CapSpecialty
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CAPITOL SPECIALTY INSURANCE CORPORATION | A Stock Company
P. O. Box 5900 | Madison, WI 53705-0900 | CapSpecialty.com

HEALTHCARE ORGANIZATIONS PROFESSIONAL LIABILITY APPLICATION

INSTRUCTIONS

- ***Answer ALL questions completely, leaving no blanks. If any questions, or any part thereof, do not apply, print "N/A" in the appropriate space.***
- ***This Application must be completed and signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application.***

SUPPORTING DOCUMENTATION REQUIRED

Along with this completed and signed application, the applicant must also submit the following:

- Five (5) years of loss information. (For losses exceeding $50,000 in value or involving loss of life, physical or sexual abuse or professional liability, please attach a detailed description of each loss/incident and describe corrective measures taken or lessons learned.)
- Provide copies of any descriptive brochure or narrative describing operations or website.
- Financial Statements— if organization is a for-profit entity.
- Completed and signed Supplemental Applications.

I. GENERAL APPLICANT INFORMATION

1.1	First Named Insured:	☐ For-Profit ☐ Not-For-Profit
	DBA:	Website:
	Address:	Phone Number:
	City, State, Zip:	County:
1.2	Risk Management Contact Name*: *Please note that this person may be contacted about Risk Management Services offered by or through the Insurer.	Title:
	Email Address:	Phone Number:
1.3	Year Established: ***If less than three (3) years in business, attach a copy of director's resume.***	Years Under Current Management:
1.4	Accreditation(s): ☐ JCAHO ☐ CARF ☐ COA ☐ Other, describe:	
	Professional Organization memberships or affiliations:	
1.5	Name of Applicant's Medical Director/Manager?	Number of Years of Management Experience: Number of Years Managing Applicant Facility:
1.6	Describe Applicant's medical services and types of patients served (attach brochure(s) if available):	
1.7	Total number of staff (including office, janitorial, maintenance, etc.): Full Time Part Time	
1.8	Does Applicant and all healthcare providers employed by and contracted by Applicant have all required licenses?	☐ Yes ☐ No ☐ N/A
1.9	Has Applicant's or any healthcare provider's license ever been revoked or suspended, or is any license proceeding pending that could result in revocation or suspension?	☐ Yes ☐ No ☐ N/A
	If yes, please explain:	
1.10	Has Applicant ever been investigated, audited or inspected by any governmental agency, insurance company or independent inspection firm?	☐ Yes ☐ No
	If yes, please provide details in an attachment, and a copy of the inspection report or other pertinent documentation. Include any deficiencies found, and corrective actions taken.	
1.11	Have there ever been any suits, legal proceedings or other claims against Applicant or any healthcare provider of Applicant that allege professional negligence or failure to comply with any regulatory or licensing standards or guidelines?	☐ Yes ☐ No
1.12	Have there ever been any complaints filed against Applicant or any healthcare provider of Applicant with any regulatory or licensing body?	☐ Yes ☐ No
	If yes to *1.11* or *1.12*, please provide details in an attachment.	
1.14	Has Applicant discontinued any medical services or sold any operations in the last five (5) years?	☐ Yes ☐ No
	If yes, please explain:	
1.15	Has Applicant acquired any medical operations or entities in the last five (5) years?	☐ Yes ☐ No
	If yes, please provide details in an attachment.	
1.16	Does Applicant act as a managed care organization or gatekeeper? For the above, a "gatekeeper" means an individual or entity which is responsible for managing a patient's treatment, and thus refers the patient to doctors and specialists (usually within a plan network).	☐ Yes ☐ No
1.17	Does Applicant lease or rent any properties or office space to third parties?	☐ Yes ☐ No

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	If yes, does Applicant obtain certificates of insurance from such parties evidencing General Liability coverage and Property coverage for such property or space?	☐ Yes ☐ No
1.18	Does Applicant have any plans for renovations or new construction at its business facilities in the next 12 months?	☐ Yes ☐ No
	If yes, please explain:	

II. PATIENT PROFILE

2.1	What is the total number of patients served annually?
2.2	Please provide the percentage of Applicant's total patients served annually at each age range listed below (total must equal 100%): Children (1-12 years): % Teenagers (13-17): % Adults (18-64): % Senior (65+): %
2.3	What is the total number of 65+ patients served annually?
2.4	What is the total number of non-ambulatory patients served annually?
2.5	What is the total number of patients with Alzheimer's and Dementia annually?
2.6	What is the total number of medically fragile patients served annually?

