GenPro/Genesee General
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APPLICATION FOR ALLIED HEALTH PROFESSIONAL AND GENERAL LIABILITY INSURANCE

1. NAME OF APPLICANT: ______________________________

2. MAILING ADDRESS: ______________________________
(If multiple name and locations, please attach list)

______________________ PHONE NO. __________

3. a) DATE ESTABLISHED Corp.______ Partnership Prof. Assoc. ______ Individual ________

b) In what states is the applicant registered and licensed to practice? ______________________

4. Is the firm engaged in, owned by, associated with or controlled by any other business? ____ if yes, give detail

____

____

____

5. State approximate division of applicant's patient among:

a) Alcoholics
b) Counseling/ Family Planning (%)
c) **Communicable** (%)
d) Dental (%)
e) Drug Addicts (%)
f) General (%)
g) Hemodialysis (%)
h) Holistic medicine (%)
i) **Medical** (%)
j) Mentally Retarded (%)
k) **Obstetrical** (%)
l) Pediatric (%)
m) Psychiatric (%)
n) Research (%)
o) Senile or Aged (%)
p) Stress Testing (%)
q) **Surgical** (%)
r) **Tubercular** (%)
s) Other_______ (%)

6. a. List the number and type of applicant's employees and volunteers: If None, State None.

Number	Type of Profession
a)__________	EMT's
b)__________	Inhalation Therapists
c)__________	Laboratory Technicians
d)__________	Nurse Anesthetists
e)__________	Nurses, Licensed Practical
f) __________	Nurse Practitioner
g)__________	**Nurses Registered**
h)__________	Opticians
i)__________	Optometrists
j)__________	Paramedics
k)__________	Perfusionists
l)__________	Pharmacists
m)__________	Physicians - Minor Surgery
n)__________	Physicians - No Surgery
o) __________	Physiotherapists
p)__________	Social Workers
q)__________	Speech Therapists
r)__________	Other

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b. List the number and type of independent contractors who provide professional services on behalf of the applicant. IF NONE, STATE NONE.____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations
______ Yes ______ No If no, attach explanation.

7. PROFESSIONAL ACTIVITIES AND SPECIALTY

Please check all that apply:

GENERAL

________ Acupuncture Clinic
________ Acupuncturist
________ Adult Day Care
________ Alcohol / Drug Rehab (Adults Only)
________ Ambulance Services (NON EMERG ONLY)
________ Artificial Limb Clinic
________ Audiologist
________ Case Management
________ **Community Health Clinic (non-surgical)**
________ Consultant
________ Counselor
________ Diagnostic Imaging / X-ray
________ **Diagnostician**
________ **Dialysis Center - Hemo**
________ **Dialysis Center - In Home Peritoneal**
________ **Dialysis Center - Peritoneal**
________ Durable medical equipment - Sales
________ EMT
________ Halfway House
________ Health and Fitness Center
________ Hearing Aid Fitter
________ Home Health Agencies
________ Home Health Aide
________ Imaging Tech
________ **LVN / LPN**
________ Massage Therapist
________ **Medical Clinic**
________ Medical Clinic -LVN
________ Medical Clinic - Counseling
________ Medical Clinic - Nurse Practitioner
________ **Medical Clinic - Physician**
________ Medical Clinic RN / PT
________ **Medical Director**
________ Medical Lab Tech
________ Medical Lab All Other
________ **Medical Lab - DNA Testing**
________ Medical Lab - Drug Testing
________ **Medical Lab - Fertility Testing**
________ **Medical Personnel Services - Home Health**
________ **Medical Personnel Services - Staff Relief**
________ Mental Health Clinics
________ Mental Health Tech
________ **Nurse**
________ Nurse Practitioner
________ Nurse Aide
________ Occupational Therapist
________ Occupational Therapist Assistant
________ Ocularist
________ **Oncology Treatment**
________ Optical - related establishments
________ Optical Goods Stores
________ Optometrist
________ Pastoral Counselor
________ Pharmacy - non prescription
________ **Pharmacy - prescription**
________ **Phlebotomist**
________ Physical Therapy Assistant
________ Physical Therapy Clinic
________ Physician Assistant (no surgery exposures)
________ **Physician Assistant (surgery exposures)**
________ **Pregnancy Center**
________ Psychiatric Social Worker
________ Psychologist
________ **Radiation Therapy Technician**
________ Respiratory Therapist
________ School for Handicapped
________ Sheltered Workshops
________ Speech Therapist
________ Speech / Language Pathologist
________ **Surgical Technician**
________ **Surgicenter**
________ **Surgicenter - w/ Anesthe**
________ Surgicenter - w/out Anesthe
________ **Testing Services**
________ Testing Services (specimen collection only)
________ Ultrasound Technician
________ Veterinarian
________ X Ray Technician

