



Healthcare Facility Liability Protection Renewal Application

Name of Applicant: _____ **Policy Number:** _____
 (Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

A. General Information

1. Please use the Comments section to advise us of any changes to the contact information we have for you including the following:

- Address Phone/Fax Number Email Address Contact Person

2. Please use the Comments section to advise us of any desired changes to your insurance program including the following:

- Deductible Limits Umbrella Coverage Physician Coverage Other

For the following questions, please explain all "yes" answers in the Comments section.

3. Have there been any changes to the Applicant's operation within the past 12 months related to the following?

- Obtaining another operation/entity? Yes No
- Selling or discontinuing any operation/entity? Yes No
- Adding or reducing the number of employees? Yes No
- Adding or reducing the number of locations? Yes No
- Adding or reducing current services? Yes No
- Operating in new states? Yes No
- Entering into any joint ventures or limited partnerships? Yes No
- New construction or renovation projects? Yes No

4. Are future operational changes anticipated related to the items listed in question #3? Yes No

5. Have there been any changes to the Applicant's additional named insureds? Yes No

6. Does the Applicant provide management services to other entities for a fee? Yes No

7. Does the Applicant sell or rent any equipment to others? Yes No

8. Has the Applicant employed any new physicians in the past 12 months that are not currently listed on the schedule? If yes, please complete an individual application for each person. Yes No

9. Please specify exposure information based upon the following:

Type	Number	Exposure
Total Number of Employees	_____	Employees
Adult or Child Care Center	_____	Individuals
Vacant Land	_____	Acres
Pay Parking Areas	_____	Revenue
Fitness Center Open to the Public	_____	Revenue
Total Annual Revenue – Most Current 12 Months	_____	Revenue
Total Annual Revenue – Projected 12 Months	_____	Revenue

***Please attach a listing of locations or a copy of your statement of values.**

B. Professional Services

DIRECTIONS: Check each box that applies, giving the requested information for each classification using the most recent 12 months. Use the Comments section for additional classifications not listed or for further explanation.

Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed. Include visits made to a client's home when home health care is provided.
Revenue	Use total annual revenue resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Beds	Use the average number of occupied beds by dividing the total annual inpatient days by 365.
FTE	Use the full-time equivalent based upon 2080 annual hours.
Donations	Rate for each unit received from a donor.
Sub-Acute Care	Applicable to facilities offering ventilator care, wound management, post-operative care/trauma recovery, intravenous/antibiotic/hydration therapy, spinal cord/head injury care, oncology, total parenteral nutrition (TPN), blood/plasma transfusion, central line care, tracheostomy and dialysis.
Skilled Care	Applicable to facilities administering medications by injection, catheter insertion, sterile irrigation, physical/occupational therapy, administration of oxygen, inhalation therapy and routine changing of dressings.
Intermediate Care	Applicable to facilities administering oral medications, assisting with ADLs (activities of daily living - bathing, dressing, walking, eating), preventative turning/repositioning and restorative rehabilitation.
Assisted Living	Applicable to facilities offering housing and personalized support services, assistance with ADLs and self administration and/or assistance with medication.
Independent Living	Applicable to facilities offering meals, transportation, recreation and guidance with ADLs and medication.

Behavioral Health	Visits	Beds
<input type="checkbox"/> Mental Health Counseling	_____	_____
<input type="checkbox"/> Substance Abuse Counseling	_____	_____
<input type="checkbox"/> Developmental Disability	_____	_____
<input type="checkbox"/> Crisis Center	_____	_____

Rehabilitation	Visits	Beds
<input type="checkbox"/> Cardiac Rehabilitation	_____	_____
<input type="checkbox"/> Physical or Occupational Rehab	_____	_____
<input type="checkbox"/> Trauma Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Trauma Rehab/Transitional Living	_____	_____

Surgical/Specialized Services	Visits	Beds
<input type="checkbox"/> Birthing Center	_____	_____
<input type="checkbox"/> Endoscopy	_____	_____
<input type="checkbox"/> Lithotripsy	_____	_____
<input type="checkbox"/> Surgicenter	_____	_____
<input type="checkbox"/> X-Ray/Imaging	_____	Revenue

Home Care/Hospice/Medical Registry	Visits	Beds
<input type="checkbox"/> Hospice Care	_____	_____
<input type="checkbox"/> Intravenous Therapy	_____	_____
<input type="checkbox"/> Personal/Companion Care	_____	_____
<input type="checkbox"/> Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Respiration Therapy	_____	_____
<input type="checkbox"/> Skilled Care	_____	_____
<input type="checkbox"/> Durable Medical Equipment	_____	Revenue
<input type="checkbox"/> Pharmacy	_____	Revenue
<input type="checkbox"/> Medical Registry	Refer to supplemental application.	

