GROUP – ENTITY – ORGANIZATION APPLICATION

Please type or print

Please read this before filling out your application for coverage. You warrant and represent that the following statements are yours and that you know the statements to be true. You know and intend that we will rely on the truth of the information you have provided in deciding to issue a policy to you, and that providing any materially false information in this application is grounds for us to deny you insurance.

APPLICATION INSTRUCTIONS

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE CONTAINS CLAIMS MADE AND REPORTED COVERAGE WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED TO THE UNDERWRITER IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

Prior to completing the attached application, please read and follow these instructions. Please verify that all required attachments are included so that we may process the Application promptly and efficiently.

- Please complete this form electronically or print responses legibly.
- Please sign and date the application in two places where indicated.
- All information requested must be fully and accurately completed.
- If a particular question does not apply, do not leave it blank, please write "N/A."
- If additional space is needed, please continue answers on a separate page and attach it to the Application.
- Claims information should be provided for a seven-year experience period if you have been in practice for at least seven years even if the requested retroactive period is less than seven years. This applies to open and closed claims and to any incidents reported to a previous carrier.

ENTITY/ORGANIZATION INFORMATION

Organization Name:	
Other trade or brand names used (i.e., DBA):	
Year Established:	
State of Domicile:	
FEIN:	
Type of legal structure:	☐ PC ☐ Partnership ☐ LLC ☐ Corp. ☐ Inc. ☐ PA ☐ Other:
Website(s):	

AUTHORIZED REPRESENTATIVE FOR INSURANCE

Name:	
Title:	
Phone:	☐ Cell ☐ Home
Email:	

SENIOR LEADERSHIP

Risk Manager(s):	
Medical Director(s):	
Chief Executive Officer:	

MAILING OR OFFICE ADDRESS

Address 1:		
Address 2:		
City:	State:	Zip Code:

HOURS OF OPERATION

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Open:	Open:	Open:	Open:	Open:	Open:	Open:
Close:	Close:	Close:	Close:	Close:	Close:	Close:

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CURRENT PRACTICE LOCATIONS

Please provide any locations where the organization has provided patient care during the retroactive period. These include any locations that are not still active. Include any hospital locations where providers have active privileges.

1st Location:		From:	To:
Address:			Ste:
City:	State:	Zip Code:	
2nd Location:		From:	To:
Address:			Ste:
City:	State:	Zip Code:	
3rd Location:		From:	To:
Address:			Ste:
City:	State:	Zip Code:	
4th Location:		From:	To:
Address:			Ste:
City:	State:	Zip Code:	
5th Location:		From:	To:
Address:			Ste:
City:	State:	Zip Code:	
6th Location:		From:	To:
Address:			Ste:
City:	State:	Zip Code:	
7th Location:		From:	To:
Address:			Ste:
City:	State:	Zip Code:	

Indicate the facility type where the applicant organization provides services. Check all applicable and provide percentages totaling 100% in the box to the right.

☐ Clinic		☐ Nursing Home	
☐ Clinical Trial		☐ Physician Office	
☐ Correctional Facility		☐ Surgery Center	
☐ FTCA – Eligible Clinic		☐ Long Term Care Facility	
☐ Hospital		☐ Nursing Home	

APPLICANT HISTORY

Please provide a complete explanation for each question answered "Yes". Questions should be answered in the affirmative if at any time during the retroactive period the question would apply.

Has the organization had significant changes to the practice during the retroactive period (i.e.,) deletion or addition of procedures, providers, locations, key leadership, etc.?	☐ Yes	☐ No
Has the organization ever had medical professional liability insurance declined, canceled, surcharged, nonrenewed, or issued with a reduction in coverage?	☐ Yes	☐ No
Has the organization's professional liability insurance ever been cancelled for non-payment of premium? *Not Applicable to Missouri Applicants.*	☐ Yes	☐ No
Has the organization ever been suspended by any government health program payer? *(e.g., Medicare or Medicaid)?*	☐ Yes	☐ No
Does the organization employ, or contract providers who maintain staff privileges at a hospital?	☐ Yes	☐ No
Does the organization provide professional services in a patient compensation fund state? *(Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, and Wisconsin)*	☐ Yes	☐ No
Does the organization routinely screen employees for drugs and/or alcohol use?	☐ Yes	☐ No
Does the organization utilize electronic medical records?	☐ Yes	☐ No
Does the organization secure a fully completed medical record from each new patient?	☐ Yes	☐ No

