

AMERICAN INTERNATIONAL COMPANIES®**APPLICATION FOR
HOSPITAL PROFESSIONAL LIABILITY/GENERAL LIABILITY
AND
UMBRELLA EXCESS LIABILITY INSURANCE**

Please review this application carefully and discuss it with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

Instructions:

1. Please type or print clearly.
2. Answer **ALL** questions completely, leaving no blanks. If any questions, or part thereof, do not apply, state "N/A."
3. If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.
4. When necessary, check all boxes that apply.

SECTION I

Please attach the following:

1. Loss History, hard copy carrier loss runs and, when available, in electronic format:
 - a. Ten years of historical PL and GL losses including current year, ground-up and unlimited, including all self insured, insured, and uninsured losses.
 - b. Date of loss valuation must be within past ninety days.
 - c. Lost run must include: carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL), and narrative of claim.
 - d. Full details of allegations on all losses paid or outstanding in excess of \$50,000 even if greater than 10 years old.
2. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or if accrediting agency reports are unavailable please submit the state licensure report with recommendations and the institution's response to any contingencies.
3. CPA prepared and audited financial statement, including balance sheet, income statement, and cash flow.
4. Identity of each employed physician, indicating name, specialty, date of hire, retro date, primary PL carrier, primary occurrence or claims made, PL limits. See Section IV, B 2 for table.
5. Identity of each Named Insured on the policy including a brief explanation of their relationship to the applicant and their retro date (if historically written on claims made basis).
6. Copy of current risk management and quality improvement plan.
7. Recent actuarial review supporting the funding of any self insured retention.
8. Copy of current Organizational Chart (Corporate and Risk Management)
9. Copy of Claim Management Procedures.
10. Completed Hospital Addendum. Please request addendum from your broker.
11. Completed Bariatric Surgery Addendum, if applicable. Please request addendum from your broker.

12. Complete schedule of locations owned, leased or operated.
13. For Excess coverages (when AIG is not primary carrier) please provide copies of all underlying policies.
14. For Umbrella coverages please provide copies of Primary Declaration pages or COI for all applicable coverages (auto, employers liability, heliport, helipad, etc.)
15. Copy of underlying automobile carrier's loss run for the past 5 years including the following information: carrier, date of loss, report date, total incurred, status (open or closed), and narrative of claim. Date of loss valuation must be within past ninety days.

The items requested above are mandatory before a quotation can be promulgated.

SECTION II

A. General Information:

New Applicant or Renewal

Employer Federal Tax ID #

Requested Effective Date of Coverage: _____

Retro Date: _____

Applicant name (the legal name of the hospital or entity to be insured)

Address _____

City _____

County _____

State _____

Zip _____

Website Address _____

Contact Person _____

Title _____

E-mail _____

Phone Number _____

Fax# _____

Number of years in operation _____

Number of years under current ownership _____

B. Applicant is (check all that apply):

<input type="checkbox"/> Hospital – General Acute Care	<input type="checkbox"/> Profit	<input type="checkbox"/> Individual	<input type="checkbox"/> Accredited by JCAHO
<input type="checkbox"/> Hospital – Children's	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Partnership	<input type="checkbox"/> Accredited by AOA
<input type="checkbox"/> Hospital – Teaching	<input type="checkbox"/> Governmental	<input type="checkbox"/> Corporation	<input type="checkbox"/> Accredited by CARF
<input type="checkbox"/> Hospital – Psychiatric		<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Licensed by State
<input type="checkbox"/> Hospital – Rehabilitation			<input type="checkbox"/> Medicare Approved
<input type="checkbox"/> Hospital – LTAC			<input type="checkbox"/> Member of AHA
<input type="checkbox"/> Hospital – Women's			<input type="checkbox"/> Member of NPSF
<input type="checkbox"/> Other – Please explain			

C. Teaching Hospitals:

1. Please identify the type of training program(s) offered:
 Residency , Nursing , Physicians Assistants , Physical Therapy other _____
 Please provide the number of trainees enrolled in each program in the past 12 months: Residency _____,
 Nursing _____, Physicians Assistants _____, Physical Therapy _____, other _____
2. The training program(s) is/are accredited by _____

