



Malpractice Insurance For Professional Healthcare Groups

- 1) Please print a copy of this application to your desktop printer.
- 2) Complete this hard copy by hand, answering all questions
- 3) Sign, date and either:
 - a. Mail your completed application providing your credit card information OR with check payable to:
**CM&F Group, Inc., 99 Hudson Street, 12th Floor,
New York, NY 10013**
 - OR
 - b. Fax your signed and completed application providing your credit card information (per the application) to CM&F Group, Inc. at (212) 608.4378
- 4) Once your application is processed & approved, your policy will be mailed within 5-7 business days. Your payment — whether by check or credit card – will NOT be processed until your coverage has been approved.

Mail Completed Application To:
CM&F Group, Inc.
99 Hudson Street, 12th Floor
New York, New York 10013-2815
(212)233-8911 (800)397-3008 Ext.105
Fax (212)608-4378
info@cmfgroup.com

Coverage provided by
Lexington Insurance Company
Wilmington, Delaware
100 Summer Street, Boston, MA 02110-2103
(A Capital Stock Insurance Company)

Producer Code _____

ALLIED HEALTHCARE PROVIDER GROUP APPLICATION

All questions must be answered completely.

The application and all supplemental forms must be signed and dated by the applicant.

INSTRUCTIONS

- 1) Please type or print clearly.
- 2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Applicable).
- 3) If you need more space for your responses, continue on a separate sheet with company letterhead and indicate question number.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED

- LOSS HISTORY – Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.

If you have no claims, initial here: _____

Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? Yes No

If yes, give dates, allegations and disposition of each claim or suit on a sheet with company letterhead.

- Copies of most recent accreditation and inspection reports within the past three years

- Copies of current marketing materials pertaining to your services provided

GENERAL INFORMATION

Name of the Allied Healthcare Provider GROUP: _____

Date of GROUP Establishment: _____ E-Mail Address: _____

Website Address: _____ Telephone Number: _____

Business Address: _____

City: _____ County: _____ State: _____ Zip: _____

Practice Administrator Name/Title: _____

Requested Effective Date: _____

Requested Coverage:

RETRO DATE

Professional Liability Claims-made _____ Occurrence

Commercial General Liability Claims-made _____ Occurrence

Requested Limits of Liability – Primary:* \$1,000,000/\$3,000,000 Other

**Professional Liability and General Liability Limits must be the same, but apply separately.*

Deductible: (applies separately to Professional Liability and General Liability) \$0 \$2,500

\$5,000 \$10,000 Other

COMPANY OVERVIEW

1. Description of Operations: _____

2. What is the professional specialty of the group? _____

3. How many locations do you have? _____

4. If more than (1) location or different from business address provided – please list:

Name of Location	Address	Description of Operations

5. Are your locations part of a franchise? Yes No

6. Do you sell products? Yes No

7. EXPOSURE INFORMATION

Breakdown of Total Number of Healthcare Professionals:

Employee Type	Number Full Time	Number Part Time
Registered Nurse		
Certified Registered Nurse Anesthetist		
Perfusionist		
Physical Therapist		
Occupational Therapist		
Respiratory Therapist		
Dietitian		
Nutritionist		
Medical Assistant		
Massage Therapist		
Wellness Counselor		
Colon Hydro Therapist		
Other (Define)		

8. List the number of outpatient visits per year:

Prior Year	Current	Projected 12 Months

9. Practice Settings: Locations where services are provided.

- Outpatient Clinic _____%
- Patient Home _____%
- Hospital _____%
- Nursing Home _____%
- School _____%
- Correctional Facility _____%

Other: Describe _____

10. Does your group practice have a Medical Director? Yes No

If yes, does the Medical Director have direct patient contact? Yes No

11. Does the group practice operate a (check all that apply) Radiology Center Surgical Center Urgent Care Center

Pharmacy Other Miscellaneous Facility

(Describe) _____

12. Do you require coverage for any physicians? Yes No If Yes, list number: _____

RISK MANAGEMENT/LOSS CONTROL

1. Is the practice accredited by a national healthcare accreditation BODY (AAAHC, AAAASF)? Yes No

If yes, please specify _____

2. Has the group practice, any of its members, or any employees:

a. Ever been the subject of disciplinary or investigative proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? Yes No

b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No

c. Ever had any state professional license or license to prescribe or dispense narcotics refused, reduced, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No

d. Ever had privileges reduced, suspended or revoked? Yes No

e. Ever been denied a license or certification to practice? Yes No

f. Ever had Medicare or Medicaid authorities initiate and investigate for alleged billing fraud and abuse? Yes No

3. Does the applicant verify pending license suspensions, revocations or pending disciplinary actions? Yes No

4. Is there a written plan of care developed for each patient? Yes No

5. Is there a formal quality improvement/clinical safety program? Yes No

a. Written policies and procedures for FALLS Prevention? Yes No

b. Written policies and procedures for BURNS Prevention? Yes No

c. Written policies and procedures for INFECTION CONTROL? Yes No

d. Are Safety Rounds conducted at least monthly? Yes No

6. Are federal criminal background screens and a review of the national sex offenders database completed before new staff are permitted to start working? Yes No

7. Is there a formal referral process in place for those patients who require additional clinical assessment, diagnosis and treatment?

Yes No

8. Do you have a formal preventative maintenance program for all biomedical equipment that includes:

- a. Proper training of all equipment users? Yes No
- b. Controls over staff owned equipment? Yes No N/A
- c. Repairs by qualified personnel? Yes No
- d. Policies and procedures for borrowing, lending, selling or donating equipment? Yes No N/A
- e. Documentation of all activities (preventive maintenance, repairs, education)? Yes No N/A

9. Do you have a documented electrical safety program to test electrical current to electric equipment immediately prior to use?

- Yes No

HISTORICAL CARRIER INFORMATION

Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

	Policy Period	Insurer	Premium	Limits	Attachment	CM (w/ Retro) Or Occurrence
PRIMARY						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. ANY MATERIAL MISSTATEMENTS AND/OR OMISSIONS MAY RESULT IN RESCINDED COVERAGE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THE EARLIEST EFFECTIVE DATE FOR WHICH A POLICY MAY BE ISSUED IS THE DATE THIS APPLICATION IS RECEIVED IN OUR OFFICE.

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA 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 ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

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 MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY 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 MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

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 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, 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 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 OREGON 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 TENNESSEE, VIRGINIA AND WASHINGTON 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.

NOTICE TO VERMONT 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Applicant's Signature: _____
(MUST BE OFFICER OR PRINCIPAL OF GROUP)

Title: _____

Date: _____

Name of Agent: _____

Submitted by: _____

Date: _____

Address: _____

License #: _____

Program Administered By:

CM&F Group, Inc.
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New York, NY 10013
Ph: (212) 233-8911 or (800) 221-4904
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