III. REVENUE INFORMATION

3.1	Fiscal Year End Date:	Annual Revenue: $	Annual Payroll: $	
3.2	Does Applicant sell any goods, products or services to third parties? (If yes, please fill in details below)			☐ Yes ☐ No
	Goods/Products	Annual Receipts: $	Description:	
	Services	Annual Payroll: $	Description:	

IV. CURRENT / PRIOR COVERAGE

Please provide the requested information below for Applicant's current insurance coverage.

4.1	**Current Coverage Type(s)**	**Per Occ. / Per Claim Limit**	**Aggregate Limit**	**Retroactive Date**	**Claims-Made?**	**Current Annual Premium**
	Professional Liability	$	$		☐	$
	General Liability	$	$		☐	$
	Abuse & Molestation Liability	$	$		☐	$
	Employee Benefits Liability	$	$		☐	$

4.2	Is any Extended Reporting Period currently in force?	☐ Yes ☐ No
	If yes, indicate the coverage it applies to, and provide the duration and expiration date of the extended reporting period:	
4.3	Has Applicant ever applied for Professional Liability Insurance or any similar type of insurance coverage and been denied, cancelled or non-renewed? (**NOT APPLICABLE TO MISSOURI APPLICANTS.**)	☐ Yes ☐ No
4.4	Is Applicant aware of ANY claims, suits, proceedings, investigations, complaints or allegations of negligence or misconduct (including those of abuse or molestation) made against Applicant organization, or against anyone working on Applicant's behalf, brought or made against any proposed insured in the past five (5) years?	☐ Yes ☐ No
	If yes, please provide details in a separate attachment, including dates, current status, amount paid/incurred, and resulting organizational/policy changes implemented as a result.	

V. OPERATION SAFETY PRACTICES

5.1	Does Applicant have sign-in / sign-out procedures for: ☐ Staff ☐ Patients ☐ Visitors/Public	
5.2	Type(s) of security provided for patients: ☐ Guards ☐ Cameras ☐ Other:	
5.3	Does Applicant have a committee in place that reviews and investigates all incident reports to determine whether any action, including correction action, should be taken?	☐ Yes ☐ No
5.4	Does Applicant have an enterprise-wide media plan in place for emergencies?	☐ Yes ☐ No
5.5	Does Applicant have a plan for medical emergencies?	☐ Yes ☐ No
5.6	Is there always someone on premises who is trained in CPR and First Aid?	☐ Yes ☐ No
5.7	Does Applicant have a written and enforced "No Smoking" policy?	☐ Yes ☐ No

VI. AUTO EXPOSURE

6.1	Does Applicant purchase a Business/Commercial Auto Liability Policy for the purpose of covering owned auto(s)?	☐ Yes ☐ No
6.2	Does Applicant transport clients?	☐ Yes ☐ No
	If yes, please provide details:	
	How many clients does Applicant transport weekly?	
6.3	Does Applicant require that its drivers have at least three (3) years of driving experience before being allowed to transport clients?	☐ Yes ☐ No

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6.4 What is the total number of individuals in each category who drive autos on the Applicant's behalf for business purposes?

Staff Type	Number of Drivers
Employees	
Independent Contractors	
Officers	
Partners	
Volunteers	
Other, please describe:	
Total Number of Drivers	

6.5 Please complete the schedule below. Indicate what evidence of auto insurance the Applicant requires when employees/independent contractors/volunteers use their personal vehicle for business purposes. Also indicate, for each category, what Applicant requires for minimum auto insurance Limits of Liability on personal vehicles used for business purposes.

