LAMMICO

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		Entity TIN #
DBA (if applicable)		Administrator/Contact Person
Entity Business Address		Phone Number
Email Address	Website Address	Fax Number

B. Coverage Information

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

1. Current form of insurance for entity: ☐ Claims-Made ☐ Occurrence ☐ Self-Insured ☐ None
2. If claims-made, was a reporting endorsement purchased from current carrier? ☐ Yes ☐ No
3. Are you requesting **separate limits of liability** from LAMMICO for the entity? (add'l premium charge applies) ☐ Yes ☐ No
4. Are you requesting prior acts coverage from LAMMICO for the entity? ☐ Yes ☐ No
   If yes, please attach entity certificate of insurance from current carrier.
5. Retroactive date used by current carrier: _____

C. Practice and Operations Information

1. Are all entities and health care providers currently enrolled in a state Patient Compensation Fund? ☐ N/A ☐ Yes ☐ No
2. Type of Practice:
   ☐ Professional Corporation ☐ Partnership ☐ LLC ☐ LLP ☐ Joint Venture ☐ Professional Association
   ☐ Other- describe: _____
3. 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
4. Is the entity/facility used by anyone other than the owner(s), members, or employees? ☐ Yes ☐ No
   If yes, please describe: _____
5. Are there any services or business operations conducted outside of your primary state? ☐ Yes ☐ No
   If yes, please describe: _____
6. Number of owners: _____ Number of partners: _____ Are all owners and partners insured with LAMMICO? ☐ Yes ☐ No

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call 800.452.2120
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One Galleria Blvd., Suite 700
Metairie, LA 70001

LAMMICO

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 LAMMICO Insured and list carrier
		☐
		☐
		☐

8. Employed or contracted physicians/surgeons, **non-owners/partners**, of entity listed above. (Attach separate sheet, if necessary)

Name	Specialty	Check if NOT LAMMICO Insured and list carrier
		☐
		☐
		☐

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

9. Do you (or does your partnership/association/corporation/joint venture) employ or contract with any of the following: ☐ Yes ☐ No

Indicate the number of personnel in each applicable category.

Professional Type:	Employed	**Contract	Professional Type:	Employed	Contract
*Certified Nurse Midwife (CNM)			Aesthetician		
*Chiropractor			*Orthotist		
*Clinical Nurse Specialist (CNS)			*Perfusionist		
*Nurse Anesthetist (CRNA)			Physical Therapist		
*Nurse Practitioner			*Prosthetist		
*Optometrist			RN First Assistant		
*Pharmacist			Surgical Assistant		
*Physician Assistant			Specify type:		
*Podiatrist			Other:		
*Psychologist					
***Separate LAMMICO application is required for coverage.**					

NOTE: If you answered "yes" to any part of question 9, please list all names in the "Remarks" section. If you want to apply for insurance for these medical professionals through LAMMICO, please indicate in the "Remarks" section.

10. Are there any subsidiaries that provide health care related services? If yes, please list below: ☐ Yes ☐ No

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

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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.

_____

_____

_____

Question No.	"Remarks" (Attach additional sheets, 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.

_____ _____
Signature of Authorized Representative **Title**

_____ _____
Printed or Typed Name **Date Signed**

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.

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