AXIS INSURANCE
10000 Avalon Blvd. Ste. 200
Alpharetta, GA 30009
Telephone**: (678) 746-9000** | Toll-Free**: (866) 259-5435** | Fax: **(678) 746-9315**

AXIS HAS THE ABILITY TO OFFER COVERAGE ON AN OCCURRENCE FORM POLICY BASIS, ON A CLAIMS-MADE POLICY BASIS, AND WITH CLAIMS-MADE COVERAGES ATTACHED TO AN OCCURRENCE FORM POLICY.

SOLELY AS RESPECTS CLAIMS-MADE LIABILITY COVERAGES UNDER THE POLICY FOR WHICH THIS APPLICATION IS BEING SUBMITTED: THIS INSURANCE POLICY MAY CONTAIN COVERAGES THAT ARE PROVIDED ON A CLAIMS-MADE AND REPORTED BASIS AND APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED TO THE INSURER AS SET FORTH IN THE REPORTING OF CLAIMS AND EVENTS SECTION. DEFENSE COSTS ARE INCLUDED IN THE LIMITS OF INSURANCE, AND PAYMENT THEREOF WILL ERODE, AND MAY EXHAUST, THE LIMITS OF INSURANCE.

NEW BUSINESS APPLICATION

- "Applicant," herein refers individually and collectively to all proposed insureds. All responses shall be deemed made on behalf of all proposed insureds.
- This Application and all materials submitted herewith shall be held in confidence.
- The submission of this Application does not obligate the Applicant to buy insurance nor is the Insurer obligated to sell insurance or to offer insurance upon any specific terms requested.
- If the policy applied for is issued, this Application, which shall include all Supplemental Applications and material and information submitted in connection with this Application, will be deemed attached to and will form a part of the policy.

INSTRUCTIONS

- Respond to all questions completely, leaving no blanks. Check responses when requested.
- If space is insufficient, continue responses on your letterhead.
- This Application must be completed, dated, and signed by an authorized officer of the entity identified in the section entitled "Applicant Information" below.

APPLICANT INFORMATION

1. Legal Name(s) (including any DBA) and Address of Applicant:

   _____

   City: _____ State: _____ Zip Code: _____

   Telephone: _____ Fax: _____ Website Address: _____

2. The Applicant is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Other _____

3. Name and Title of Primary Contact: _____

   E-Mail Address: _____

4. Description of Operations: _____

5. Date Established: _____ Years under present ownership: _____

6. Tax Status: ☐ For Profit ☐ Not For Profit ☐ Other _____

7. Please list all states where the Applicant is operating and providing services:

_____

8. Is the Applicant certified or accredited by any organization?

☐ AAAASF ☐ AAAHC ☐ ACHC
☐ CARF ☐ CHAP ☐ CLIA
☐ The Joint Commission ☐ Other_____ ☐ N/A

9. Date of latest accreditation/reaccreditation: _____

10. Please list any professional societies or associations of which the Applicant is a member:

_____

AFFILIATIONS

11. In the past 36 months, has the Applicant merged, acquired, consolidated with, sold, or divested any other entity or facility? ☐ Yes ☐ No

If yes, please explain:_____

12. Within the next 12 months, does the Applicant plan to merge, acquire, consolidate with, sell or divest any other entity or facility? ☐ Yes ☐ No

If yes, please explain:_____

13. Please list all entities for which the Applicant is seeking coverage under this policy:

Entity Name and Address	Description of Operations	Percentage Ownership
		☐ %
		☐ %
		☐ %
		☐ %

14. Does the Applicant or any of the Applicant's owners, partners or directors own, operate or manage any business or facility other than those described in Section 1 of this Application? ☐ Yes ☐ No

If yes, please explain:_____

15. Is the Applicant owned or controlled by another entity? ☐ Yes ☐ No

If yes, please explain:_____

FINANCIAL AND EXPOSURE DATA

16. Total Revenue:

Annual total gross revenue (previous FY): $___ Annual total gross revenue projected (current FY) $___

17. In the past 12 months, has the Applicant either discontinued or entered any new medical professional service or business activity? ☐ Yes ☐ No

If yes, please explain:_____

18. In the next 12 months, does the Applicant plan to discontinue or plan to enter any new medical professional service or business activity? ☐ Yes ☐ No

If yes, please explain:_____

19. Please provide exposure detail for the next 12 months (projected) for the Applicant and any other entities or persons seeking coverage under this policy. For Beds, please use the average number of occupied beds. For revenues, please use gross revenues.

