



Professional Liability/Medical Malpractice Preferred • Standard • Non-Standard

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WARNING - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files 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.

APPLICATION FOR CLINICS (MEDICAL, DENTAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER) PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully. If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

- 1. (a) Full name of Applicant:
(b) Principal practice address:
(c) Location: Stand alone Hospital School Correctional Facility Other
(d) (i) Phone: (ii) E-Mail Address: (iii) Website Address:
(e) Date Established:
Attached a proforma business plan if the Applicant is newly established.
2. Applicant is a:
[] professional corporation [] joint venture
[] limited liability company [] professional association
[] other [] partnership
3. Name(s) of all partners or members of the clinic who provide professional services:
4. Does any owner, partner or director operate or administer, wholly or in part, any hospital, nursing home or other institution where medical services are rendered?
If Yes, provide details, including name, location, size and number of beds.
5. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?
If Yes,
(a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?
(b) Provide the name and title of the Applicant's Privacy Officer.
Our Business Associate Agreement is available by calling us at (502) 244-1056. This is the only Business Associate Agreement we will recognize.

II. OPERATIONS

- 1. Days/hours of operation:
2. (a) Provide the name and specialty of the Applicant's Medical Director:
(b) Does the Applicant's Medical Director have direct patient contact?
(c) Is the Applicant's Medical Director full-time or part-time?
3. Applicant's professional specialty:

4. Provide the percentage of patients/clients:

Bariatrics _____%	Holistic medicine _____%	Sleep Disorders _____%
Communicable Disease _____%	Obstetrical _____%	Stress Testing _____%
Correctional Medicine _____%	Oncology _____%	Students _____%
Dental _____%	Pain Management _____%	Substance Abuse _____%
Disability Evaluation _____%	Pediatric _____%	Surgical _____%
Family Planning _____%	Physical Rehabilitation _____%	Urgent Care _____%
Free Clinic _____%	Psychiatric _____%	
Hemodialysis _____%	Research or Experimental _____%	

5. List all Locations where Applicant is registered and licensed to operate:

Location 1: _____
 Location 2: _____
 Location 3: _____
 Location 4: _____

6. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: _____

7. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered?[] Yes [] No
 If Yes, provide details. _____

8. List all accreditations and association memberships held by Applicant's facility and include a copy of the most recent report: _____

9. Does the Applicant participate in any state patient compensation fund?[] Yes [] No

10. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")?[] Yes [] No
 If Yes, what percentage of services are provided under the FTCA? _____

11. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.?[] Yes [] No

12. Applicant's Gross Revenues:

	<u>Last Twelve Months</u>	<u>Next Twelve Months</u>
Fee for Service	\$ _____	\$ _____
Medicare/Medicaid Funds	\$ _____	\$ _____
Research	\$ _____	\$ _____
Other (describe)	\$ _____	\$ _____
TOTAL GROSS REVENUES	\$ _____	\$ _____

13. Number of outpatient/client visits:

	<u>Last Twelve Months</u>	<u>Next Twelve Months</u>
Clinics	_____	_____
Laboratory	_____	_____
X-ray/Imaging	_____	_____
Pharmacy	_____	_____
TOTAL VISITS:	_____	_____

NOTE: If Applicant provided services for correctional facilities, provide number of inmates: _____

14. Does the Applicant maintain any beds for overnight occupancy:

- (a) On the Applicant's premises?[] Yes [] No
 If Yes,
 (i) No. of beds: _____
 (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

