EASTERN SPECIAL RISK
INSURANCE AGENCY
P.O. BOX 218
HARVARD, MASSACHUSETTS 01451
PHONE (978) 456-8200
WATS (800) 341-1110
FAX (978) 456-3245
CA License #0619313
specrisk@charter.net

Broker _____ Date _____
Address _____ Surplus lines licensee? ☐Yes ☐No If yes,
_____ indicate State, License No. and Expiration
Phone _____ _____
Fax _____

Application for a Premium Quotation (without obligation)
PUBLIC HEALTH PROFESSIONAL LIABILITY INSURANCE
(including Comprehensive General Liability as an option)

*This is an application for a **claims-made** form. All questions **must** be completed.*

1. Applicant _____ Phone ( ) _____ Fax ( ) _____

2. Mailing Address _____
   No. Street City State Zip

3. Location(s): *(If property is owned and rented or leased to others, indicate total area leased or rented.)*
   A. _____ ☐Own ☐Rent Area _____ Sq.Ft.
   B. _____ ☐Own ☐Rent Area _____ Sq.Ft.
   (If more than two facility sites, attach a supplemental schedule including the areas of each.)

4. Entity is ☐ State ☐ County ☐ Municipal ☐ District ☐ Other _____
   Total number of employed staff _____ Population of political subdivision served _____
   Name of Health Officer _____ Physician? ☐ Yes ☐ No

5. Annual Budget - Public Health/Medical Facilities

	YEAR	BUDGET/RECEIPTS
	19 _____	$ _____
	19 _____	$ _____
	19 _____	$ _____

6. Employed Professionals: (Indicate the number of employed in each category) and whether they are Full or Part Time (under 30 hours). Do not include subcontractors. Provide full details under #7 below. (If coverage is being requested for Physicians as Insureds, a separate application is required.)

	FT	PT		FT	PT		FT	PT
Physicians			Nurse Practitioners			Physician's Assistants		
Dentists			Psychologists			Registered Nurses		
X-Ray or Lab Technicians			Dental Hygienists			Social Workers		
Licensed Practical Nurses			Physical Therapists			Dental Technicians		
Sanitarians			Other (Specify)			Other (Specify)		

7. Subcontractors: Do you contract for service of any outside health care staff? ☐Yes ☐ No If yes, break down estimated annual payments as to contractors by professional category. _____
   _____
   _____
   Are there any professionals who volunteer their services? ☐Yes ☐ No If yes, provide details. _____
   _____
   Are certificates of insurance obtained from subcontract professionals? ☐Yes ☐ No If no, would the department implement this procedure? ☐Yes ☐ No
   If no, is there a reason this cannot be done? _____

8. Contractual: Does the department enter into contracts where it assumes liability from another professional or entity or agrees to provide defense? ☐Yes ☐ No If yes, please provide a copy of the agreement(s) or provide a list of any entities which must be added as additional insureds.

9. Services: *(Indicate the approximate percentage of services rendered in each category. Total should equal 100%.)*
   Laboratory _____ % Dental _____ % Home Health _____ % Geriatric _____ % Alcoholism _____ %
   Drug Addiction _____ % Psychiatric _____ % Rehabilitation _____ % Pre-Natal _____ %
   Childbirth _____ % Pediatric _____ % Abortion _____ % Jail Health _____ % Family Planning _____ %
   Communicable Disease _____ % Environmental Health _____ % Other (Specify) _____

10. Scope of Medical Practice: Explain any yes answers in the space provided after 10K.
    A. Do you perform surgical procedures? ☐Yes ☐ No If yes, describe in detail.
    B. Do you use X-Rays on premises for treatment? ☐Yes ☐ No If yes, describe in detail.
    C. Do you administer or prescribe electro-shock therapy? ☐Yes ☐ No If yes, describe in detail.
    D. Do you dispense Methadone? ☐ Yes ☐No If yes, to how many individual per year?
    E. Do you perform arteriography or angiography? ☐ Yes ☐ No If yes, describe in detail.
    F. Do you administer anesthesia other than topical or by means of local infiltration? ☐ Yes ☐ No If yes, describe in detail.
    G. Do you reduce fractures or use sclerotherapy? ☐Yes ☐ No If yes, describe in detail.
    H. Do you insert or remove Norplant? ☐Yes ☐ No If yes, how many patients per year? _____

I. Do you provide inpatient (overnight) services? ☐Yes ☐ No If yes, describe in detail.
J. Do you supervise or maintain group homes or residence facilities? ☐Yes ☐ No
K. Do you rent or otherwise provide equipment or products to others? ☐ Yes ☐ No If yes, describe and estimate annual receipts from sales or rental.
L. Does the Public Entity operate any other health care facility or engage the services of any other medical professionals operating on the entity's behalf? ☐Yes ☐ No If yes, describe in detail.