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MEDICAL SPA SPECIALTIES

________	Laser / LED Treatments - Basic	________	Laser Hair Stimulation
________	Laser Hair Removal (skin types I -IV only)	________	Tattoo Removal
________	Professional Package - Veins	________	Doctor Supervisors (Laser)
________	Professional Package - Age Spots	________	Doctor (Performing Laser Procedures)
________	Professional Package - Rosaceas	________	Sclerotherapy
________	Professional Package - Wrinkle Reduction	________	Medical strength peels (skin types I-IV only)
________	Professional Package - Acne Treatment	________	Facials / peels and microdermabrasion
________	Mesotherapy	________	Teeth Whitening

8. ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:
Has the applicant or have any of the above employees: YES NO

a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? a)________ ________

b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? b)________ ________

c) Ever been treated for alcoholism or drug addiction? c)________ ________

d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? d)________ ________

9. Number of Ground Ambulances ____________
Number of Air Ambulances ____________
Radius of Services ____________
Number of Emergency Calls ____________
Number of Non-Emergency Calls ____________

10. Does the applicant perform: YES NO

a. Acupuncture or acupuncture anesthesia? Explain:______________________________ a)______ ______
b. Angiography / Arteriography/ Venography? Describe:______________________________ b)______ ______
c. Catherterization (other than urinary or umbilical)?
Describe procedure: c)______ ______
d. Closed reduction of compound fractures and / or Normal Deliveries and/or Dermabrasion? d)______ ______
e. Injection of radioisotopes and / or use of irradiated substances?
Describe:______________________________ e)______ ______
f. Radiation Therapy and/or Chemotherapy? Describe: ______________________________ f)______ ______
g. Psychiatric shock therapy? g)______ ______
h. Silicone injections/ Describe: ______________________________ h)______ ______
i. Spinal Anesthesia (other than saddle blocks or caudals)? i)______ ______
j. Laser treatment? Describe: ______________________________ j)______ ______
k. Botox injections k)______ ______
l. Chelation Therapy / Describe______________________________ l)______ ______

11. Does the applicant perform any:

a. Surgery other than incision of superficial boils or suturing superficial fascia? a)______ ______
b. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? b)______ ______
c. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections? c)______ ______
d. Cosmetic Plastic Surgery? Describe ______________________________ d)______ ______

____

e. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? e)______ ________
f. Hysterectomies? f)______ ________
g. Open reduction of fractures? Describe:____________________________ g)______ ________
h. Surgery for weight reduction of patients? h)______ ________
i. Abortions and / or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): i)______ ________
j. Silicone Implants? Describe: ____________________________ j)______ ________
k. Sterilization Procedures? Describe:____________________________ k)______ ________
l. Biopsies and/or endoscopies? List types performed:____________________________ l)______ ________
m. Sex change operations? Describe and advise the number performed m)______ ________
per year: ____________________________
n. Other Surgery? Describe: ____________________________ n)______ ________

12. Does the applicant perform hospital emergency room care?
a) for its own regular patients? ______ \b) for patients not its own? _____ Yes ______ No
c) If answer to (b) is yes, please specify: the percentage of its time devoted to this work= _______% the number of hours per month devoted to this work= ______ hrs.

13. Does the applicant use drugs for weight reduction of patients? ___ Yes _____ No If yes, list drugs used and advise: Percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant. ____________________________

14. Does the applicant administer any methadone treatment? ______ Yes _____ No **If yes, please complete the** methadone supplementary application.

15. Is anesthesia (other than topical or by means of local infiltration) admistered by either applicant or others? _______Yes ______ No If yes, attach detailed explanation

16. Does the applicant maintain any beds for overnight occupancy? ______ Yes ______ No, If yes, number of licensed beds by location: ____________________________

17. State the number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom treatment is given and number of procedures: ____________________________

18. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? _____ Yes ______ No If yes, give details, including name, location size and number of beds. ____________________________

19. State sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
A. Charitable contributions	$______________	$______________
B. Government Funding	$______________	$______________
C. Fee for Services	$______________	$______________
D. ______________	$______________	$______________
E.______________	$______________	$______________
TOTAL GROSS REVENUE	$______________	$______________

20. Number of patient encounters last 12 months _____ and / or patient tests carried out _________
(Note:"patient encounters" refers to number of visits - not number of patients.)

21. Number of estimated patient encounters next 12 months _____ and/or patient tests carried out______
(Note:"patient encounters" refers to number of visits - not number of patients.)

22. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

If expiring insurance is a claims made policy, what is the retroactive date? ______________________________

23. Is the Applicant currently insured under a Commercial General Liability Policy? Yes ______ No_____ If yes, please give details:

Insurance Company	Type of Coverage	BI	PD	Limits From	To

24. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?
______ Yes _____ No If yes, please give details :____
____

25. Has any claim ever been made against the firm or any of its employees? Yes_____ No_____ If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

26. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? Yes_____ No______ If yes, please give full details on the same basis as item 24.

27. Has any insurer cancelled or refused to renew any similar insurance during the past five years? ___________

28. Limits of Liability requested ______________________ Deductible ______________________________

29. Desired term of policy: From ___________________ To ______________________

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: ______________________________

Please Print Title

Signature: ______________________________

Name Date

Name of Insurance Agent or Broker ______________________________

Please Print Title

Signature: ______________________________

Name Date

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