Adult Day Care	Daily Census		Laboratories*	Tests	
Adult Day Care			Histology/Cytology/Virology		
Allied Health Training	No. Students		Pathology/Cytopathology		
Nurses			Genetic Testing		
NPs, PAs, CRNAs			Drug Testing/Toxicology		
Medical Assistants			Lithotripsy	Procedures	
Technicians/Phlebotists			Lithortripsy Services		
Ambulance*	Transports	Providers	Medical Spas - Please Complete the Medical Spa Supplement		
Ambulance - Air			Mental Health - Inpatient*	Beds	Revenues
Ambulance - Ground, Emergency			Inpatient - General		
Ambulance - Ground, Non-Emergency			Inpatient - Eating Disorders		
EMT Services			Inpatient - Drug and Alcohol Rehab		
Blood, Tissue, Organ*	Revenue	Donations	Mental Health - Outpatient*	Visits	Revenues
Blood Banks - Whole Blood			Outpatient - Counseling		
Blood Banks - Blood Components			Outpatient - Drug and Alcohol Rehab		
Tissue Banks			Outpatient - MAT		
Organ Procurement			Outpatient - IOP/PHP		
Cancer Care	Visits		Employee Assistance		
Chemotherapy			Outpatient - Crisis Management		
Radiation			Pharmacy*	Prescriptions	Revenues
General Infusion (Non-Oncology)			Retail		
Clinics*	Visits		Specialty		
Audiology			Compounding		
Eye Care/Optometry			Physical & Occupational Therapy	Visits	
Primary Care			Physical Therapy		
Community Health/FQHC			Occupational Therapy		
School Health			Speech Therapy		
Abortion/Family Planning			Respiratory Therapy		
Urgent Care			ABA		
Emergency Care			Cardiac Rehabilitation		
Clinical Research*	Trial Subjects		Prosthetics and Orthotists	Providers	Revenues

CROs - Phase I			Prosthetists		
CROs - Phase II			Orthotists		
CROs - Phase III			Sleep Services	Visits	
Dental Laboratory	Revenues		Sleep Labs		
Dental Laboratory Services			Surgery Centers*	Procedures	
Dialysis	Visits	Patients	Cosmetic Procedures		
Hemodialysis			Endoscopy		
Peritoneal Dialysis			ENT		
Fertility	Donations	Revenues	Gynecology		
Sperm Banking			Interventional Radiology		
Embryo Banking			IVF		
Healthcare Staffing - Please complete the Healthcare Staffing Supplement Home Healthcare - Please complete the Home Healthcare Supplement			Ophthalmology		
			Orthopedic - No Spine		
Hospice	Visits	Beds	Orthopedics - Spine		
Inpatient			Orthopedics - Joint Replacement		
Outpatient			Podiatry		
Imaging*	Procedures		Weight Loss	Visits	
Bone Density			Weight Loss Coaching		
CT Scans			Veterinary Services	Visits	
Mammograms					
MRIs			For all Classes of Business with an asterisk, please complete the corresponding Supplemental Application		
PET Scans					
X-Rays/Plain Films					
Ultrasounds					
Other:					

20. Does the Applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No

    If yes, please provide the number: _____

21. Does the Applicant provide services to any of the following:

    ☐ Correctional Facilities
    ☐ Hospitals
    ☐ Long Term Care Facilities

    If yes, please provide details:_____

22. Does the Applicant provide any telemedicine services? ☐ Yes ☐ No

    If yes, please describe: _____

    a) Does the Applicant ensure that the provider is licensed in the state where the patient is located at the time services are rendered? ☐ Yes ☐ No

    b) What digital platform is used to provide such services? (i.e. Webex, Zoom, store and forward technology): _____

23. What percentage of the Applicant's patient are under 18 years of age: _____

24. Does the Applicant administer anesthesia? ☐ Yes ☐ No

If yes, please provide details including the type of anesthesia administered, the licensure of the provider administering the anesthesia, and the availability of medical rescue equipment:

_____

25. Please provide the name and specialty of the Applicant's Medical Director:

_____

26. Does the Applicant's Medical Director provide direct patient care? ☐ Yes ☐ No

If yes, is the Applicant requesting coverage for its Medical Director for patient care services? ☐ Yes ☐ No

27. Please provide the following information for each physician providing patient care at the Applicant's facility:

Physician Name	Specialty	Coverage Requested Under This Policy (Yes/No)	Employment Status (Employee/ Independent Contractor)	Hours Per Month

28. Does the Applicant require professional staff not covered under the Applicant's professional liability coverage to maintain Professional Liability Insurance? ☐ Yes ☐ No

If yes, what are the minimum Limits of Insurance that the Applicant requires?