D. Accreditation:

1. Accredited Programs: _____
2. Please provide date of most recent JCAHO accreditation. _____
3. Accreditation Decision:
 - Accredited Provisional Accreditation Conditional Accreditation Preliminary Denial of Accreditation
 - Denial of Accreditation Preliminary Accreditation
4. Requirements for Improvement? Yes No
If yes, please provide list of standards scored as non-compliant: _____
5. Did the survey identify any life safety issues? Yes No
If yes, please explain _____
6. Were partially compliant standards identified in the supplemental findings? Yes No
If yes, please explain _____

E. Current Insurance Coverage: (expand the table with additional rows as needed, or attach separate page)

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	Ded <input type="checkbox"/> or SIR <input type="checkbox"/>	Premium
Professional Liab PL							
General Liab GL							
Employee Benefits							
Excess/Umbrella							
Underlying PL							
Underlying GL							
Auto Liab.							
Employers' Liab.							
Employee Benefits							
Helipad/Aviation							
Other:							

1. Are defense/expenses within policy limits? Yes No
2. Is underlying/retention eroded by indemnity only or indemnity plus defense/expenses?

*Please specify by layer if more than one Retroactive Date applies.

F. Prior Insurance History:

If commercially insured, please provide the following primary and excess/umbrella PL coverage information for each of the past 5 years.

Policy Period	Carrier	PL Limits Per Occ/Agg Primary	PL Limits Per Occ/Agg Excess/Umbrella	Ded <input type="checkbox"/> or SIR <input type="checkbox"/>	Occ. or Claims Made	Premium
Current						

G. Insurance Coverage Desired:

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	**Ded <input type="checkbox"/> or SIR <input type="checkbox"/>
Professional Liab PL						
General Liab GL						
Employee Benefits						
Excess/Umbrella						
Underlying PL						
Underlying GL						
Auto Liab.						
Employers' Liab.						
Employee Benefits						
Helipad/Aviation						
Other:						

1. Will defense/expenses be within policy limits? Yes No
2. Will underlying/retention be eroded by indemnity only or indemnity plus defense/expenses?

*Please specify by layer if more than one Retroactive Date applies.

**Deductibles require AIG approved Letter of Credit.

H. SIR Accounts:

1. To what line(s) of coverage will the SIR apply? _____
2. What are the limits of liability for the SIR? \$ _____ per occurrence, \$ _____ aggregate.
3. Are loss adjustment expenses part of or outside the SIR limit?
4. Is there a dedicated trust? Yes No.
If yes, what financial institution manages the trust? _____
If not, is there a captive? Yes No.
Details: _____
5. Has an independent actuarial review been completed? Yes No
If yes, please provide the name of the firm _____ Date: _____

I. Claims Management:

1. Who, within the organization, is responsible for claims management activities?
Name: _____ Title: _____ Phone Number: _____
Do you have written claims management procedures: Yes , please attach. No
2. Does a Third Party Administrator manage claims within the SIR? Yes No
If yes, please provide name of TPA Firm and Contact: _____ Phone Number: _____
3. Please provide names of defense firms who currently represent you in professional liability matters:

SECTION III

A. Services Provided (check all that apply):

☛ If checked below, please answer applicable questions in Sections B-I .

<input type="checkbox"/> Abortion	<input type="checkbox"/> Home Health	<input type="checkbox"/> Open Heart
<input type="checkbox"/> Ambulance ☛	<input type="checkbox"/> ICU	<input type="checkbox"/> Operating Rooms
<input type="checkbox"/> Bariatric Surgery ☛	<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Pathology
<input type="checkbox"/> Blood Bank ☛	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Pharmacy ☛
<input type="checkbox"/> Burn Unit	<input type="checkbox"/> Laser Assisted Surgery	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Cath Lab	<input type="checkbox"/> Lithotripsy	<input type="checkbox"/> Plastic / Cosmetic Surgery
<input type="checkbox"/> CCU	<input type="checkbox"/> Long Term Care ☛	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Clinical Trials	<input type="checkbox"/> Morgue	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Coronary Rescue	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Radiology
<input type="checkbox"/> Day Care ☛	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Research
<input type="checkbox"/> Dialysis	<input type="checkbox"/> NICU	<input type="checkbox"/> Self-Care

<input type="checkbox"/> Dietary	<input type="checkbox"/> Nurse Call	<input type="checkbox"/> Sex Change
<input type="checkbox"/> Emergency	<input type="checkbox"/> Nursery	<input type="checkbox"/> Shock Trauma
<input type="checkbox"/> Fitness Center ☻	<input type="checkbox"/> OB/Gyn	<input type="checkbox"/> Surgery
<input type="checkbox"/> Gift Shop	<input type="checkbox"/> Oncology	<input type="checkbox"/> Transplant ☻

- Does the hospital intend to commence a service identified above within the next 12 months? Yes No
If yes, please explain. _____
- Does the hospital intend to cease a service identified above within the next 12 months? Yes No
If yes, please explain. _____

B. Ambulances:

- Is excess/umbrella AL coverage desired for ambulance(s)? Yes No
- Are ambulances used as first responders , patient transport , or both ?
- Number of ambulances in fleet: _____
- Service radius: _____ miles.
- Number of emergency runs in the past 12 months: _____

C. Bariatric Surgery:

A completed supplemental application is required for Bariatric Surgery Programs. Please request the addendum from your broker.

D. Blood Banks:

- Please identify the screening test(s) utilized by the hospital. _____
- Accredited by AABB , ARC , ABC , CAP , JCAHO , other _____
- Is any blood or blood product bought or obtained from outside the U.S.? Yes No
If yes, please explain. _____
- Does the blood bank outsource its blood testing? Yes No
If yes, please provide details: _____
- Number of volunteer and paid donations in the past 12 months: _____
- Number of pheresis procedures in the past 12 months: _____
- Number of outpatient transfusions in the past 12 months: _____
- Number of therapeutic plasma exchanges in the past 12 months: _____

E. Day Care:

- Is the day care center on the hospital premises? Yes No
- Is the day care center open to the public? Yes No
- Number of children enrolled in the past 12 months: _____

F. Fitness Center:

- Is the fitness center on the hospital premises? Yes No
- Is the fitness center open to the public? Yes No
- Number of members enrolled in the past 12 months: _____

G. Long Term Care:

- Are the long term care beds located within the hospital or in a stand-alone facility?
- Is the stand-alone facility on the hospital premises? Yes No
- Does the stand-alone facility fall under the hospital's Risk Management? Yes No
- Does the stand-alone facility follow policies established by the hospital? Yes No

H. Pharmacy:

- Does the hospital utilize the unit dose system of dispensing medicine? Yes No
- Is the pharmacy for patient use only? Yes No
If no, annual receipts for non-patients medications are \$ _____
- Is the pharmacy staffed by a contract group? Yes No
If yes, please explain: _____

I. Transplant:

1. Number of tissue donations in the past 12 months: _____ and projected next 12 months: _____
2. Number of organ donations in the past 12 months: _____ and projected next 12 months: _____
3. Accredited by AOPO , AATB , EBAA , other _____
4. Does the hospital have a formal policy regarding the informed consent process? Yes No
5. Has the hospital been involved in any tissue FDA recalls? Yes No
If yes, please explain. _____
6. Has the hospital initiated any voluntary tissue recalls in the past 5 years? Yes No
If yes, please explain. _____
7. Are any tissues procured/recovered from outside the U.S.? Yes No
If yes, please explain. _____
8. Are any non-human tissues used in any way at the hospital? Yes No
If yes, please explain. _____
9. Do you accept John Doe Donors? Yes No
10. Do you participate in a living donor program? Yes No
11. Has the hospital agreed to unilaterally hold harmless or indemnify others under contract? Yes No
12. Does the hospital place all organs through UNOS? Yes No
If no, do you have a protocol for ensuring compatibility? Yes No
13. Please indicate all of the transplant operations at the hospital:

<input type="checkbox"/> OPO	<input type="checkbox"/> Eye Procurement	<input type="checkbox"/> Tissue Procurement	<input type="checkbox"/> Tissue Processing
<input type="checkbox"/> Tissue Labeling	<input type="checkbox"/> Tissue Distribution	<input type="checkbox"/> Tissue Storage	<input type="checkbox"/> Lab Testing
<input type="checkbox"/> OR for Procurement	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

SECTION IV

A. Professional Liability Exposures:

Beds	No. of Licensed Beds	No. of Occupied Beds Projected Next 12 months	No. of Occupied Beds Current Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior
Acute Care							
Cribs & Bassinets							
Psychiatric							
Chemical Dependency							
Rehabilitation							
Long Term Care							
Hospice							
Swing Beds							
Other: _____							
Other: _____							
Other: _____							
Other: _____							
Total							

Inpatient Services	No. Projected 12 Mos.	No. in Current Policy Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior
Inpatient Surgeries						
Bariatric Surgeries						
Births-no Csection/VBACs						
C-Sections						
VBACs						
Other: _____						
Total						

Outpatient Services	No. Projected 12 Mos.	No. in Current Policy Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior
Outpatient Surgeries						
Chemical Dependency						
Rehab/Therapy OPVs						
Psychiatric OPVs						
Home Health Visits						
Outpatient Clinic Visits						
Emergency Room Visits						
Other: <input type="text"/>						
Total						

B. Professional Employees:

1. Please provide the number of professionals employed by the hospital:

Type	No. of Full Time Equivalents	Employed Full Time Equivalents	Contracted Full Time Equivalents
Physicians			
Fellows			
Residents			
Interns			
Podiatrists			
Chiropractors			
Physicians Assistants			
Midwives			
Nurse Practitioners			
CRNAs			
Registered Nurses			
Licensed Practical Nurses			
Student Nurses			
X-Ray Technicians			
Lab Technicians			
Pharmacists			
Paramedics			
Perfusionists			
Dentists			
Oral Surgeons			
Other: _____			
Other: _____			
Total Number of			

2. Please complete the following information for each physician or surgeon for whom primary and/or excess (sharing limits with the hospital) coverage is requested. (Expand the table with additional rows as needed, or attach additional page):

Complete when coverage is requested for Excess only:

Name	Specialty	Surgery, No Surgery, or Minor Surgery	Retro Date	Employed or Contracted	Primary PL Carrier	Limits of Liability

3. Please complete the following information for each terminated physician or surgeon for whom coverage should be continued (sharing limits with the hospital) (Expand the table with additional rows as needed, or attach separate page):

Name	Date of Hire	Retro Date	Termination Date

C. Medical Credentialing / Staffing:

- Is history of previous employment verified? Yes No
- Are references checked? Yes No
- Has the license of any physician ever been restricted or suspended? Yes No
If yes, please provide details: _____
- Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action, or professional liability payment involving any member of the medical or dental staff? Yes No
If yes, please explain: _____
- How many physicians are board certified or board eligible? _____
- Do physicians, residents, and interns carry their own insurance? Yes No
- Are credentials of physicians approved by the medical staff and/or hospital review board before privileges are granted? Yes No
- Is there a probationary period of at least six months for all physicians? Yes No
- Are physicians' performance periodically reviewed by medical staff and/or hospital review board? Yes No
- Do hospital by-laws require staff physicians to carry medical malpractice insurance? Yes No
If not, please identify on a separate sheet of paper those physicians that are "bare."
If yes, what are the required limits? \$ _____ per occurrence, \$ _____ aggregate.
If yes, is evidence of compliance required by certificate of insurance? Yes No
If yes, are there any exceptions to this requirement? Yes No
If yes, please provide details: _____
- Are all privileges granted to staff physicians detailed in writing? Yes No
- Number of current Staff MDs: _____

SECTION V

A. Anesthesia:

- The anesthesia department is staffed by: Empl Physicians , CRNAs , Staff Physicians , Contract Group .
- If service provided by a contract group:
Name of group: _____
Does the hospital require the contract group to carry professional liability insurance? Yes No
If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
Are the limits shared or per physician ?
Does the hospital require contract physicians to furnish certificates of insurance? Yes No
- If service provided by CRNAs:
Is each CRNA's anesthesia care supervised and reviewed by an Anesthesiologist? Yes No
If no, please explain: _____
Are the CRNAs employed by the hospital , the anesthesiologists , the surgeons , or are they independent contractors ?
- Are the Anesthesiologists required to be board certified or board eligible in Anesthesiology? Yes No
- Is an Anesthesiologist on the premises 24 hours a day? Yes No
- Do any of the anesthesia department staff routinely work more than a 12-hour shift? Yes No
If yes, please explain: _____

B. Radiology:

- The radiology department is staffed by: Employed Physicians , Staff Physicians , Contract Group .
- If service provided by a contract group:
Name of group: _____
Does the hospital require the contract group to carry professional liability insurance? Yes No
If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
Are the limits shared or per physician ?
Does the hospital require contract physicians to furnish certificates of insurance? Yes No

3. Are the Radiologists required to be board certified or board eligible in Radiology and/or Nuclear Medicine?
 Yes No
4. Is a Radiologist on the premises 24 hours a day? Yes No

C. Emergency Department:

1. The emergency department is staffed by: Empl Physicians , Rotating Staff Physicians , Contract Group .
2. If service provided by a contract group:
 Name of group: _____
 Does the hospital require the contract group to carry professional liability insurance? Yes No
 If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
 Are the limits shared or per physician ?
 Does the hospital require contract physicians to furnish certificates of insurance? Yes No
3. Are the emergency department physicians required to be board certified or board eligible in Emergency Medicine?
 Yes No
4. The emergency department is JCAHO classified as: Level I (Tertiary) , Level II (Comprehensive) , Level III (Basic) , None (Standby) , or Other _____
5. Are the emergency physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution? Yes No
6. Is the emergency room equipped with the following:
 Emergency resuscitation care equipped with defibrillator? Yes No
 Electrocardiograph machine? Yes No
 Staffed radiology room(s)? Yes No
 Dedicated triage area and staff? Yes No
 Dedicated trauma room(s)? Yes No
 Dedicated laboratory personnel? Yes No
7. Do any of the emergency department staff routinely work more than a 12-hour shift? Yes No
 If yes, please explain: _____

D. Obstetrics:

1. Is the hospital a regional referral center for high risk pregnancies or newborns requiring intensive care? Yes No
 If no, does a written procedure exist for transferring all high-risk mothers and/or babies which the hospital is not qualified to treat? Yes No
2. Does the hospital have the following nurseries:
 Level I: Well baby? Yes No If yes, number of bassinets: _____
 Level II: Intermediate care? Yes No If yes, number of bassinets: _____
 Level III: Neonatal intensive care? Yes No If yes, number of bassinets: _____
3. Are all C-sections performed by Obstetricians? Yes No
 If no, please identify the specialties of the physicians performing C-sections: _____
4. Is continuous electronic fetal monitoring performed on all patients in active labor? Yes No
 If no, please explain: _____
5. Do nurse midwives practice at the hospital? Yes No
 If yes, how many? _____
6. Are nurse midwives subject to the hospital's credentialing process? Yes No
7. Do nurse midwives deliver babies in patients' homes? Yes No
8. Is an Obstetrician on the premises 24 hours a day? Yes No

E. Surgery:

1. Are sponge, needle and instrument counts performed in the course of a surgical procedure? Yes No
 If yes, at what intervals of the operation? _____
2. Are any of the following performed at the hospital?
 Experimental Surgery Yes No
 Sex Change Operations Yes No
 Bariatric Surgery Yes No
 Laser Assisted Surgery Yes No
3. Is there a surgeon on the premises 24 hours a day? Yes No

