Physicians' Reciprocal Insurers

General Liability Insurance Application

IMPORTANT: Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

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AC-1 (5/95), Rev. 10/98, Rev. 4/01, Rev. 6/02, Rev. 11/02, Rev 3/04, 1/11, 3/14

PHYSICIANS' RECIPROCAL INSURERS
GENERAL LIABILITY INSURANCE APPLICATION

PART I - APPLICANT

1. ***Name of Facility***: ____

2. ***D/B/A***: ____

3. ***Main Location***: ____

4. ***Number of years in business***: _____________ 4a. ***Number of years under current management***: ________

5. ***Facility Tax I.D. Number:*** ____________________

6. ***Type of Facility (check all that applies)***

☐ For Profit
☐ Hospital
☐ Surgery Center
☐ Home Health Care Agency
☐ Other:

☐ Not For Profit
☐ Nursing Home
☐ Healthcare Clinic
☐ Laboratory

____

7. ***Named Insureds***: List all subsidiaries, date acquired, description of operation, ownership in percentage and if coverage is desired.

Subsidiaries	Date Acquired	Description Of Operation	% of Ownership	Coverage Requested?

PART II – REQUESTED LIABILITY LIMIT AND DEDUCTIBLE OPTIONS

1. ☐ Primary
   ☐ Excess
2. Coverage Period: Effective Date: _____________ Expiration Date: ______________

PLEASE NOTE THAT ONLY OCCURRENCE COVERAGE IS AVAILABLE FOR GENERAL LIABILITY IN NEW YORK STATE.

3. ***Requested Liability Limits***:

Per Location Aggregate	$___________________________
General Aggregate (Other Than Products-Completed Operations)	$___________________________
Products-Completed Operations Aggregate	$___________________________
Personal & Advertising Injury	$___________________________
Each Occurrence	$___________________________
Fire Damage Legal Liability (Any One Fire)	$___________________________
Medical Expense (Any One Person)	$___________________________
Other (Hired and Non Owned Auto, Employee Benefits, etc.)	$___________________________

4. ***Requested Deductible*** (Check only one):

☐ No deductible
☐ $2,500 ☐ $10,000 ☐ $25,000 ☐ $100,000
☐ $5,000 ☐ $20,000 ☐ $50,000 ☐ Other: ______________

PART II A - INSURANCE PROFILE (FIVE YEARS)

1. ***Primary General Liability Coverage*** **- Failure to complete will delay the process of the application**

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability	Premium
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	

2. ***Excess General Liability Coverage***

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability	Premium
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	
			☐ Ded ☐ SIR	☐CM ☐Occ		☐Yes ☐No	

3. Has the Applicant's policy or coverage ever been declined, cancelled or non- renewed during the past three (3) years?

   If yes, please explain: ____

PART III – SCHEDULE OF EXPOSURES

1. Please list all properties owned, controlled or occupied by the Applicant (including leased properties and parking areas). If needed, please attach a current Statement of Values.

Location #	Description	# of Stories	Owned/Leased	Area Sq. Ft

2. Please list any construction, alteration or additions which have been proposed, are currently being performed or have been newly completed.

Location #	Description	# of Stories	Owned/Leased	Area Sq. Ft

PART IV – GENERAL INFORMATION (All questions must be answered)

Where applicable, provide a copy of each agreement.

1. Is there a formal safety program in operation? Yes ☐ No ☐
2. Is there sufficient lighting? Do the stairwells have lighting? Is there sufficient lighting in the hallways? Is there sufficient lighting in the operating areas? Yes ☐ No ☐
3. Is the facility wheelchair accessible? Are protocols in place to address emergency situations? Yes ☐ No ☐
4. Are the premises designed to minimize hazards? Is the infrastructure in proper working condition? Yes ☐ No ☐
5. Is ventilation more than 10 years old? Are corridors properly ventilated? Is there a sprinkler system throughout the facility? Are there fire extinguishers appropriately placed throughout the facility? Yes ☐ No ☐
6. Is any equipment loaned/rented to others? Yes ☐ No ☐
7. Are employees leased to or from other employers? Yes ☐ No ☐
8. Are employees subject to training? Are employees supervised? Yes ☐ No ☐
9. Are respective employees vetted to aptitude and ability? Yes ☐ No ☐
10. Does your facility have a management contract to provide management services to other facilities or does another facility provide management services to your hospital? Yes ☐ No ☐
11. Any there any services provided by contractors/subcontractors? Yes ☐ No ☐
12. Are certificates of insurance required from all subcontractors? Yes ☐ No ☐
13. Are parking facilities owned? Yes ☐ No ☐
14. Are parking facilities leased? Yes ☐ No ☐
15. Any elevators or escalators on premises? Yes ☐ No ☐
    - If yes, do you require elevator collision coverage? Yes ☐ No ☐
    - If yes, indicate number of elevators: __________
16. Does the Applicant have a heliport/helipad? Yes ☐ No ☐
    - If yes, do you require heliport/helipad coverage? Yes ☐ No ☐
17. Does the Applicant own and/or operate a daycare service? Yes ☐ No ☐
    - If applicable, is such daycare open to the public? Yes ☐ No ☐
18. Does the Applicant own a Pharmacy? Yes ☐ No ☐
    - If yes, are prescriptions dispensed to persons other than patients? Yes ☐ No ☐

PART V - QUALITY ASSURANCE/RISK MANAGEMENT

Safety Officers			
a. Who coordinates the facility's risk management program:			
Name:		Title:	
Telephone #:	( ) -	Email:	
Years of experience:		Reports to:	

PART VI - ADDITIONAL INFORMATION AND DOCUMENTS TO ACCOMPANY APPLICATION

1. Copies of any hold harmless agreements.
2. Copy of loss runs for the last ten (10) years.

APPLICATION IS NOT ACCEPTED WITHOUT SIGNATURE ON THE NEXT PAGE

The answers to the foregoing questions are complete and correct to the best of my knowledge and belief.

NOTICE

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.

Signature: ____

Name (please print): _____________________________________

Title: ____

Date: ____