Northland INSURANCE

APPLICATION - HEALTH CARE PROVIDER

BUSINESS INFORMATION

1. Named Insured _____
2. Mailing Address _____
   Street City County State ZIP Code
3. Location of Premises: ❒ Same as mailing address
   ❒ Other _____
4. Telephone ( ) _____ Fax ( ) _____
5. Contact person/phone #: Inspection _____
   Accounting/Records _____
6. Business type: ❒ Individual ❒ Partnership ❒ Corporation ❒ LLC
   ❒ Trust ❒ Other (specify) _____
7. Operating as: ❒ For Profit ❒ Nonprofit ❒ Other _____
8. Interest of Named Insured in premises: ❒ Owner ❒ General Lessee ❒ Tenant ❒ Other _____
9. Part occupied by Named Insured: ❒ Entire ❒ Portion (____ %) ❒ Other (Lessor's Risk Only)
10. Date business established _____

DESIRED TERMS AND CONDITIONS

1. Coverage Desired: ❒ General Liability ❒ Professional Liability
2. Limit of Liability Desired: ❒ $100,000/$300,000 ❒ $300,000/$600,000 ❒ $500,000/$1,000,000
   ❒ $1,000,000/$1,000,000 ❒ Other _____

Note: Standard coverage includes the following:

Damage to Premises Rented to You	$100,000
Personal and Advertising Injury	Same as Occurrence Limit
Medical Payments	$5,000

3. ❒ Contractual Liability
4. Effective Date Desired _____ Term Desired _____

TYPE OF FIRM

1. Check your specific professional occupation:
   ❒ Aide/Homemaker
   ❒ Artificial Limb Fitter
   ❒ Audiologist *Do you operate a mobile unit?* ❒ Yes ❒ No
   ❒ Counselor ❒ Psychiatrist ❒ Psychologist ❒ Social Worker

Indicate type of services performed and percentage:

❒ Abortion/Family Planning	____ %	❒ Crisis Intervention	____ %	❒ Occupational	____ %
❒ Alcohol/Drug	____ %	❒ Family/Marital	____ %	❒ School/Youth	____ %
❒ Child Abuse/Sexual Offenders	____ %	❒ General Guidance	____ %	❒ Other	____ %
❒ Criminal	____ %	❒ Hot Line	____ %	_____	____ %

Do you utilize shock and/or drug therapy? ❒ Yes ❒ No

❒ Dental Hygienist
❒ Dietician/Nutritionist *Do you market products under your own label?* ❒ Yes ❒ No
❒ Druggist/Pharmacist *Do you prescribe medications?* ❒ Yes ❒ No
❒ Hearing Aid Specialist
❒ Massage Therapist

❒ Nurse: *Type* _____ *Check if appropriate:* ❒ *X-ray specialist* ❒ *Midwife* ❒ *Nurse anesthetist*

❒ Occupational Therapist
❒ Optician
❒ Optometrist
❒ Physical Therapist
❒ Respiratory Therapist
❒ Speech Therapist
❒ X-Ray Technician
❒ Other _____

2. Description of operations _____

_____

_____

_____

_____

OPERATIONS

1. Do you treat children exclusively? ❒ Yes ❒ No
2. Indicate percentage of time spent in the following work locations:

Administrative Office	____ %	Hospice	____ %	Professional Office	____ %
Classroom	____ %	Outpatient Clinic	____ %	Nursing Home	____ %
Emergency Dept. of Hosp.	____ %	Laboratory	____ %	Other ____	____ %
Hospital Ward (Specify) ____	____ %			Patient's Home	____ %

3. Are you engaged in, associated with, or involved in any other enterprises? ❒ Yes ❒ No
   If yes, explain. _____
4. Are you self-employed? ❒ Yes ❒ No
   If no, provide name of employer. _____

		Yes	No	N/A
5. Does your employer carry insurance limits in an amount equal to or greater than the limit of this policy for the following?	General Liability	❒	❒	❒
	Professional Liability	❒	❒	❒
6. Are you an owner, operator, officer, partner, administrator, or have a similar capacity for any other health care or related services organization?		❒	❒	
If yes, is there separate insurance in place with limits equal to or greater than the limits of this policy?		❒	❒	
7. Have you entered into any contractual agreements?		❒	❒	
If yes, is legal advice sought to write and approve?		❒	❒	
Does the agreement require you to hold any third party harmless?		❒	❒	

