, 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.
4	This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.	
5	You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or 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

Notice to Applicants of all states except New Jersey, New York, Pennsylvania, and Washington D.C.:

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 material 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 the person to criminal and civil penalties 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 New York Applicants:

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 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 provision.

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 a 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 Washington D.C. 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.

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.

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.

General Star Indemnity Company is a "non-admitted" or "surplus lines" insurer in all states except Connecticut (where General Star National Insurance Company is "non-admitted or "surplus lines"), and is not subject to the financial solvency regulation and enforcement which applies to licensed companies. The insurance company does not participate in any state insurance guarantee fund; therefore, these funds will not pay your claims or protect your assets if the insurance company becomes insolvent and is unable to make payments as promised. Your agent or broker can verify with the State Insurance Commissioner that General Star Indemnity Company is an approved

surplus lines insurer in the state.

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

Signature of Owner, Officer or Partner:	Date:
Print or Type Name and Title:	

ADDITIONAL INFORMATION

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

Section # and Question #	**Comments**

Signature:	Date: