



Facility Application

1. Name and Mailing Address of Facility:

2. Agent: _____

Contact Person: _____

Phone: _____

Fax: _____

E-Mail: _____

Website: _____

3. Tax ID: _____

4. License No. _____

5. Type of Coverage: Claims-Made Positive Protection Occurrence

6. Requested effective date: _____

7. Retroactive date: _____

8. Limits of Liability: \$1,000,000/\$3,000,000 \$2,000,000/\$4,000,000

9. Number of locations: _____, **(please attach a schedule)**

	past 12 months	projected next 12 months
10. Patient Visits	_____	_____

11. Gross receipts:	_____	_____
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12. Payroll:	_____	_____
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13. Hours of Operation: _____

14. Describe the type of organization and ownership:

Professional Association Partnership Corporation

For Profit Not for profit Community Clinic

Other _____

15. Are there subsidiaries that are to be included in this coverage?

If yes, please provide the name and relationship.

16. List all members, partners, or stockholders. Indicate which ones work at the organization and their positions.

17. Is coverage desired for staff of this organization? Yes No

If yes, complete Appendix A, - Staff schedule of this application

If no, are employees required to carry their own coverage? Yes No

If yes, will the staff share the limits of insurance with the organization? Yes No

If employees maintain their own insurance, at what limits? \$ _____

Do you require proof of insurance? Yes No

18. How long has the organization been in business? _____ years _____ months

19. Has the organization ever been sued or have any claims been made against it? Yes No

If yes, attach a copy of insurance company's loss run(s)

20. Name of the current professional liability insurance carriers: _____

Attach a copy of the declarations page showing, retroactive date, limits of liability, policy period, and endorsements

21. Has your professional liability insurance ever been cancelled or non-renewed? Yes No

If yes, why and when? _____

22. Are procedures in place for patient transfers to another facility in the even of an emergency: Yes No

If yes, please describe:

23. Are medications administered? Yes No

If yes, by whom? _____

24. Do you provide any services over the internet? Yes No

25. Do you treat patients from or at a correctional facility: Yes No

26. Are physicians' services rendered? Yes No

If yes, are the physicians?

- private physicians
- contracted physicians
- employed physicians

27. Are you accredited by any nationally recognized accrediting agency? Yes No

If yes, please list the agency: _____

If no, explain why the organization didn't apply or why it was not eligible.

28. Are you licensed by the NJ Department of Health and Human Resources: Yes No

29. List names of employed personnel who are certified in CPR or ALCS.

30. Does the organization have a written Quality Assurance/Risk Management Program? Yes No

31. Name of designated Risk Manager: _____
Phone: _____

32. Does the facility have any non-expendable medical or surgical machines or services that are used for diagnostic or treatment procedures by individual other than members of your organization? Yes No

33. Do you sell or lease any medical equipment or other product in connection with your operation? Yes No
If yes, please describe:

34. If you lease equipment to others, do you provide maintenance on the equipment? Yes No
If yes, please describe:

35. Do you participate as a principal investigator for any clinical trials? Yes No
If yes, do you follow FDA – approved protocols? Yes No
If yes, please explain on a separate sheet of paper.

Signature

This section must be completed by all applicants.

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind Positive Physicians Insurance Exchange to complete the insurance, but it is agreed that this application shall be the basis of contract should a policy be issued. I authorize release and exchange of any underwriting or claims information between all prior carriers and Positive Physicians Insurance Exchange. I understand that Positive Physicians Insurance Exchange reserves the right to reject any applicant that does not meet its underwriting standards.

Signature of Applicant _____ Date _____
Officer of Organization

List all other staff

Name	Position	Date of hire	Average # of hours per week

Signature: _____ Date: _____