HALLMARK HEALTHCARE FACILITIES PROGRAM
NEW BUSINESS APPLICATION

SECTION A. – PRODUCER CONTACT INFORMATION
To be Completed by Agent/Broker

Wholesale Broker Company:	
Office City:	
State:	

Broker Name/Contact:	
Phone Number:	
E-mail address:	

Instructions to Applicant:

A. Type or print clearly, answer **all** questions completely. This information is required to make an accurate underwriting evaluation before a quote can be released. The responses & statements made herein are material to that evaluation.
B. Leave no blanks. If a question is not applicable, state 'n/a' on that item. Where more space is required to fully answer a question, include additional information on company letterhead, indicate question #, and sign & date.
C. This application, and any required Supplement(s) must be signed and dated by an authorized representative of the applicant facility.
D. All information supplied in this application, and any supplemental information provided, shall be used for underwriting analysis purposes and such information does not constitute notice to the Company of a claim or potential claim, if a Policy is ever issued.
E. The following Supporting Information is also required:
   (1) Brochures, pamphlets or similar literature which provides a description or advertisement of your facility, operations and/or services provided;
   (2) Copies of any surveys conducted by any accreditation body or similar private or Governmental organization within the past 3 years,
   (3) Copy of the current, in-force State and/or local License evidencing facility licensing compliance;
   (4) Detailed, currently valued, Company identified loss runs, evidencing at least the immediately past 5 years;
   (5) Current income statement and balance sheet, or Pro-Forma statements for newly formed business ventures.

SECTION B. – FACILITY/ENTITY GENERAL INFORMATION

The Legal Entity Name, to be the First Named Insured if a Policy is issued:

1. Applicant/Entity Name: ____________________	Fed. Tax ID #: __________

2. **Mailing Address**: Street:

City:	State:	Zip Code:	County:
Telephone Number:____________________			

3. **Business Address**: Street:

City:	State:	Zip Code:	County:

Telephone Number:____________________	e mail:____________________
Regular Hours of Operation at this location:	Web Site:____________________

4. Applicant is a/an:

☐ Individual
☐ Partnership
☐ Corporation
☐ Joint Venture
☐ Limited Liability Company
☐ Other: ______________

☐ For Profit
☐ Not-For-Profit

5. List all owners, partners, members or stockholders of the applicant entity and their respective ownership interest:
Ownership total must reflect 100%

Name	Ownership %	Name	Ownership %
	%		%
	%		%
	%		%

6. Description of Operation: _(* also complete & attach the appropriate SUPPLEMENTAL APPLICATION)_

☐ Ambulance Service*, ☐ Ground ☐Air	☐ Pain Management Facility*
☐ Banking Facility* for☐Blood, ☐Organ or ☐Tissue	☐ Rehabilitation Center
☐ Birthing Center*	☐ Sleep Center
☐ Community Health Clinic or Health Dept.	☐ Student Health Center
☐ Durable Medical Equipment Supplier*	☐ Surgery Center/SurgiCenter*, Outpatient ASC
☐ Home Health Care*	☐ Treatment Center, Outpatient
☐ Hospice Care*	☐ Urgent Care Center/Facility*
☐ Imaging Facility*	☐ Walk-In Clinic*
☐ Medical Laboratory*	☐ Other, describe:
☐ Medical Spa/MediSpa*	

Please provide additional details as necessary: ____
____

Please list the Number of Years the facility has been:

7. In Business: _______ 8. Owned by Present Ownership: _______ 9. Managed by Present Management: _____

10. Does applicant provide any overnight bed facilities? If yes, number of beds:_______	☐ Yes	☐ No
11. Does the applicant own or manage any residential facilities. If Yes, provide details on letterhead.	☐ Yes	☐ No
12. Are Professional Services provided at any other/additional locations other than the **Business Address** listed above? If Yes, please complete the following, and provide a complete list of locations on letterhead.	☐ Yes	☐ No

13. Indicate all locations where the applicant(s) provides services. (Total of all locations must = 100%.)

☐ Business Address, Above: _______ %	☐ Hospital _______ %	☐ Long Term Care Facility _______ %
☐ Patients' Homes _______ %	☐ Prison/Jail Facility _______ %	☐ Mobile Facility _______ %
☐ Other, Describe location: _______ %	☐ Other, Describe location: _______ %	☐ Other, Describe location: _______ %

