LAMMICO

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APPLICATION FOR COMMERCIAL GENERAL LIABILITY COVERAGE

Instructions:

1. **Please read the instructions carefully**. Complete and submit all requested information and/or required attachments.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space for your responses, continue in the Comments Section indicating question number.

Please attach the following:

1. Carrier Loss History (MS Excel or compatible format if possible):
   a. Ten years of historical CGL losses including current year.
   b. Date of loss valuation must be within the past 90 days.
   c. Loss run must include carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), and narrative of claim.
   d. Full details of allegations on all losses paid or outstanding in excess of $25,000.
2. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.
3. Copy of current risk management and quality improvement plan.
4. Copy of current organizational chart (corporate and risk management).
5. Copy of claim management procedures.
6. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.
7. Copy of current CGL policy, including Declarations Pages and Endorsements.

The above information is mandatory before an indication can be released. This application must be completed, signed and dated by an authorized officer of the entity. The application is subject to review and acceptance by LAMMICO and does not bind coverage. Additional information may be requested by LAMMICO.

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (1) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

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COMMERCIAL GENERAL LIABILITY INSURANCE

SECTION 1: GENERAL INFORMATION

Please complete a separate application for EACH location requiring CGL coverage if multiple locations exist. If additional space is needed to answer any questions fully, use the Comments Section or attach a separate page.

Agency Name: (If using Agent)	Agency Address: *(City, State, Zip)*	Producer:

PART I – APPLICANT INFORMATION

Applicant Name:	Tax ID# (TIN)

Applicant Mailing Address: *(Street, City, State, Zip)*	Website Address:

Primary Contact Person:	Primary Contact Title:	Primary Contact Phone:	Primary Contact Fax:	Primary Contact Email:

Contact Person (Accounting):	Contact Title (Accounting):	Contact Phone (Accounting):	Contact Fax (Accounting):

Contact Person (Risk Management):	Contact Title (Risk Management):	Contact Phone (Risk Management):	Contact Fax (Risk Management):

Description of Operations:

Applicant's legal structure *(Check all that apply)*:

☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Governmental ☐ Charitable ☐ For Profit ☐ Not for Profit ☐ Medicare Approved

Complete the following information for each location you own. Location No. 1 should be the primary business address of the applicant.

Business Name & Address *(Street, City, State, Zip)*	Your Ownership Percentage	Description of Operations	Is this location a subsidiary?	Is coverage desired for this location?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Indicate the number of years the applicant has been:

Operating: _____ Owned by present owners: _____ Managed by Present Management: _____

Hava any of your operational licenses ever been suspended, revoked or placed under probation?
(If "yes", please indicate the date and provide details below. Use the Comments Section for additional space if necessary). ..... ☐ Yes ☐ No

PART II – PRIOR INSURANCE HISTORY

1. Please list all Commercial General Liability policies for the past ten years.

Policy Period	Name of Carrier or Self-Insured	CGL Limits (per occ / agg)	Claims-Made Or Occurrence	Retro Date (if applicable)	Deductible/ SIR Amount	Premium

Has any insurer cancelled, declined to issue, or non-renewed any of the coverages listed above? ..... ☐ Yes ☐ No
(If "Yes", please attach an explanation including the name of the carrier, the date and the reason)

PART III – PRIOR CLAIMS HISTORY

Is any claim listed in your 10 year claims history subject to a deductible or self-insured retention? ..... ☐ Yes ☐ No

If "Yes", are the amounts shown in your loss history **inclusive** or **exclusive** of the deductible or self-insured retention? ..... _____

If "inclusive", what is the amount of the deductible or self-insured retention? ..... $ _____

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PART IV – INSURANCE COVERAGE DESIRED

Primary Coverage	Requested Effective Date	Desired Limits	
		Per Claim	Annual Aggregate
Commercial General Liability (CGL)		$	$
Limited Pollution Liability ($1M max limits)			
Employee Benefits Coverage ($1M max limits)			

PART V – DEDUCTIBLE / SELF-INSURED RETENTION REQUESTED*

☐ **Deductible** ☐ Indemnity Only ☐ Indemnity & Expense

Commercial General Liability ☐ None ☐5K/15K ☐ 10K/30K ☐ 25K/75K ☐ 50K/150K ☐ 100K/300K ☐ Other: _____

☐ **Self-Insured Retention**

COMPLETE THE FOLLOWING IF CHOOSING THE SIR OPTION

Please provide a copy of the following documents (if applicable):

- Most recent actuarial funding study
- Trust agreement of the self-insured retention or policy form(s) for captive or RRG
- Claims handling policy and procedure manual
- Trust fund or Captive / RRG financials

i. What are the limits of liability for the SIR / Captive / RRG?