APPLICANT HISTORY (continued)		
Does the organization secure a signed Informed Consent Document from each patient?	☐ Yes	☐ No
Does the organization utilize electronic medication contraindication system?	☐ Yes	☐ No
Does the organization have implemented procedures to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule?	☐ Yes	☐ No
Does the organization own in whole or in part another entity, another practice for which you carry separate coverage? *If yes, please attach a copy of a declarations page or certificate of insurance.*	☐ Yes	☐ No
Does the organization maintain any beds for overnight occupancy? Minors: Psychiatric: *If yes, how many:*	☐ Yes	☐ No
Does organization require that all biomedical equipment receive scheduled preventative maintenance annually by a qualified technician?	☐ Yes	☐ No
Does the organization employ member(s) of the physician staff to operate as medical director on behalf of the organization? *If requesting coverage for medical directors in your organization please provide names, start dates, and end dates if applicable.*	☐ Yes	☐ No
Does the organization utilize Telemedicine for: ☐ Visits ☐ Consultations ☐ Patient Onboarding *If yes, please complete telemedicine supplement.*	Percentage of Practice %	
Are all W-2 and Non W-2 healthcare providers licensed in all states where services are rendered, including the state where the patient received services and the state in which the provider provided the services?	☐ Yes	☐ No

EMPLOYMENT/CONTRACT PRACTICE PROFILE		
Does the organization employ, or contract providers who have ever treated celebrities, professional, collegiate, or Olympic athletes?	☐ Yes	☐ No
Does the organization employ, or contract providers who have ever treated patients at a prison, correctional facility, detention facility, or individuals detained by ICE? *If yes, please note total percentage of your practice.* %	☐ Yes	☐ No
Does the organization employ, or contract providers who have ever treated patients in an emergency room or urgent care setting? *If yes, please provide percentage of practice.* %	☐ Yes	☐ No
Does the organization employ, or contract providers who have treated patients as a Hospitalist? *If yes, please note total percentage of practice.* %	☐ Yes	☐ No
Does the organization employ, or contract providers who have ever treated or intend to treat patients by means of unconventional therapy which may be considered human experimentation, or conceivably be subject to regulatory approval?	☐ Yes	☐ No
Does the organization employ, or contract providers who have ever had hospital privileges suspended, limited, or revoked whether voluntarily or involuntarily?	☐ Yes	☐ No
Does the organization employ, or contract providers who have had hospital privileges expanded in the last 12 months to include procedures for which your staff completed additional training required by the State Licensing Board and/or Specialty Board?	☐ Yes	☐ No
Does the organization employ, or contract providers who have ever had a complaint filed or any action taken against their license by a State Licensing Board?	☐ Yes	☐ No
Does the organization employ, or contract providers who have ever been treated for alcoholism, narcotic addiction, or mental impairment?	☐ Yes	☐ No
Does the organization employ, or contract providers who have ever been indicted, charged, or convicted of a felony other than a minor traffic violation?	☐ Yes	☐ No

EMPLOYMENT SCREENING PRACTICES		
Check all the following employment screening guidelines applicable to the provider screening process.		
☐ Application	☐ Personal Interview	☐ Validate Current Licenses/Certifications
☐ Criminal Background Check	☐ Reference Check	☐ Validate Work History/Education
☐ Disciplinary Actions	☐ Sex Abuse Registry	☐ *Other:*
☐ Drug Test	☐ Validate Claims History	☐ *Other:*

EMPLOYMENT SCREENING PRACTICES (continued)		
If a job applicant falls outside the employment screening guidelines, will the applicant organizations Medical Director make the final determination of eligibility? *If no, please provide details attached to this application.*	☐ Yes	☐ No
Is the initial employment period on a probationary basis?	☐ Yes	☐ No
Does the organization create a practice profile for W-2 and Non W-2 healthcare providers prior to assignment in each facility?	☐ Yes	☐ No
Is the organization accredited by any credentialing organization? *If yes, please provide details attached to this application.*	☐ Yes	☐ No
Are the recruitment and credentialing of healthcare providers carried out by separate individuals?	☐ Yes	☐ No

MEDICAL STAFF

Does the organization employ/contract/supervise any of the following personnel?
Indicate the number of the following in the box to the right.

☐	Audiologist	☐	Occupational Therapist	☐	Physical Therapist		
☐	CNM	☐	Optician	☐	Physician's Assistant		
☐	CRNA	☐	Optometrist	☐	Podiatrist		
☐	Fellows	☐	Orthodontist/Dentist	☐	Residents		
☐	Interns	☐	Other Physicians	☐	Respiratory Therapist		
☐	Laboratory Technician	☐	Pharmacist	☐	Social Worker		
☐	Nurse Practitioner	☐	Psychologist	☐	Speech Therapist		

Are you requesting coverage for the above providers?	☐ Yes	☐ No
Do any of the above staff have his/her own coverage?	☐ Yes	☐ No
If providers above have his/her own coverage, do you require Vicarious Liability Coverage?	☐ Yes	☐ No

INSURANCE HISTORY

Please provide all insurance history for the past 7 years.