14. Does the applicant facility hold current, in-force Federal, State, County/Local Licenses? If Yes, list current Licenses and expiration date(s):	☐ Yes	☐ No
15. Is the applicant facility a "Covered Entity" under the Health Insurance Portability and Accountability Act (HIPAA)?	☐ Yes	☐ No
16. Does the applicant facility hold any current, in-force formal Accreditations (TJC/JCAHO, AAAHC, etc.)? If Yes, List the Accreditation(s), the most recent survey date & expiration date(s), and include a copy of the report/survey:	☐ Yes	☐ No

17. Is the applicant facility a member of any professional organization or association? If Yes, list the organization or association:	☐ Yes ☐ No
18. Is applicant certified for Medicare reimbursement?	☐ N/A ☐ Yes ☐ No

19. Has the applicant facility's license, certification or accreditation ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any Federal, State/Local licensing board, regulatory agency or accreditation board? This includes, but is not limited to Medicare, Medicaid or any other reimbursement type programs. *If yes, provide complete details on letterhead.*	☐ Yes ☐ No

20. List below any subsidiary or affiliate(s) and accompanying information. Provide details on letterhead if space below is inadequate.

Legal Business Name & Address	Relationship to Parent Entity	Description of Operation	Date Acquired	Ownership %	Retroactive Date
				%	
				%	
				%	

21. Has the applicant acquired or sold another organization, subsidiary, affiliate or operation(s):
- within the past 5 years? ☐ Yes ☐ No
- within the current Retroactive Period? ☐ Yes ☐ No

22. Within the next 12 months, does the applicant plan to: *(Please ☒ those that apply)*
- ☐ Purchase, acquire or dispose of any operation or entity?
- ☐ Add any additional operations, exposures or services?
- ☐ Expand the number of locations?
- ☐ Expand operation into other states?

Please provide details on letterhead.

23. Provide contact information for each of the following:

	Office Manager	Risk Manager	Claims Contact
Name:			
Title:			
Phone Number:			
Mailing Address:			
E-mail Address:			

SECTION C. – OPERATIONS/EXPOSURES

1. **Revenues;** Please provide prospective and historical annual gross revenues, as follows:

	Projected for Requested Coverage Period	Current / Expiring Year	Immediately Past Year	2nd Previous Year
Gross Revenue*:	$	$	$	$

*(*Provide total Annual Gross Revenue, do not adjust for profit, uncollectible/write-offs, charity works or amounts billed but not yet paid.)*

2. **Outpatient Visits;** If the applicant is an outpatient facility, please provide the annual number of outpatient visits, as follows:

	Projected for Requested Coverage Period	Current / Expiring Year	Immediately Past Year	2nd Previous Year
Outpatient Visits:				

(*For Visit count, count each time a patient enters your facility for healthcare related services.)

3. Does any applicant prescribe medications to patients? If Yes, describe:	☐ Yes	☐ No
4. Does the applicant utilize methadone in the treatment of patients? If Yes, describe:	☐ Yes	☐ No
5. Does the applicant sell or distribute any products to patients, including, but not limited to, vitamins, minerals, supplements, homeopathic remedies, nutraceuticals, anti-aging creams, lotions, skincare products, cosmetics, stimulants, soaps, bath soaps, etc.	☐ Yes	☐ No
• Are any medical-grade, 'by prescription only' type products?	☐ Yes	☐ No

SECTION D. – PROFESSIONAL EMPLOYEES AND STAFF

1. Identify below the number & type of Employed, Contracted & Volunteer health care professionals providing services at the applicant facility(ies): Check Here if NONE ☐

Professional Type/Description	Number of Employees		Number of Contractors		Number of Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Aesthetician (Esthetician)						
Aides/Assistants, Indicate type:						
Chiropractor						
CM/Certified Midwife						
CNM/Certified Nurse Midwife						
Companion/Personal Care Asst						
Dentist						
Dialysis Technician						
Dietician/Nutritionist						
Electrologist						
EMT/Emergency Med Tech						
Massage Therapist						
Mental Health Counselor						
Midwife (non- certified)						
Nurse Practitioner						
Nurse/R.N./L.P.N.						
Occupational Therapist						
Paramedic						
Pharmacist						
Phlebotomist						
Physical Therapist						
Physician Assistant						
Psychologist						
Radiation Technician						
Rehabilitation Counselor/ Therapist						

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Professional Type/Description	Number of Employees		Number of Contractors		Number of Volunteers	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Respiratory Therapist						
Social Worker						
Speech Therapist						
Technician *(specify type)*:						
Other *(specify)*						
GRAND TOTAL:						

Note: Not all the above listed may qualify for coverage under the Policy, if one is so issued. Independent Contractors are not covered as Insureds and will not have coverage under the Policy, if one is issued, unless specifically endorsed as covered. Independent contractors should obtain their own insurance coverage.