Staff Type	Evidence of Auto Insurance		Minimum Insurance Requirements
Employees	☐ None ☐ Certificate of Insurance ☐ Other, please explain:	☐ Copy of Auto ID Card ☐ Copy of Auto Policy	☐ Not Required ☐ Statutory, if checked: $ per person/$ per accident ☐ Other, please explain:
Independent Contractors	☐ None ☐ Certificate of Insurance ☐ Other, please explain:	☐ Copy of Auto ID Card ☐ Copy of Auto Policy	☐ Not Required ☐ Statutory, if checked: $ per person/$ per accident ☐ Other, please explain:
Volunteers	☐ None ☐ Certificate of Insurance ☐ Other, please explain:	☐ Copy of Auto ID Card ☐ Copy of Auto Policy	☐ Not Required ☐ Statutory, if checked: $ per person/$ per accident ☐ Other, please explain:

6.6 Does Applicant have a formal written policy that addresses acceptable use of personal, company-owned or rental vehicles for business purposes, acceptable driving records, and safety practices and procedures? ☐ Yes ☐ No

6.7 Does Applicant review the Motor Vehicle Records (MVRs) of applicants for employment or others prior to hiring or retaining them for a position that requires them to drive a vehicle for business purposes? ☐ Yes ☐ No

6.8 Does Applicant review the MVRs of its drivers at least annually? ☐ Yes ☐ No

If yes, does Applicant have procedures in place for responding to unacceptable MVRs, including termination of employment? ☐ Yes ☐ No

VII. PROFESSIONAL LIABILITY

7.1 Does Applicant require staff (paid and volunteer) to complete an employment application? ☐ Yes ☐ No

7.2 Does Applicant conduct a personal interview for each prospective staff member? ☐ Yes ☐ No

7.3 Does Applicant verify employment-related references? ☐ Yes ☐ No

7.4 Does Applicant verify licenses and other credentials for professional staff? ☐ Yes ☐ No

7.5 Does Applicant obtain a criminal background check on all staff members (paid and volunteer) prior to hiring? ☐ Yes ☐ No

If yes, are negative findings considered in the decision to employ? ☐ Yes ☐ No

7.6 Does Applicant require drug tests on all staff members, including drivers? ☐ Yes ☐ No

If yes, check all that apply: ☐ Before Hiring ☐ After Hiring ☐ Random

What actions does Applicant take, if any, if these reports are unfavorable?

7.8 Are files maintained in a manner to protect the confidentiality of patients and HIPAA compliant? ☐ Yes ☐ No

7.9 Does Applicant provide or utilize telemedicine or telehealth services? ☐ Yes ☐ No

a. What percent of Applicant's total operations? %

b. Please provide complete description of the services provided:

7.10 Does Applicant operate any free or federally-funded public health clinic? ☐ Yes ☐ No

If yes, do all such clinics qualify for FTCA (Federal Tort Claims Act) Program Coverage? ☐ Yes ☐ No

Please explain deemed services:

7.11 Does Applicant dispense medications? ☐ Yes ☐ No

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	a. Are all medications stored under lock and key? If no, please explain:	☐ Yes ☐ No
	b. Which staff members have the authority to dispense medications?	
	c. Are over-the-counter medicines dispensed to patients without written permission from a physician?	☐ Yes ☐ No
	d. Does Applicant maintain a written or electronic medication log for each client?	☐ Yes ☐ No
7.12	Are contracted professionals used by Applicant?	☐ Yes ☐ No
	a. Does Applicant require them to sign a Hold Harmless or Indemnification agreement in favor of Applicant?	☐ Yes ☐ No
	b. Are Certificates of Insurance evidencing professional liability coverage required and kept on file for those contracted professionals?	☐ Yes ☐ No
	If yes, what are the minimum limits that are required? $ Each Claim $ Aggregate	