Ambulance Companies	FTE
<input type="checkbox"/> Ambulance Service Company	_____ EMT _____ Paramedical

Schools for Healthcare Professionals			
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Dental	<input type="checkbox"/> Medical	<input type="checkbox"/> Optometry
<input type="checkbox"/> CRNA	<input type="checkbox"/> EMT	<input type="checkbox"/> Nursing	<input type="checkbox"/> Other

Non-Direct Healthcare Services	Number
<input type="checkbox"/> Dental Laboratory	_____ Revenue
<input type="checkbox"/> Medical Laboratory	_____ Revenue
<input type="checkbox"/> Ocular Laboratory	_____ Revenue
<input type="checkbox"/> Pathology Laboratory	_____ Revenue
<input type="checkbox"/> Pharmacy	_____ Revenue
<input type="checkbox"/> Durable Medical Equipment	_____ Revenue
<input type="checkbox"/> Blood/Plasma Bank	_____ Donations
<input type="checkbox"/> Organ Bank - direct processing	_____ Donations
<input type="checkbox"/> Organ Bank - no direct processing	_____ Donations

Treatment Centers	Visits
<input type="checkbox"/> College/University Health Center	_____ Visits
<input type="checkbox"/> Community Health Center	_____ Visits
<input type="checkbox"/> Convenience Care/Retail Clinic	_____ Visits
<input type="checkbox"/> Dialysis Center	_____ Visits
<input type="checkbox"/> Medi-Spa	_____ Visits
<input type="checkbox"/> Municipal Health Department	_____ Visits
<input type="checkbox"/> Oncology Services	_____ Visits
<input type="checkbox"/> Optical Establishment	_____ Revenue
<input type="checkbox"/> Sleep Lab	_____ Beds
<input type="checkbox"/> UrgiCenter	_____ Visits
<input type="checkbox"/> Weight Loss Center	_____ Visits

Long Term Care	Total Licensed Beds	Average Occupancy
<input type="checkbox"/> Sub Acute Care	_____	_____
<input type="checkbox"/> Skilled Care	_____	_____
<input type="checkbox"/> Intermediate Care	_____	_____
<input type="checkbox"/> Assisted Living	_____	_____
<input type="checkbox"/> Home Health Care	_____ Visits	_____
<input type="checkbox"/> Independent Living	_____ Units	_____ Total
		Number of Residents at Full Occupancy

C. Comments

Section and
Question

Comments

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another 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 the person to criminal and civil penalties.

MMIC FRAUD STATEMENT: Signing this application does not bind MMIC Insurance, Inc. to complete insurance. All information requested in this application is considered material and important. If MMIC Insurance, Inc. agrees to be bound under the terms of this application, the policy is void if the Applicant hides any important information, misleads or attempts to defraud or lie about any matter contained in this application.

CLAIMS-MADE DISCLOSURE: If any portion of the policy to be issued is on a claims-made basis, such portions shall apply only to claims or suits first made against the Applicant during the policy period arising out of the performance of professional services or caused by an occurrence or offense occurring on or after the retroactive date shown on the policy. Claims or suits must be reported to MMIC Insurance, Inc. during the policy period or under a reporting endorsement.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: The Applicant authorizes access by and release to MMIC Insurance, Inc. of any and all information pertaining to underwriting the undersigned Applicant and relating to medical claims or any other matter in the possession, custody or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organizations; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimbursing, including State Departments of Welfare.

PRIVACY STATEMENT: MMIC Insurance, Inc. agrees to hold in confidence, use only for its proper business purposes and, unless otherwise constrained by law, not to re-release to third parties any and all information concerning Applicant which comes into its possession. Applicant acknowledges that it is within the proper business purposes of MMIC Insurance, Inc. to discuss any such information within its committees and boards.

The Applicant hereby certifies the foregoing information is true and correct.

Applicant Signature

Title

Date

Notice Concerning Policyholder Rights In An
Insolvency Under The Minnesota Insurance Guaranty Association Law

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
4640 West 77th Street, Suite 342
Edina, Minnesota 55436
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY OR LIABILITY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE OR LIABILITY POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.