_____

RISK MANAGEMENT PROCEDURES

29. Does the Applicant have a designated Risk Manager? ☐ Yes ☐ No

If yes, please provide the Risk Manager's name, contact information and qualifications:

_____

30. Does the Applicant maintain:

a) A formal Risk Management, Quality Assurance, or Patient Safety Program? ☐ Yes ☐ No
b) A formal process in place to evaluate and address unexpected patient outcomes? ☐ Yes ☐ No
c) A formal process for reporting any suspected sexual or physical abuse? ☐ Yes ☐ No
d) A formal process for reporting and investigating incidents? ☐ Yes ☐ No

If no to any of the above, please explain:_____

31. Does the Applicant maintain an infection control program? ☐ Yes ☐ No

32. Does the Applicant prescribe or dispense any narcotics? ☐ Yes ☐ No

If yes, please provide details on policies and procedures governing the prescribing of antibiotics or narcotics:

_____

33. Is the Applicant and all medical professionals providing services at the Applicant's facility licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

    If no, please explain: _____

34. Does the Applicant credential all medical professionals providing services to patients at the Applicant's facility including evaluating competencies to assess providers' clinical skills? ☐ Yes ☐ No

    If no, please explain: _____

35. On hiring medical professionals and any others who provide patient care, does the Applicant:

    a) Verify educational background? ☐ Yes ☐ No

    b) Verify employment history? ☐ Yes ☐ No

    c) Verify professional and/or personal references? ☐ Yes ☐ No

    d) Verify hospital privileges, if applicable? ☐ Yes ☐ No ☐ N/A

    e) Verify the providers license including any past or pending suspensions, revocations or disciplinary actions? ☐ Yes ☐ No

    f) Conduct a criminal background check at the County, State and Federal level? ☐ Yes ☐ No

    g) Conduct drug and/or alcohol testing? ☐ Yes ☐ No

    h) Require information on any professional liability claims or allegations, including, but not limited allegations of sexual or physical abuse? ☐ Yes ☐ No

    If no to any of the above, please explain:
    _____

36. Does the applicant maintain transfer agreements with a hospital(s) for patients in need of care beyond the scope of the Applicant's facility? ☐ Yes ☐ No

    If Yes, please provide the name of the hospital(s) and its distance from the Applicant's facility.
    _____

GENERAL LIABILITY

37. Does the Applicant sell or lease medical equipment or products in connection with its operations? ☐ Yes ☐ No

    If yes, please provide the Annual Total Sales or Annual Total Rental Receipts for medical equipment and products sales or rentals: _____

38. At any location, does the Applicant have any exposure to flammables, explosives, chemicals or radioactive materials? ☐ Yes ☐ No

    If yes, please describe: _____

39. Does the Applicant store, treat, discharge, dispose, transport or handle any hazardous materials? ☐ Yes ☐ No

    If yes, please describe: _____

40. Is the Applicant required by a Landlord, Mortgagor or Lessor to list them as an Additional Insured? ☐ Yes ☐ No

If yes, please provide the name of each Additional Insured Landlord, Mortgagor or Lessor:

_____

PRIOR INSURANCE, COVERAGE REQUESTED, LOSS HISTORY AND PRIOR KNOWLEDGE

41. Does the Applicant have liability insurance currently in force? ☐ Yes ☐ No

If Yes to Question 41. complete the chart below:

	Expiring Carrier	Limits of Insurance	Deductible or SIR	Retroactive Date if applicable	Premium
Professional Liability		$	$		$
General Liability		$	$		$
Excess/ Umbrella		$	$		$
Other:		$	$		$

42. Is the Applicant requesting the same Limits of Insurance and Deductible? ☐ Yes ☐ No

If No, please provide details on Limits Of Insurance and Deductible requested:

_____

43. Does the Applicant or any of it employed healthcare providers participate in any Patient Compensation Fund? ☐ Yes ☐ No

If yes, which one(s):

_____

44. Has any claim or lawsuit for malpractice been made against the Applicant or any of its employees or contractors in the last five years? ☐ Yes ☐ No