2. Is there a **Medical Director** associated with services at the applicant's facility? If Yes, provide the following information: ☐ Yes ☐ No

Medical Director's Name	Specialty	American Board Certified?	Employee/ Contractor	Hrs/ Week	Have Own Ins Cvg?	Limits	Administrative Duties Only?	Clinical, Direct Patient Care?
		☐ Yes ☐ No			☐ Yes ☐ No	$	☐ Yes ☐ No	☐ Yes ☐ No

Note: Medical Director coverage is limited only to administrative duties, unless specifically scheduled otherwise, as described in the policy.

3. Are Employed or Contracted **Physician(s)** providing services at the applicant's facility? ☐ Yes ☐ No
If Yes, provide the following information:

Physician Name	Specialty	American Board Certified?	Employee/ Contractor	Weekly Hrs	Have Own Ins Cvg?	Limits
		☐ Yes ☐ No			☐ Yes ☐ No	$
		☐ Yes ☐ No			☐ Yes ☐ No	$
		☐ Yes ☐ No			☐ Yes ☐ No	$
		☐ Yes ☐ No			☐ Yes ☐ No	$

Note: Independent Contractors are not covered as Insureds and will not have coverage under the Policy, if one is issued. Independent Contractors should obtain their own insurance coverage.

4. Does the facility have a formal, written credentialing program for all Physicians, Surgeons & Anesthetists? If No, explain.	☐ Yes ☐ No
5. Is Primary Source Verification credentialing performed on all Physicians, Surgeons & Anesthetists? If No, explain.	☐ Yes ☐ No
6. Are all of the health care professionals in the above sections each properly licensed and/or certified in accordance with applicable federal, state and/or local regulations? If No, explain.	☐ Yes ☐ No
7. Does applicant have any contractual agreements with independent contractors to provide services at applicant's facility?	☐ Yes ☐ No
• If Yes, Does contractual agreement contain a hold harmless or indemnification clause favorable to applicant?	☐ Yes ☐ No

8. Does applicant obtain certificates of insurance from all Healthcare Professionals, (e.g., Resident, intern, Physician, Surgeon, Dentist, Psychiatrist, Licensed or Certified Registered Nurse Anesthetist, Midwife, Podiatrists, Chiropractors) rendering professional services at the facility?	☐ Yes	☐ No
• If Yes, what is the minimum amount in Insurance Coverage the applicant facilities requires?	$________ per occ/$________ aggregate	
9. Does applicant provide services to others on a contractual agreement? If yes, please describe services provided on letterhead.	☐ Yes	☐ No
• If Yes, Does the applicant agree to hold harmless or indemnify others under contract? If yes, please provide details on letterhead.	☐ Yes	☐ No

SECTION E. – RISK MANAGEMENT/QUALITY ASSURANCE & LOSS CONTROL

1. Does applicant facility have and utilize a formal, written, in-force **Risk Management** or **Quality Assurance Program**? If No, please explain.	☐ Yes	☐ No
2. Are patient records safeguarded & protected in accordance with HIPAA regulations (Health Insurance Portability and Accountability Act)?	☐ Yes	☐ No
3. Are written patient "INFORMED CONSENT" forms utilized prior to professional services being rendered?	☐ Yes	☐ No
• Maintained in Patient Files?	☐ Yes	☐ No
4. If Independent Contractors are utilized, are Certificates of Insurance obtained?	☐ Yes	☐ No
• Reviewed Annually or Periodically?	☐ Yes	☐ No
5. For equipment used for diagnosis, monitoring or treatment purposes, are Inspections & Maintenance performed according to the manufacturer's recommendations?	☐ Yes	☐ No
• Logged and recorded appropriately?	☐ Yes	☐ No
6. Are written job descriptions in place for all professionals & clinical support staff?	☐ Yes	☐ No
7. Does the applicant facility have in place, written protocols and Transfer Agreements for patient transfer in the event of a life-threatening emergency situation? Name of receiving facility: ________________________________ Number of miles to the facility: ____________________ Miles Est. Driving time to facility ____________________ Minutes	☐ Yes	☐ No
8. Has any applicant ever had an incident that resulted in an allegation of sexual abuse/ molestation? If Yes, please provide details on letterhead.	☐ Yes	☐ No