SECTION VI

A. Other Exposures:

1. How many patient care buildings does the hospital own, lease, or operate? _____
2. How many other, non-patient care buildings does the hospital own, lease, or operate? _____
3. Do all the patient care buildings have:
Sprinklers? Yes No
Smoke detectors? Yes No
Heat detectors? Yes No
Automatic alarms? Yes No
4. Does the hospital conduct period evacuation drills? Yes No
If yes, how often? _____
5. Does the hospital conduct period fire drills? Yes No
If yes, how often? _____
6. Does the hospital have a written Emergency Management Preparedness Plan? Yes No
If yes, please provide a copy. _____
7. Is new construction and/or abatement contemplated or pending ? Yes No
If yes, please explain: _____
8. Does the hospital have a heliport or helipad? Yes No
If yes:
How many landings in the past 12 months? _____
Where is it located? _____
What is the distance between the heliport or helipad and the closest hospital building? _____
Does the hospital require the heliport or helipad to carry liability coverage? Yes No
If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
What is the name of the commercial carrier? _____
9. Does the hospital own, lease, or operate any aircraft? Yes No
If yes, how many of each: _____
Please describe purpose: _____
10. Does the hospital own, lease, or operate any watercraft? Yes No
If yes, how many of each: _____
Please describe purpose: _____
11. Is the hospital's administration managed by an outside vendor? Yes No
If yes:
Please identify the name of the management company: _____
Please describe the nature of the contract between the hospital and the management company:

Is the management company to be named as an Additional Insured under the hospital's insurance policy?
 Yes No
Is the management company also involved in the management of clinical services at the hospital? Yes
 No
If yes, please explain: _____
12. Who coordinates your risk management program?
Name: _____ Title: _____
Telephone: _____
13. Is there a written risk management program that has been approved by a governing body? Yes No
14. Does the governing body review the effectiveness of the risk management program and approve necessary changes? Yes No
15. Is the risk manager accountable and solely responsible for risk management? Yes No
If not, explain other responsibilities: _____
16. Does the risk management program include the following:
Occurrence reporting Yes No
Claim management Yes No
Formal link to quality management Yes No
Safety program and safety committee Yes No

Review and participation in medical staff committees Yes No
 Contract review and evaluation Yes No

17. Has the hospital agreed to hold harmless or indemnify others under contract? Yes No
 If yes, please explain: _____

18. Does the hospital rent or lease any equipment from an outside vendor? Yes No
 If yes, please explain: _____

19. Does the hospital conduct formal clinical research under the auspices of an Institutional Review Board (IRB)?
 If yes, Internal IRB External IRB

B. Excess Automobile Liability:

Vehicle Type	Service Radius (in miles per vehicle)	Number of Urban Use Vehicles	Number of Non Urban Use Vehicles	Used for Patient Transport?
Private Passenger Delivery				<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Passenger Service				<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Passenger Other				<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Ambulance				<input type="checkbox"/> Yes <input type="checkbox"/> No
Non Emergency Van (< 8 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Non Emergency Van (8-15 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Delivery				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Service				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Other				<input type="checkbox"/> Yes <input type="checkbox"/> No
Medium Truck				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bus (15-30 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bus (> 30 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Hired & non-Owned Autos				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____				<input type="checkbox"/> Yes <input type="checkbox"/> No

C. Employer's Liability and Employee Benefit Liability:

- Number of employees: _____
- Are employee benefits self-administered? Yes No
 If not, are they administered by an outside vendor? Yes No
 If yes, what is the name of the vendor: _____

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A

POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.”

NOTICE TO DISTRICT OF COLUMBIA 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.”

NOTICE TO FLORIDA APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.”

NOTICE TO KENTUCKY APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.”

NOTICE TO LOUISIANA APPLICANTS: “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.”

NOTICE TO MAINE APPLICANTS: “IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A 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 MEXICO APPLICANTS: “ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.”

NOTICE TO NEW YORK 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, 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 SUCH VIOLATION.”

NOTICE TO OHIO APPLICANTS: “ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.”

NOTICE TO OKLAHOMA APPLICANTS: “WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY” (365:15-1-10, 36 §3613.1).

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 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 VIRGINIA APPLICANTS: “IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.”

Signature of Applicant: _____
(must be an officer or principal of the Insured)

Print Name: _____

Title: _____

Date: _____

Signature of Producer: _____

Print Name: _____

Company: _____

License #: _____

Date: _____

NJ SLA# (if a NJ Risk): _____

Broker responsible for Surplus Lines
Filings Agreement: _____