Physicians' Reciprocal Insurers

Supplemental Application for

Additional Insureds – Mergers & Acquisitions

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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Acknowledged by NYSID for Informational Purposes Only
10/13

SUPLEMENTAL APPLICATION FOR
ADDITONAL INSUREDS
MERGERS & ACQUISITIONS

PART I - ENTITY INFORMATION

1. Name of Entity: _____

2 D/B/A: _____

3. Main Location: _____

   a. Is this an additional location: Yes ☐ No ☐

   b. Please describe nature of Entity's business: _____

   _____

   _____

4. Type of organization:

   ☐ For profit ☐ Not for profit

5. Accreditation: JCAHO/CARF/COA/OMH/OASAS/Other_____

6. Licensure by: (Example DOH) _____

7. Date of transaction:_____

   Type of transaction:

   ☐ Asset Purchase (If so, name of previous owner):

   _____

   ☐ New Creation

   ☐ Assumption of Liability

   ☐ Acquisition

   ☐ Merger

   ☐ Other (please specify) _____

8. Will this venture expand outside of New York State and if so, please describe _____

_____

PART II – INSURANCE INFORMATION

1. Current insurance coverage:

Type	Insurer	Limits	Deductible Retention	Policy Period

2. Anticipated insurance coverage: PL ☐ GL ☐ Other ☐ (Please specify) _____

COMPOSITION OF ENTITY:

Management Group Yes ☐ No ☐
Shareholders Yes ☐ No ☐

If yes, please provide the name of Management Group or Shareholders _____
_____

PART III - SERVICES PROVIDED

1. Number of current annual outpatient visits/treatments/revenue: _____
2. Number of projected annual outpatient visits/treatments/revenue in next 12 months: _____

***Visits** – Use a threshold count. Count each patient each time they enter your facility for health related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.

***Gross Revenue** – This figure can be found on your financial statement. Do not adjust this figure for items such as profit, uncollectible accounts or amounts billed but not paid by third party payers. This number must represent the annual gross figure.

MISCELLANEOUS SERVICES – IF APPLICABLE

List and explain any other comments not listed above: _____

_____

PART IV - ADMINISTRATIVE/PROFESSIONAL STAFF

1. Is coverage being requested for employed physicians under the facility policy?

Shared limit option Yes ☐ No ☐

***Please note that above referenced physician will only be covered for administrative duties, no clinical activities or direct patient care coverage will be afforded.**

2. Please list Employed Physicians (include Medical Directors and Dentists). Attach separate sheet, if necessary.

Name	Specialty	Board Certified	F/T	P/T	Years Employed at Facility	Has Own Insurance Yes or No	Coverage Requested Yes or No

APPLICATION IS NOT ACCEPTED WITHOUT SIGNATURE ON THE NEXT PAGE

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.

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

Signature: _____

Name (please print): _____

Title:_____

Date:_____

Please attach a copy of the following documentation for every entity seeking coverage:

1. **The latest annual report, including audited financial statements.**
2. **Organization chart.**
3. **Charter and By-laws.**

Completion of this supplement does not bind PRI to provide coverage.