9. Hiring/Screening protocols used for Employees, Contractors or Volunteers (please check all that apply):
☐ References checked: ☐ In writing ☐ By telephone

☐ Criminal records checked?	☐ Verification of current licenses, suspensions, revocations or pending disciplinary actions by licensing bodies?
☐ Verification of prior facility(ies) employment including potential disciplinary actions?	☐ Verification of Professional Liability related claims/suits?
☐ Drug/Alcohol/Abuse Screening?	☐ Verification of any claims or allegations of past abuse, molestation or related offenses?

10. Do written policies or procedure protocols exist for each of the following:			
a. Acceptance & Documentation of Physician Verbal Orders	☐ N/A	☐ Yes	☐ No
b. Advanced Directive/Living Will	☐ N/A	☐ Yes	☐ No
c. Compliant Handling	☐ N/A	☐ Yes	☐ No
d. Drug Administration Procedures	☐ N/A	☐ Yes	☐ No
e. Employee training	☐ N/A	☐ Yes	☐ No
f. Incident Reporting (Medical/Professional)	☐ N/A	☐ Yes	☐ No
g. Infection Control	☐ N/A	☐ Yes	☐ No
h. Medical Equipment Training	☐ N/A	☐ Yes	☐ No
i. Medical Records Storage	☐ N/A	☐ Yes	☐ No
j. Medication Safeguarding & Inventory Control	☐ N/A	☐ Yes	☐ No
k. Patient Discharge	☐ N/A	☐ Yes	☐ No

l. Patient Rights	☐ N/A ☐ Yes ☐ No
m. Patient Selection/Admissions	☐ N/A ☐ Yes ☐ No
n. Suspected Impaired/Substance Abuse Practitioner Event Policy	☐ N/A ☐ Yes ☐ No

SECTION F. – COVERAGE REQUESTED

1. ☒ Professional Liability Coverage: ☒ Claims-Made Coverage Basis

2. Effective Date: ________________ 3. Retroactive Date: ________________

A copy of your current, in-force Policy Declarations page must be submitted as evidence of Retroactive Date.

4. Is the Applicant Entity enrolled in, eligible for, or required to participate in any (State) Patient Compensation Fund or similar assessment and funding mechanism for medical liability claims? If Yes, please provide details on letterhead. ☐ Yes ☐ No

5. ☐ General Liability Coverage: ☐ Occurrence Coverage Basis
   ☐ Claims-Made Coverage Basis Retroactive Date:

6. Limits of Liability:	7. Deductible:
☐ $100,000/$300,0000	☐ $ - 0 -
☐ $200,000/$600,0000	☐ $2,500
☐ $250,000/$750,0000	☐ $5,000
☐ $500,000/$1,500,000	☐ $7,500
☐ $1,000,000/$1,000,000	☐ $10,000
☐ $1,000,000/$3,000,000	☐ $15,000
☐ Other, specify:	☐ $20,000
	☐ Other, specify:

The limits for Professional Liability must be the same for General Liability, if so purchased.

SECTION G. – PRIOR COVERAGE, PRACTICE HISTORY AND LOSS INFORMATION

1. Applicant's current & immediately past 5 years of Professional Liability Coverage:

Policy Term	Company/Carrier	Limits of Liability	Deductible	Coverage Type	Premium	# Claims*
			$	☐ c/m ☐ occ	$	
			$	☐ c/m ☐ occ	$	
			$	☐ c/m ☐ occ	$	
			$	☐ c/m ☐ occ	$	
			$	☐ c/m ☐ occ	$	

*Applicant must provide currently-valued, Company/Carrier generated Loss Runs evidencing Loss History, and Company requested Claim Information Supplement(s) for each loss/claim valued over $5,000.