8. Indicate: Receipts _____ Payroll _____ Outpatient Visits _____
   (Number of patient encounters per year)
9. How are funds obtained? (i.e. Medicare, donations, fees, government grants, etc.) _____
10. Do you have recordkeeping procedures? ❒ Yes ❒ No
11. Do you practice: ❒ Full Time (30+ hours/week) ❒ Part Time (30 hours or less/week)
12. Do you have independent contractors working for you? ❒ Yes ❒ No
    Describe, including number of contractors, type, total hours per month worked by all contractors, and in what capacity the independent contractor is working. _____

    _____
13. Do you require independent contractors working for you to carry their own professional insurance and provide proof of this coverage? ❒ Yes ❒ No
14. Do you use the services of volunteers or students? ❒ Yes ❒ No
    If yes, describe selection, duties, training, and extent to which they are used. _____

    _____

EMPLOYEE PROCEDURES & STAFFING

1. Check the highest level of education you have completed relating to practice in your field:
   - ❒ None required
   - ❒ Associate Degree
   - ❒ Master's Degree
   - ❒ Bachelor's Degree
   - ❒ Doctorate Degree
   - ❒ Post-Doctorate Degree
   - ❒ Other

   School where degree was obtained: _____

   For multiple employees, attach list with names, degree(s), and school(s).
2. Describe any professional training, licensing, or certification needed for this operation. _____
3. Are you certified/licensed? ❒ Yes ❒ No
   If yes, name of board/licensing body. _____

		Yes	No	N/A
4.	Has your license ever been: Restricted?	❒	❒	❒
	Suspended?	❒	❒	❒
	Revoked?	❒	❒	❒
a.	Have you ever been denied a license or board certification?	❒	❒	❒
b.	Have you ever been a patient in any chemical dependency program?	❒	❒	❒
c.	Have your privileges ever been restricted, suspended, or revoked by any heath care facility?	❒	❒	❒
d.	Do you prescribe drugs?	❒	❒	❒
e.	Do you participate in any peer review or utilization review activities?	❒	❒	❒

Explain all YES answers. _____

5. Years practicing current professional occupation _____
6. Years in business under the above name _____
7. List any professional association or organization of which you are a member. Show complete name.
   ❒ None _____

		Yes	No
8.	Do you have employees?	❒	❒
9.	Do you conduct criminal background checks of employees?	❒	❒
	If yes, are copies kept on file?	❒	❒

10. Check all procedures you use when hiring professional, paraprofessional, or any other employee providing patient care services at your facility:

		None	Written	Verbal
a.	Educational background or residency program check, when applicable.	❒	❒	❒
b.	Previous employers check.	❒	❒	❒
c.	Personal references check.	❒	❒	❒
d.	Verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities, or any professional liability or work-related claim that has previously been made against any individuals?	❒	❒	❒

PREVIOUS EXPERIENCE

1. Have you or any partner, officer, director, or employee ever been the subject of disciplinary action by a regulatory authority as a result of their professional activities? ❒ Yes ❒ No
   If yes, explain. _____

2. **MISSOURI APPLICANTS: DO NOT ANSWER THIS QUESTION.**
Has insurance of this type been canceled, refused, or nonrenewed by any company during the past 3 years?
❒ Yes ❒ No *If yes, give name of company, date and reason.*

PRIOR CARRIER INFORMATION FOR THE PAST THREE YEARS					
Year	**Carrier**	**Policy Number**	**Coverage**	**Check if Claims-Made**	**Premium**
				❒	
				❒	
				❒	

3. Provide the following information for all claims, suits, or incidents which may give rise to a claim for the past five years.
Attach separate sheet if necessary.

Dates (Month/Year)	**Allegations**	**Amount**	**Paid**	**Reserve**
			❒	
			❒	
			❒	

FRAUD STATEMENT

I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE.

Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud and subject to fines and/or imprisonment. Any changes in your operation must be reported to your agent.

Signature of Applicant Title Date

Signature of Producing Agent Date

Agent Name and Address

IMPORTANT NOTICE REGARDING COMPENSATION DISCLOSURE

For information about how Northfield compensates its agents, brokers and program managers, please visit this website:

http:/ / www.northlandins.com/ Producer_Compensation_Disclosure.asp

If you prefer, you can call the following toll-free number: 1-866-904-8348. Or you can write to us at Northfield Insurance Company, c/ o Law Department, 385 Washington St., St. Paul, MN 55102.