_____
_____
_____
_____

11. Services - Medical:

	Patient Contacts *(Visit to one or more departments or clinics of the applicant in a single day.)*	Immunizations *(List the total number administered irrespective of the duplication with patient contacts.)*
Past 12 months	_____	_____
Anticipated, next 12 months	_____	_____

	School Health Visits/Home Health Visits *(if applicable)*	*(if applicable)*	WIC Programs *(No. of participants - mother & Children)*
Past 12 months	_____	_____	_____
Anticipated, next 12 months	_____	_____	_____

Services - Environmental *(List the total number in each category irrespective of duplication with each other):*

	Inspections	Investigations	Permits/Licenses Applied For
Past 12 months	_____	_____	_____
Anticipated, next 12 months	_____	_____	_____

12. Coverage Extensions: Are any coverage extensions required beyond the basic form? *(The basic form includes Comprehensive General Liability, Broad Form Comprehensive General Liability, Malpractice, Errors & Omissions, and employees and volunteers as additional insureds.)*

_____

13. Limits: ☐ $500,000/$500,000 ☐ $1,000,000/$1,000,000 ☐ $1,000,000/$3,000,000 ☐ Excess/Umbrella (additional application required)

14. Options
☐ Non-Owned Auto Liability: *(Indicate total number of employees)* _____
☐ Other _____

15. Insurance History: If no existing coverage, so state indicating "none" Proposed Effective Date _____ (if quotation is issued and accepted)

	General Liability	Malpractice	Errors & Omissions Public Officials
Present Carrier(s)	_____	_____	_____
Limits of Liability	_____	_____	_____
Expiration Date	_____	_____	_____

Is current carrier willing to renew? ☐Yes ☐ No If not, why? _____

16. Is any coverage now on a claims-made basis? ☐Yes ☐ No Date(s) of first claims-made coverage(s) _____
Claims History: In the past 5 years, has any claim or suit been brought against the applicant, its board members, employees or volunteers, or physicians working on its behalf? ☐Yes ☐ No If yes, describe what occurred, against whom, when, and dollar value reserved or settled for on a copy of your letterhead and attach it to this form.

17. Does the applicant have knowledge of, or reason to foresee, any circumstance which occurred prior to the date of this application which might result in a claim or suit being brought? ☐Yes ☐ No If yes, give details in full. _____
Applicant agrees to report any claim or incident of which he/she receives knowledge **after** the signing of this application as a condition precedent to effecting coverage.

Warranty: The undersigned risk manager, health officer, chairman, president or commissioner of the applicant declares that to the best of his or her knowledge the information given above is true and correct.

Signed: _____ Title: _____ Date: _____

Completion of this form does not bind coverage or obligate the applicant; however, should a quotation be acceptable, the information given above will be the basis of the contract. Application must be currently singed (within 45 days) and dated to consider the quotation. The policy being applied for is limited to only those claims that are first made against the insured while the policy is in force and which occur after the inception of the contract, unless prior acts coverage is specifically provided.

Important: Attach a copy of your most recent operational annual report. and the declaration page of your current policy

In Arkansas, Colorado, Florida, Hawaii, Kentucky, Maine, Minnesota, New Jersey, New Mexico, New York, Ohio Oklahoma, Pennsylvania and Virginia, notice concerning false or fraudulent statements must be attached.

NOTICE REQUIRED BY CERTAIN STATES

NOTICE TO ARKANSAS APPLICATIONS: "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 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 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 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 IN THE THIRD DEGREE."

NOTICE TO HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

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 AND VIRGINIA APPLICANTS: "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."

NOTICE TO MINNESOTA APPLICANTS: "A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

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 MEXICO 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 CIVIL FINES AND CRIMINAL 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, 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 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 AN INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCLOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

NOTICE TO PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION SHALL UPON CONVICTION BE SUBJECTG TO IMPRISONMENT FOR UP TO SEVEN YEARS AND PAYMENT OF A FINE OF UP TO $15,000."

Signature: _____