VIII. PROFESSIONAL STAFF

8.1 Please complete the schedule below for all Physicians, Surgeons, Medical Residents, Medical Interns/Externs, Certified Registered Nurse Anesthetists, Nurse Midwives, Podiatrists or Dentists contracted or employed by Applicant. If necessary, provide information in a separate attachment:

	#1	#2	#3	#4
Name				
Specialty				
Employed or Contracted	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted	☐ Employed ☐ Contracted
DEA License	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Years in Practice				
Average Number of Hours working per week for Applicant				
Board Certified	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Does Professional carry his/her own medical malpractice insurance?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, does it provide coverage for his/her conduct while providing services for or on behalf of Applicant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Have any claims, suits, proceedings or investigations related to this Professional been brought in the past five (5) years?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

8.2 Please complete the schedule below indicating the number of all staff, as well as the other information requested. Do not include the staff already listed in question *8.1* above.

Staffing Position	**Number of Employees**		**Number of Contractors**		**Number That Carry Their Own Insurance Coverage**		**Total Number of Hours Worked Annually**	**Annual Payroll (or IRS Form 1099 amount)**
	Full Time	**Part Time**	**Full Time**	**Part Time**	**Yes**	**No**		
Case Manager/Counselor								
Chiropractor								
Clerical/Office Staff								
CNA								
Home Health Aid								
Medical Director (Admin Only)								
Medical Technician								
Nurse Practitioner								
Nurse - RN, LPN								
Nutritionist/Dietician								
Optometrist								
Pharmacist								
Pharmacy Assistant/Tech								
Physician Assistant								
Psychologist								
Social Worker								
Teacher								
Therapist – Occupational								
Therapist – Physical								
Therapist – Recreational								

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Staffing Position	Number of Employees		Number of Contractors		Number That Carry Their Own Insurance Coverage		Total Number of Hours Worked Annually	Annual Payroll (or IRS Form 1099 amount)
	Full Time	Part Time	Full Time	Part Time	Yes	No		
Therapist – Respiratory								
Therapist – Speech								
Other, specify:								
Other, specify:								
Totals								

IX. ABUSE AND MOLESTATION ☐ N/A

9.1	Does Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex-related offense, before an offer of employment is made?	☐ Yes ☐ No
9.2	Is there a written supervision plan that monitors staff in day-to-day relationships with patients both on and off premises?	☐ Yes ☐ No
9.3	Has Applicant organization ever had an incident which resulted in an allegation of sexual abuse or molestation?	☐ Yes ☐ No
	a. Please describe incident:	
	b. What procedures where put in place to prevent future reoccurrence?	
9.4	Does Applicant have a written crisis management plan in place for dealing with employees, victims, parents and the media if there is an incident of abuse?	☐ Yes ☐ No
9.5	Does Applicant have procedures in place to make sure no relationship occurs between staff and patients?	☐ Yes ☐ No
9.6	Are there written procedures and documented training for staff and volunteers on recognizing the signs of physical, sexual and emotional abuse?	☐ Yes ☐ No
9.7	Does Applicant have procedures in place to avoid one-on-one situations, so that more than one employee or volunteer is present at all times when a child is in Applicant's care?	☐ Yes ☐ No ☐ N/A
9.8	Is there more than one person responsible for the welfare of any single patient?	☐ Yes ☐ No
9.9	Have any of Applicants current or former employees been the subject of a child abuse/neglect investigation?	☐ Yes ☐ No
	If yes, what were the results of the investigation?	
9.10	Does Applicant run criminal background checks, prior to employment or volunteering, on all: Employees: / Volunteers:	Employees: ☐ Yes ☐ No Volunteers: ☐ Yes ☐ No ☐ N/A

