IRONSHORE your safe harbour	IRONSHORE COMPANIES 175 Powder Forest Drive Weatogue, CT 06089	Federally Supported Health Centers Professional and General Liability Application

NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE.

APPLICANT			
Legal Name:		Telephone No:	( ) -
Address:			
City:	County:	State:	ZIP:
Years in Operation:	Years Under Present Ownership:		
FTCA:	Years of Continuous Deemed Status:		
Website: www.			
Executive Director or Administrator:	Phone Number:	Number of Years:	
Please list all affiliates and subsidiaries to which this insurance is to apply. Please include a complete description of the operations of each affiliate or subsidiary, and the relationship to the Applicant. (Attach a separate sheet, if necessary):			

COVERAGE STRUCTURE:		
Requested Coverage:	☐ PL ☐ GL ☐ EBL Effective Date:	Retroactive Date:
Per Claim Limit:		
Aggregate Limit:		
Per Claim Deductible:		
Current Coverage	☐ PL ☐ GL ☐ EBL	
Carrier		
Policy Period		
Limits		
Deductible		

GENERAL INFORMATION: *(check all that apply)*			
☐	Corporation	☐	For Profit
☐	Partnership	☐	Not for Profit
☐	Municipal		
☐	Other		

Licensed as:	
Professional and industry association affiliations:	
Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency?	☐ Yes ☐ No
If "Yes", please explain:	
Is any part of the Applicant operated/leased by a management corporation?	☐ Yes ☐ No
If "Yes", please give the name of the corporation and details of structure. Please attach a separate sheet of paper if necessary.	

PERSONNEL:

Indicate the number of persons employed by or working under the control of the Applicant in each of the following classifications:

Classification	FTE's	Classification	FTE's	Classification	FTE's
Physicians		Nurse Practitioners		Psychologists	
Dentists		Optometrists		RNs / LPNs / LVNs	
CRNAs		Pharmacists		Social Workers	
EMTs / Paramedics		Physician Assistants		Therapists Occupational / Speech / Physical	
Nurse Midwives		Podiatrists		Other:	

Is this insurance to apply to all persons indicated above? If not, please explain:

Are all providers indicated above covered under the FTCA? ☐ Yes ☐ No
If not, please explain and provide the names of the individuals who do not have FTCA protection on a separate sheet:

OPERATIONS:

SERVICES (Please provide average number of visits in each category)

	Projected	Current Year
Deliveries (excluding C-Sections and VBAC's)		
Cesarean Sections		
VBACs		
Outpatient Surgeries		
Other Outpatient Visits		
Psychiatric Visits		

Alcohol / Drug Abuse Visits			
Clinic Visits			
Rehabilitation Visits			
Home Health Care			
Reference Lab			
Other:			

TOTAL number of outpatient visits provided during the current year:
TOTAL number of outpatient visits projected for next year:

STAFF PRIVILEGES:	
Are credentials for new staff members checked and approved prior to granting staff privileges?	☐ Yes ☐ No
If "No", please explain:	
Does the Applicant have any staff members who have restricted licenses or privileges?	☐ Yes ☐ No
If "Yes", please explain:	
Are all staff privileges reviewed at least every two (2) years?	☐ Yes ☐ No
Does the Applicant require all foreign school graduates to be certified by the Educational Council for Foreign Medical School graduates?	☐ Yes ☐ No
Are all staff members required to maintain professional liability insurance?	☐ Yes ☐ No
Limits of liability required:	

RISK MANAGEMENT:	
Is there a written, formalized risk management program?	☐ Yes ☐ No
Name of person in charge of implementing your risk management program:	
Do you require staff to report all incidents or unexpected patient outcomes, which might result in a liability claim?	☐ Yes ☐ No
Are all records of incident reports kept on file?	☐ Yes ☐ No

CONTRACTUAL AGREEMENTS:	
Do you enter into any contracts to provide professional health care services? If "Yes", provide a list of contracting parties and services provided to each:	☐ Yes ☐ No
Does the Applicant require these contractors to provide evidence of insurance?	☐ Yes ☐ No
If "Yes", what limits of liability does the Applicant require?	
Are there any other service contracts in effect?	☐ Yes ☐ No

If "Yes", please describe services:	
Does the Applicant indemnify (hold harmless) the service provider?	☐ Yes ☐ No
Do you rent or provide any equipment or products to others? ☐ Yes ☐ No If "Yes", describe and indicate the estimated annual receipts of each.	
Do you have an obligation to include your landlord or any other entity or organization as an Additional Insured? ☐ Yes ☐ No If "Yes", list name, address, and insurable interest or reason on a separate sheet.	

PHYSICAL PREMISES:

Please indicate below all the buildings the Applicant owns, controls or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. Please attach a separate schedule, if more space is needed.

	Address:				Year Built:	
	Construction (brick, fire-resistive, etc.)		No. of Stories:		Total Sq. Feet:	
	Use:		Inpatient / Outpatient:			
	Address:				Year Built:	
	Construction (brick, fire-resistive, etc.)		No. of Stories:		Total Sq. Feet:	
	Use:		Inpatient / Outpatient:			
	Address:				Year Built:	
	Construction (brick, fire-resistive, etc.)		No. of Stories:		Total Sq. Feet:	
	Use:		Inpatient / Outpatient:			

Are all locations deemed as FTCA covered health centers? ☐ Yes ☐ No
If not, please explain and identify the locations that do not have FTCA protection on a separate sheet.

COVERAGE: (MISSOURI RESIDENTS DO NOT ANSWER)

Past coverage:	Has any insurer canceled or declined to renew professional liability coverage? ☐ Yes ☐ No
Claims / Incidents:	Please attach a loss run describing all claims/incidents during the past 5 years made against the Applicant or any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. (Attach additional sheets, if necessary). If answer is "none", so state:
	Neither the Applicant nor any individual or entity proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is "none", so state:

ADDITIONAL INFORMATION:
Please disclose any information material to the risk which has not otherwise been addressed in this application (please attach additional sheets of paper if necessary). Please provide the following information: 1. Loss history for the last five (5) years, including any claim paid or outstanding. Detailed losses should be provided including any paid or reserved amounts for both indemnity and defense expenses. Losses should be valued no earlier than ninety (90) days prior to the proposed effective date. 2. Physician, Surgeon and Dentist Application for each non-employed provider to which this insurance is to apply. 3. Copy of the current FTCA deeming letter. 4. Copy of expiring Medical Professional Liability insurance policy.

THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER'S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLEE THE INSURANCE OR ISSUE A POLICY.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AN DWITH 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 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 KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICETO MENNESOTA, OHIO, AND ARKANSAS APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATION A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AN DWITH 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.

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 FAC TMATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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 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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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.

Applicant (signature):		
By (Executive Director – Print Name)	Title:	Date:

NOTE: This Application must be signed by the Executive Director of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.