2. Have any Professional Liability and/or General Liability Claims or suits been made against the facility during the last 5 years?	☐ Yes ☐ No
3. Has any insurance company ever canceled, declined, rescinded or non-renewed any Professional Liability and/or General Liability Insurance Policy? (Notice: Missouri Applicants Need Not Answer This Question, It Will Not Be Used in an Underwriting Determination for Missouri Applicants.)	☐ Yes ☐ No
4. Are you aware of any incident, event, accident, circumstance or loss that has occurred that might give rise to a claim or suit in the future? If Yes,	☐ Yes ☐ No
• Have all such incidents been properly reported to and acknowledged as accepted by a prior carrier? Please list each such incident separately on a Claim Information Supplement.	☐ Yes ☐ No
5. Has the facility, an employee or staff member ever been the subject of a disciplinary proceeding, investigation or reprimanded by a governmental or administrative agency, hospital or professional association?	☐ Yes ☐ No
6. Has the applicant facility ever been the subject of any license suspension, revocation or probation?	☐ Yes ☐ No

7. Are you aware of any outstanding or pending request for medical records by a patient or their attorney which might give rise to a claim or suit in the future?	☐ Yes ☐ No
• Has this event been properly reported to and acknowledged as accepted by a prior carrier? Please list each such incident separately on a Claim Information Supplement.	☐ Yes ☐ No
8. Are you aware of any information relating to any service on a Board which might result in a claim?	☐ Yes ☐ No
9. Are you aware of any prior Carrier/Insurer refusing coverage for, or declining to accept your report of a medical incident, a threat of claim, a letter of intent, adverse outcome/event notice or patient attorney contact?	☐ Yes ☐ No
** If Yes to any of the above, please provide complete details on your letterhead.*	

SECTION H. –GENERAL LIABILITY EXPOSURE INFORMATION
Complete this section only if you are requesting General Liability Coverage.

1. Provide the following for each location owned, occupied, or leased by the applicant:

Location	Square Footage	Year Built	Type of Construction	# of Floors	# Exits per Floor	Fire Protection Type*

*Fire Protection Type: AS = Approved Sprinkler; HD = Heat Detector; SD = Smoke Detector; AL = Monitored, Central Station Automatic Alarm

2. Are HVAC, electrical & plumbing systems up to current codes?	☐ Yes ☐ No
• Regularly inspected and documented appropriately?	☐ Yes ☐ No
3. Are life-safety equipment/fire extinguishers placed according to local codes?	☐ Yes ☐ No
• Regularly inspected and conditions documented appropriately?	☐ Yes ☐ No

4. Does the applicant sell, rent or lease Medical Supplies and/or Equipment in connection with your facility operation(s)? If Yes, please complete the DME/Durable Medical Equipment Supplement. If Yes,	☐ Yes ☐ No
• are the Medical Supplies and/or Equipment 'branded' or labeled with the Applicant's name?	☐ Yes ☐ No
• Does the applicant re-package, re-label or re-design any products, supplies or devices obtained from suppliers?	☐ Yes ☐ No

5. Total Annual Sales $ ________ 6. Total Annual Rental/Lease Receipts: $ ________
Include only receipts as respects the Medical Supplies, Products, and Equipment sold/rented/leased at your facility in connection with your facility operation(s).

NOTICE TO THE APPLICANT—PLEASE READ CAREFULLY

If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy.

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom, shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application, including any supplemental application(s), and all previous applications related hereto and material changes to any of the foregoing of which the Company and/or affiliates thereof receives notice is on file with the Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the entity(ies) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the entity(ies), person(s) and/or organization(s) proposed for this insurance understand that the policy for which application is made applies only to “Claims” first made during the “Policy Period”. 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 then current policy term may result in a lack of coverage.

WARRANTY

I warrant to the Company that:

- I am legally and duly authorized to represent and to sign on behalf of the applicant entity/facility; and
- I understand and accept the notice stated above, and that the information contained herein is true and complete and that it shall be the basis of the underwriting decision for the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy; and
- I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof; and
- I have made a thorough and comprehensive internal investigation to determine whether any person(s) from the applicant facility is aware of any actual or alleged act, error, omission, incident, accident, fact, circumstance or situation which may reasonably be expected to result in a claim, and all such items, if any, have been fully and completely disclosed within the application and/or accompanying materials thereto, or have been reported to, and acknowledged as accepted by a prior insurance carrier/company.

Must be signed by an authorized representative of the Applicant Entity/Facility within 45 days of the proposed effective date.

Printed Name of Authorized Representative	Title (e.g. Owner, Officer, partner, etc.)
Signature of Applicant	Date

Signing this form does not bind the Applicant or the Company to complete the Insurance.

Notice to Applicants: Any person who knowingly and with 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 subjects the person to criminal and civil penalties.