

- 1.15 Total Premises Square Footage Occupied by Applicant: _____
- 1.16 List applicant entity's memberships in professional organizations: _____

- 1.15 Is the applicant eligible for certification or accreditation? Yes No
 If yes, is applicant certified and/or accredited? Yes No
 If no, explain the reason. _____

PART II. EXPOSURES

- 2.1 Service is licensed as _____
- 2.2 Describe the nature of insured's operation including types of services rendered and activities conducted: _____

2.3 What was your total number of patient/client visits last year? _____ Estimated next year? _____

- 2.4 Breakdown of patient services:
- | | | |
|------------------------------|-----------------------------|----------------------------|
| ___% AIDS | ___% Alcoholic | ___% Bariatric |
| ___% Communicable | ___% Dental | ___% Disability |
| ___% Drug Addiction | ___% Emergency Medical | ___% Family Planning |
| ___% General Exams | ___% Gynecological | ___% Hemodialysis |
| ___% Holistic Medicine | ___% Major Surgery | ___% Minor Surgery |
| ___% Nutritional (Diet) | ___% Obstetric | ___% Occupational Medical |
| ___% Optometry/Ophthalmology | ___% Orthopedic | ___% Pediatric |
| ___% Psychiatric | ___% Rehabilitative Therapy | ___% Research/Experimental |
| ___% Stress Testing | ___% Substance Abuse | ___% Other(describe) _____ |

- 2.5 Are any of the following performed?
- | | |
|--|--|
| Administer anesthesia (general or local)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Catheterization | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diagnostic tests | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| X-Rays | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Radiation Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Reduction of Fracture | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Shock Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Prescribe medication | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Obstetric procedures | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For all "yes" answers, give detailed description on separate page or back of application.

- 2.6 Total number of all staff _____
- Total payroll or remuneration paid last year (E&C): \$ _____ Estimated payroll or remuneration next year (E&C): \$ _____
- If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors by professional category. _____

- 2.14 Do you provide any of the following services:
- A) Blood Bank/Plasma Centers ___ Yes ___ No
 - B) Cemeteries/Funeral Homes/Morticians ___ Yes ___ No
 - C) Medical Arts Schools and Colleges ___ Yes ___ No
 - D) Pharmacies ___ Yes ___ No
 - E) Nursing Homes ___ Yes ___ No

IF YES, complete the appropriate supplement application.

PART III. RISK MANAGEMENT

3.1 Name, qualifications and number or years of experience of the Medical Director:

Name	Title	Experience/Training	Association Membership
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3.2 Does your Agency have a written credentializing policy and procedure for all individual's associated with or practicing within the Applicant? ___ Yes ___ No

3.3 Do you conduct pre-employment screening and investigation? ___ Yes ___ No

3.4 Do you prepare job descriptions and instructional manuals for your staff? ___ Yes ___ No
If so, enclose a copy of each.

3.5 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ___ Yes ___ No

3.6 Are patients' accepted for health care services only upon a written plan of treatment established by an attending physician? ___ Yes ___ No

Explain any exceptions:

3.7 Are you equipped with an emergency 24 hour telephone call line for all of staff and patients? ___ Yes ___ No

3.8 Do you enter into any contractual agreements (other than lease of premises agreements)? ___ Yes ___ No
If yes, attach explanation.

3.9 Does the applicant advertise its services other than an ordinary local telephone directory listing? ___ Yes ___ No
If yes, please attach a copy of each advertisement.

3.10 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? ___ Yes ___ No
If not, are you agreeable to instituting this procedure? ___ Yes ___ No

3.11 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws?
If no, attach explanation of any exception.

- 3.12 Has the applicant or any of its employees:
- a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ___ Yes ___ No
 - b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ___ Yes ___ No
 - c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ___ Yes ___ No

IF THE ANSWER TO ANY OF 3.12 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

3.13 Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home healthcare operations.
 _____None _____Description Attached

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made	
						Yes	No
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?
 ___ Yes ___ No If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary). _____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?
 ___ Yes ___ No If yes, describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or

private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant/Title