X. IN-HOME CARE (SERVICES PROVIDED IN CLIENT'S HOME) ☐ N/A

10.1	Please provide Applicant's annual payroll for staff (employees and independent contractors) providing in-home services: $	
10.2	Are any one-on-one in-home services provided to children without a parent/guardian present?	☐ Yes ☐ No
10.3	Does Applicant sell and/or rent medical equipment to patients?	☐ Yes ☐ No
	If yes, provide Applicant's annual receipts for: Sales: $ Rentals: $	
10.4	Does Applicant have documented procedures and methods in place to prevent theft of valuables from a patient's home?	☐ Yes ☐ No
10.5	Does Applicant have a Commercial Crime Bond that covers loss or theft of client valuables by staff?	☐ Yes ☐ No
10.6	Are all staff that provide in-home services CPR certified?	☐ Yes ☐ No
10.7	Are all home visits documented by staff?	☐ Yes ☐ No
	a. Is documentation periodically audited to ensure complete and detailed record-keeping?	☐ Yes ☐ No
	b. How is staff monitored?	

XI. CLAIMS AND INCIDENTS

Please respond to the following questions to the best of your knowledge and belief, after conducting due diligence and inquiry with any individuals who may have knowledge or information about the matters described below.
The term "Applicant" as used below, means any proposed insured, including any individual or entity for whom coverage is sought.

11.1	During the past five (5) years, has Applicant received notice of any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured, relating to the coverage sought under the policy applied for?	☐ Yes ☐ No

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11.2	During the past five (5) years, has Applicant, or any agent on its behalf, given written notice to any current or prior professional or general liability insurance carrier of: a. Any claim, suit, legal proceeding, or regulatory proceeding or investigation, or licensure action or investigation against or involving any proposed insured? b. Any facts, circumstances or situations, which might give rise to a claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured?	☐ Yes ☐ No ☐ Yes ☐ No
11.3	Is Applicant aware of any facts, circumstances, situations, transactions, events, acts, errors or omissions which could reasonably be expected to give rise to a claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation, against or involving any proposed insured, relating to the coverage sought under the policy applied for?	☐ Yes ☐ No
11.4	During the past five (5) years, has any proposed insured had a professional license or certification suspended or revoked?	☐ Yes ☐ No

The policy applied for, if issued, will not insure: any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation disclosed, or which should have been disclosed, in response to the above; or any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation that arises from any fact, circumstance, situation, transaction, event, act, error or omission disclosed, or which should have been disclosed, in response to the above.

XII. FRAUD WARNINGS

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 and subjects that person to criminal and civil penalties.

- **(Not applicable in AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, VT, WA and WV).**

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

APPLICABLE IN CO

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 Agencies.

APPLICABLE IN FL AND OK

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 (of the third degree)*. *Applies in FL only.

APPLICABLE IN KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KY, NY, OH AND PA

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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

APPLICABLE IN ME, TN, VA AND WA

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 and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

APPLICABLE IN VT

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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XIII. REPRESENTATIONS AND SIGNATURE

By signing this Application, the undersigned represents and agrees, on behalf of Applicant and all proposed insureds, to the following

a. ***After conducting due diligence, the statements and answers furnished to the Company in this Application are accurate and complete to the best of Applicant's knowledge;***
b. ***Those statements and answers furnished to the Company are representations Applicant makes on behalf of all proposed insureds;***
c. ***Those representations are a material inducement to the Company to provide a Quotation;***
d. ***If a policy is issued, the Company will have issued that policy in reliance upon those representations;***
e. ***If there is any material change in the Applicant's condition, activities or services, or in the statements or answers provided in this Application, that occurs or is discovered between the date this Application is signed and the effective date of any policy, if issued, Applicant agrees to immediately notify the Company in writing; and***
f. ***The Company reserves the right, upon receipt of such notice, to modify or withdraw any Quotation previously offered by the Company.***

As used above, the term "Company" refers to Capitol Specialty Insurance Corporation.

NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED TO APPLICANT, OR THAT ANY PERSONS, EVENTS OR OTHER SPECIFICS REFERENCED IN QUESTIONS, OR ANSWERS TO QUESTIONS, WILL BE COVERED UNDER ANY POLICY BOUND OR ISSUED TO APPLICANT.

This Application must be signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application.

Signature of Authorized Representative of Applicant	**Title**
Type / Print Name	**Date**
E-mail Address of Authorized Representative	

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