



SUPPLEMENTAL ENTITY APPLICATION

PROFESSIONAL LIABILITY COVERAGE FOR PROFESSIONAL CORPORATIONS, ASSOCIATIONS AND OTHER ORGANIZATIONS

* Complete one supplement for each entity *

Attach copy of Articles of Incorporation, Partnership Agreement or documents setting up entity listed below

A. General Information

Legal Name of Entity		DBA	Entity TIN #
Entity Business Address			Administrator / Contact Person
Phone Number	Fax Number	Email Address	Website Address

B. Coverage Information

Requested Effective Date: ____ / ____ / ____
MM DD YYYY

- Current form of insurance for entity: Claims-Made Occurrence None
- If claims-made, was a reporting endorsement purchased from current carrier? Yes No
- Are you requesting separate limits of liability from LAMMICO for the entity? (additional premium charge applies) Yes No
- Are you requesting prior acts coverage from LAMMICO for the entity?
If yes, please attach entity certificate of insurance from current carrier Yes No
- Retroactive date used by current carrier: _____

C. Practice and Operations Information

- Are all entities and health care providers currently enrolled in a state Patient Compensation Fund? Yes No N/A
- Type of Practice:
 Professional Corporation Partnership LLC LLP Joint Venture Professional Association
 Other- describe: _____
- Description of Operations:
 Private doctor's office Urgent Care Facility Pain Clinic Medical Spa Outpatient surgery
 Physician owned and operated lab – owner use only Physician owned and operated lab – used by other than doctor/owner patients
 Doctor's office with diagnostic equipment – describe: _____
 Other- describe: _____

ADDITIONAL APPLICATIONS MAY BE NEEDED, DEPENDING ON THE OPERATIONS

- Is the entity/facility used by anyone other than the owner(s), members, or employees? Yes No
If yes, please describe: _____
- Are there any services or business operations conducted outside of your primary state? Yes No
If yes, please describe: _____
- Number of owners: ____ Number of partners: ____ Are all owners and partners insured with LAMMICO? Yes No

7. List the names of all **owners**, partners or members of the entity listed above. (Attach separate sheet, if necessary)

Name / Specialty	Check if NOT insured by LAMMICO	Carrier if NOT insured by LAMMICO *
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

8. Employed or contracted physicians/surgeons with the above named entity (exclude owners/partners)
(Attach separate sheet, if necessary)

Name / Specialty	Check if NOT insured by LAMMICO	Carrier if NOT insured by LAMMICO *
	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

*Attach current certificate of insurance from professional liability carrier, if NOT insured by LAMMICO.



9. Number of employed or contracted:

- Physician Assistants _____
- Surgeon Assistants _____
- Nurse Anesthetists _____
- Nurse Midwives _____
- Nurse Practitioners _____
- Other employees of this entity (not listed or counted above) _____

How many?

Are all insured with LAMMICO?

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

* Attach current certificate of insurance from professional liability carrier, if not insured by LAMMICO.

10. Are there any subsidiaries that provide health care related services? Yes No
 If yes, list below the subsidiary name, description of operations, % of ownership and date acquired)

Subsidiary Name	Description of Operations	Ownership %	Date Acquired

11. If subsidiaries are not 100% owned by the parent, provide details of other owners and the percentage owned by each.

12. Does this entity perform utilization review for a fee for others? Yes No

If yes, please describe: _____

13. Is this entity currently under contract to supervise or administer any departments within a hospital or other facility, for an HMO or PPO or any government agency program? Yes No

If yes, please describe: _____

14. Is the entity required to be licensed to provide medical professional services? Yes No

If yes, by whom? _____

Has a license been granted for the entity? If no, please explain in comments.

Yes No

15. Is the entity eligible to be JCAHO certified? Yes No

If yes, is it certified?

Yes No

Date of certification: _____

16. Has this entity's license ever been suspended, restricted, revoked, surrendered or has probation ever been invoked? Yes No

If yes, please explain: _____

17. Have any claims or suits ever been made or brought against this entity? Yes No

Give dates, allegation and disposition of each claim made.

18. Do you have knowledge of any claims which might be made against this entity or activities that might give rise to a claim or suit in the future? (include any requests for medical records) Yes No

Include a description of each claim or activity.

19. Comments (attach a separate sheet if necessary):

Signing this application does not bind the company to issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 of insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Authorized Representative

Title

Printed or Typed Name

Date Signed