Current Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:
Prior Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:
Prior Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:
Prior Carrier:				
Coverage Period:	Start:	End:	Retroactive:	Limit of Liability:

COVERAGE REQUESTED

Requested Date of Coverage:		
Organization's Retroactive Date:		
Requested Limit of Liability:		
Limit Structure Requested:		
Physicians:	☐ Shared	☐ Separate
Advanced Practice Providers:	☐ Shared	☐ Separate
Entity:	☐ Shared	☐ Separate
Deductible:		

PATIENT VISITS	
Number of Visits (Last 12 Months)	**Number of Visits (Next 12 Months)**
Clinic:	Clinic:
Emergency:	Emergency:
Laboratory:	Laboratory:
Urgent Care:	Urgent Care:
Total No. of Visits:	Total No. of Visits:

RISK MANAGEMENT		
Does the organization have a formal risk management program?	☐ Yes	☐ No
If no, does the organization plan to implement a formal program in the next 12 months?	☐ Yes	☐ No
Do you practice within the Guidelines for Disinfection and Sterilization in Healthcare Facilities – published by the Center for Disease Control and Prevention (CDC)?	☐ Yes	☐ No
Does the organization have a quality assessment/improvement plan or risk management plan in place?	☐ Yes	☐ No
Does the organization require medical staff to participate in ongoing CE?	☐ Yes	☐ No
Does the organization have an incident reporting process?	☐ Yes	☐ No
Does the organization monitor the quality of care provided by its W-2 and Non W-2 employees?	☐ Yes	☐ No
Are claims reviews conducted as part of the risk management process?	☐ Yes	☐ No
Does the organization have a dedicated full time Risk Manager or third-party Risk Management Consultant?	☐ Yes	☐ No

CLAIMS HISTORY		
Has any claim or suit for alleged malpractice ever been brought against you and/or any of your employees?	☐ Yes	☐ No
Are you aware of any circumstances that might reasonably lead to a claim or suit being made against you or any of your employees that has not been reported to your current carrier?	☐ Yes	☐ No
Total number of claims ever filed against you:	Number of open/reserved claims against you:	
Total number of closed claims:		
Please provide any changes you've made to your practice as a result of any claim made against you.		

ROSTER OF ACTIVE INSUREDS

Please include all Doctors and Advanced Practice Designations. The organization may provide an excel spreadsheet in lieu of completing this portion of the application.

Name:	Specialty:	Start/Retro Date:

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ROSTER OF DEPARTED INSUREDS

Only complete the following if your organization is applying for departed insureds coverage.
Please include all Doctors and Advanced Nursing Designations.
The organization may provide an excel spreadsheet in lieu of completing this portion of the application.

Name:	Specialty:	Start/Retro Date:	End/Termination Date:

Any binder of coverage issued by ALTOR National as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Underwriting Criteria and Risk Management Inspection Regulations. I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company. In consideration of the forgoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source. I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possessions or under their control which pertains to my background, competence, and qualifications. *Some state laws permit the statements on the application to be only representations. If the policy will be issued in one of these states, your statements will be representations and not warranties. Acknowledged and Agreed:

Applicant Signature Date

Signing this application does not bind the Company to complete the insurance. All information in this application is considered material and important. If the Company agrees to be bound under the terms of this application, your policy is void if you withhold any information, mislead, or attempt to defraud or lie about any matter contained in this application.

RELIANCE ON APPLICATION, FRAUD WARNINGS, AND SIGNATURE

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THIS RISK THAT HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY.

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares, warrants and represents, to the extent permitted by applicable law, that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. Should any of the information in this Application be false or inaccurate, this policy may be void *ab initio*, as if the policy had never existed. This insurance shall provide no coverage for any matter that is based upon, arising out of, directly or indirectly resulting from or in any way involving any actual or alleged false or inaccurate information in this Application.

The information contained in and submitted with this Application is on file with the Insurer, and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

The undersigned declares that all individuals and entities proposed for this insurance understand that:

A. If any portion of the policy to be issued is written on a "Claims Made" basis, then such portion(s) shall apply only to "Claims" that are first made against the "Insured" during the "Policy Period" and are reported to the Insurer in writing during the "Policy Period" or within the time period set forth in the policy or to "Claims" that are first made against the "Insured" during the Extended Reporting Period or within the time period set forth in the policy; and
B. the limit of liability available under the policy to be issued available to pay damages, settlements, or judgments may be reduced, and may be exhausted, by payment of "Defense Expenses," and "Defense Expenses" also shall be applied against the retention.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 ALABAMA APPLICANTS: 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.

NOTICE TO ARKANSAS, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND, VERMONT & 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 CALIFORNIA APPLICANTS: For your protection, California law requires the following 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 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 agencies.

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 of the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines and confinement in prison. 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 or insurance agent or broker, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for insurance or the rating of an insurance policy, or a claim for payment or other benefit under an insurance policy, which such person knows to contain materially false information concerning any material fact thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

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 MAINE, TENNESSEE, VIRGINIA & WASHINGTON APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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 the 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.

NOTICE TO OREGON APPLICANTS: 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. Misstatements, misrepresentations, omissions or concealments on your part are not fraudulent unless they are made with the intent to knowingly defraud.

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.

ACKNOWLEDGEMENT

This applicant acknowledges that the applicant has read and understood this application, and further declares that the statements set forth herein are true. The applicant agrees that if the information supplied on the application by the applicant changes between the date of the application and the effective date of insurance, applicant will immediately notify the Company of such changes and the company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signature:	Date:
Printed Name:	Title:

This application is not valid without your complete signature, date, printed name, and title above.