If yes, please provide details: _____

45. Have all such claims or lawsuits for malpractice been reported to the Applicant's current or prior insurance carrier? ☐ Yes ☐ No

If no, please provide details: _____

46. Is the Applicant or any individual proposed for coverage under this insurance aware of an act, error, omission, fact, or circumstance that may give rise to a malpractice claim or lawsuit? ☐ Yes ☐ No

If yes, please provide details: _____

47. Is the Applicant licensed in accordance with all applicable state and federal laws and regulations? ☐ Yes ☐ No

If no, please explain: _____

48. Has the Applicant ever had its license or certification investigated, suspended, revoked, voluntarily surrendered or renewed with conditions? ☐ Yes ☐ No

    If yes, please provide details: _____

49. Has any medical professional providing patient care services on behalf of the Applicant ever had their license investigated, suspended, revoked, voluntarily surrendered or renewed with conditions? ☐ Yes ☐ No

    If yes, please provide details: _____

50. Has the Applicant or any of its employed or contracted medical providers been convicted for any act committed in violation of any law, regulation or ordinance? ☐ Yes ☐ No

    If yes, please provide details:_____

51. Has any insurance company ever cancelled, declined or refused to renew any professional liability insurance issued to the Applicant? ☐ Yes ☐ No

    If yes, please provide details:_____

Without prejudice to any other rights and remedies of the Insurer, the Applicant understands and agrees that any claim arising from any facts, circumstances, situations or claims required to be disclosed in response to questions 44., 45., and 46. in this section is excluded from the proposed insurance.

REPRESENTATIONS AND SIGNATURE

By signing this document, the undersigned authorized representative of the Applicant represents on behalf of all persons and entities proposed for coverage, after inquiry, that to the best of their knowledge:

52. The statements and answers given in and all materials submitted with this Application are true, accurate and complete.

53. No facts or information material to the risk proposed for insurance have been misstated or concealed.

54. These representations are a material inducement to the Insurer to provide a proposal for insurance.

55. Any policy the Insurer issues will be issued in reliance upon these representations.

56. The Applicant will report to the Insurer immediately in writing any material change in the Applicant's activities, products and services.

57. The Applicant will report to the Insurer immediately in writing any material changes to the answers provided in this Application which occur or are discovered between the date of this Application and the effective date of the policy for which coverage is sought by submission this Application.

58. The Insurer reserves the right, upon receipt of any such notice, to modify or withdraw any proposal for insurance the Insurer has offered.

WARNING

PLEASE REVIEW THE STATE FRAUD STATEMENT CONTAINED AT THE END OF THIS APPLICATION APPLICABLE TO THE STATE IN WHICH THE APPLICANT RESIDES.

Any person who, with intent to defraud or knowingly facilitates a fraud against the insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

This Application must be signed by the Applicant's Chief Executive Officer, Chief Financial Officer, Chief Operations Officer or General Counsel, or their functional equivalent, unless the Insurer instructs the Applicant otherwise.

Name	**Name *(signature)***
Title	**Date**

Produced By:

Agent: _____ Agency: _____

Agency Taxpayer ID or SS No.: _____ Agent License No.: _____

Address: _____

City: _____ State: _____ Zip: _____

STATE FRAUD STATEMENT

ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison or any combination thereof.

ARKANSAS

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.

CALIFORNIA

For your protection, California law requires the following warning to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO

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.

DISTRICT OF COLUMBIA

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.

FLORIDA

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.

KANSAS

A “fraudulent insurance act” means an act committed by 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.

KENTUCKY

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.

LOUISIANA

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.

MAINE

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.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

NEW JERSEY

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

NEW MEXICO

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 civil fines and criminal penalties.

NEW YORK

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.

OHIO

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.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

In order for us to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on your part, we must show that:

A. The misinformation is material to the content of the policy;

B. We relied upon the misinformation; and

C. The information was either:

1. Material to the risk assumed by us; or

2. Provided fraudulently.

For remedies other than the denial of a claim, misstatements, misrepresentations, omissions or concealments on your part must either be fraudulent or material to our interests.

With regard to fire insurance, in order to trigger the right to remedy, material misrepresentations must be willful or intentional.
Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.

PENNSYLVANIA

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.

PUERTO RICO

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

RHODE ISLAND

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.

TENNESSEE

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.

VERMONT

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.

VIRGINIA

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.

WASHINGTON

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.

WEST VIRGINIA

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.