$_____ per claim $_____ aggregate

ii. What coverages are contemplated? Specify the claims basis for each line of business:

_____

_____

iii. Is there a dedicated trust? ☐ Yes ☐ No

iv. Has an independent actuarial funding study been completed? ☐ Yes ☐ No

v. Does the ALAE erode the limits of the SIR / Captive / RRG? ☐ Yes ☐ No

vi. Who handles the claims within the SIR / Captive / RRG? _____

vii. Does the applicant have written policies and procedures regarding incident reporting, claims handling and reserve philosophy? ☐ Yes ☐ No

Provide authority levels for setting reserves and determining whether cases are tried or settled:

_____

_____

viii. Is there a specific law firm used to defend claims? ☐ Yes ☐ No

If "Yes", provide the name and address of law firm: _____

**Reimbursement amount means the amount you would reimburse LAMMICO following a loss and / or loss adjustment expense payment on your behalf. A letter of credit or deposit may be required to secure deductible. Provider will remain responsible for payment of deductible amounts even after termination of coverage.)*

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PART VI – ADDITIONAL ENTITIES REQUIRING COVERAGE

Identify related entities or subsidiaries to be considered for coverage on the policy or attach a list from your current policy. Please use Comments Section for additional entities if needed.

Entity Name: _____

Address: _____

_____

Tax ID No: _____ Retroactive Date: _____

Ownership and relationship to the policyholder: _____

_____

Description of all operations and activities: _____

_____

SECTION 2: FACILITY / LOCATION INFORMATION

Please attach a separate schedule of locations including address, primary function (clinical, administrative, storage, etc.) and square footage.

PART I – APPLICANT FACILITIES

Location	Total Area (sq. ft.)	Age	Type of Construction	Number of Floors	Type of Fire Protection*
Patient Care Building(s):					
Other Buildings:					
Garages:					
Parking Lots:					
Vacant Lots:					

***Fire protection key:** AS – Approved Sprinkler S – Smoke Detector H – Heat Detector A – Automatic Alarm

PART II – APPLICANT OPERATIONS

Do any of the facilities listed in Part I above have: *(Explain all "Yes" answers in the Comments Section)*

A. An exposure to flammables, explosives, chemicals? ☐ Yes ☐ No

B. A catastrophe exposure? ☐ Yes ☐ No

C. An exposure to radioactive materials? ☐ Yes ☐ No

D. Any operations involving the storage, treatment, discharge, application, disposal or transport of hazardous materials? ☐ Yes ☐ No

E. Any elevators or escalators that are owned by you? ☐ Yes ☐ No

(If "Yes", please indicate the model and if the elevator and / or escalator is serviced by you under a maintenance contract)

_____

F. Parking facilities? ☐ Yes ☐ No

(If "Yes", please indicate if the parking facilities are owned or rented) ☐ Owned ☐ Rented ☐ Maintained

G. Recreation Facilities / Health Club? ☐ Yes ☐ No

(If "Yes", please indicate the annual number of members / users of the facility) _____ *Estimated Annual Gross Receipts:* _____

Are the Recreation Facilities / Health Club open to the public? ☐ Yes ☐ No

H. A swimming pool on the premises? ☐ Yes ☐ No

(If "Yes", please describe how and when used) _____

Are there supervising staff? ☐ Yes ☐ No

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Are the supervising staff CPR certified? ☐ Yes ☐ No

I. Any sponsored sporting or social events? ☐ Yes ☐ No

(If "Yes", please indicate the annual number of events) _____ *(Is alcohol served at any of these events?)* ☐ Yes ☐ No

J. Any off-site events such as health fairs or screenings? ☐ Yes ☐ No

K. A Heliport? ☐ Yes ☐ No

(If "Yes", state by location where each pad is located (e.g., parking lot, top of building, etc)):

Please describe the type of construction: _____

Is the heliport separately insured? ☐ Yes ☐ No

Does the applicant obtain a certificate of insurance from the helicopter service? ☐ Yes ☐ No

Is the applicant named as an additional insured on the helicopter service's policy? ☐ Yes ☐ No

Is the heliport: ☐ Owned? ☐ Leased? *(Please check one)* What is the number of annual landings? _____

L. A Gift Shop? ☐ Yes ☐ No

M. A Cafeteria? ☐ Yes ☐ No

N. Security Guards? ☐ Yes ☐ No

If "Yes", are the Security Guards armed? ☐ Yes ☐ No

(If the Security services are contracted, please provide a copy of any contract agreements)

O. Does the applicant's Attorney review and approve all sales literature, advertisements and brochures prior to their use? *(Attach copies of your sales and advertising materials)* ☐ Yes ☐ No

P. Does the applicant's Risk Manager review and approve all sales literature, advertisements and brochures prior to their use? *(Attach copies of your sales and advertising materials)* ☐ Yes ☐ No

PART III – PRODUCT / SERVICES INDEMNIFICATION

A. Estimated annual sales of medical equipment supplies: $ _____

B. Estimated annual receipts from any Retail Pharmacy operation $ _____

C. Estimated annual rental receipts of medical equipment: $ _____

D. Estimated annual receipts from servicing equipment of others: $ _____

E. Do you obtain revenue from contracting with others for services (i.e., laundry, food, maintenance)? ☐ Yes ☐ No

If yes, sales from service contract: $ _____

F. Do you modify the design or function of any medical equipment? ☐ Yes ☐ No

If yes, please explain:

G. Describe any other products or services _____

PART IV – ADDITIONAL INTEREST / CERTIFICATE RECIPIENT

A. Does your facility have any signed contracts which require your facility to name another party as an additional insured or extend contractual indemnity coverage? *(If "Yes", please include a copy of contract)* ☐ Yes ☐ No

B. Do you lease or rent any medical equipment from others? ☐ Yes ☐ No

If yes, describe. _____

If yes, do you indemnify (hold harmless) the owner for liability? ☐ Yes ☐ No

C. Have you signed any contractual agreements where you have agreed to provide services to others? ☐ Yes ☐ No

If yes, describe the types of services. _____

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SECTION 3: EMPLOYEE BENEFITS LIABILITY

PART I – LIMITS DESIRED — **Coverage Not Desired ☐**

A. PRIMARY EMPLOYEE BENEFITS LIABILITY LIMITS

☐ $100,000 Per Claim / $300,000 Total Annual Aggregate
☐ $500,000 Per Claim / $500,000 Total Annual Aggregate
☐ $1,000,000 Per Claim / $3,000,000 Total Annual Aggregate

PART II – CURRENT CARRIER INFORMATION

A. Name of Employee Benefits Carrier: _____

B. Policy Number: _____ C. Expiring Limits: _____ D. Expiration Date: _____ E. No. of Employees: _____

F. Are Employee Benefits Self-Administered? ☐ Yes ☐ No

If "Yes", what is the name of the vendor? _____

SECTION 4: SUPPLEMENT FOR LIMITED POLLUTION COVERAGE

PART I – ADDITIONAL INFORMATION REQUIRED — **Coverage Not Desired ☐**

Please include the following additional information with your application:

1. State Certification for Incinerator, if applicable.
2. Any contracts for disposal of infectious waste.
3. Copy of maintenance records demonstrating state compliance for leak detection.
4. Certification of installation for *each* storage tank.
5. Copies of Certificate of Insurance furnished you by others providing other insurance for any item(s) mentioned in the "*Storage Tanks*" section below.

PART II – INCINERATORS

A. Do you operate an incinerator? ☐ Yes ☐ No

If yes, who is responsible for disposal of infectious waste and maintenance of incinerator?

_____

B. Do you contract for services? ☐ Yes ☐ No

If yes, with what company? _____

Please indicate the EPA # of the company named above: _____

PART III – NUCLEAR MEDICINE / HAZARDOUS WASTE

A. What kinds of pollutant or toxic wastes do you generate and dispose of (check all that apply)?

i. Chemical: Toxic ☐ Yes ☐ No
Reactive ☐ Yes ☐ No
Corrosive ☐ **Yes** ☐ **No**
ii. Organic (i.e., bacteriologic, viral, etc.): ☐ Yes ☐ No
iii. Radioactive: ☐ Yes ☐ No
iv. Other: _____ ☐ Yes ☐ No

B. Do you operate a nuclear medicine department at this facility (or any subsidiary, site or location listed in "Section 1 – General Information" at the beginning of this application? ☐ Yes ☐ No

C. If "*Yes*", list below and indicate what substance(s) are used and disposed of on a regular basis

_____

_____

D. Does this facility have and promulgate a policy on the handling, disposal and management of pollutants? ☐ Yes ☐ No

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PART IV – STORAGE TANKS

A. Do you have storage tanks? ..... ☐ Yes ☐ No

If "*Yes*", please complete the following questions.

1. Do you own the tanks? ..... ☐ Yes ☐ No
2. Please complete the chart below for each tank

TANK	1	2	3	4	5	6	7	8	9	10
Capacity of tank (gallons)										
Age of tank (years)										
Installation date (month / year)										
Was the tank new upon installation (Y / N)?										
Was tank precision tested after installation (Y / N)?										
Is tank below ground (Y / N)?										
Material stored in tank (indicate by "X" under appropriate tank)										
Gasoline										
Diesel										
Kerosene										
Heating Oil										
Other:										
Construction of tank (indicate by "X" under appropriate tank)										
Tank in vault										
Double walled tank										
Fiberglass Steel Coated										
Cathodically protected steel										
Fiberglass										
Fiberglass lined steel tank										
Spill / Overfill protection (Y / N)?										
Leak detection (Y / N)?										
Are tanks in compliance w/ State & Federal regs (Y / N)?										
How often are tanks tested?										

B. Environmental Factors:

i. What is the distance to the nearest surface water source? _____

ii. What is the distance to the nearest drinking water source? _____

iii. What is the depth to the groundwater? _____

iv. What is the distance to the sewer line hook-up? _____

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SECTION 5: PHYSICAL / SEXUAL ABUSE INFORMATION

PART I – GENERAL INFORMATION

A. Do you have Abuse Coverage with your current carrier? ☐ Yes ☐ No

If 'Yes', please provide a copy of the current endorsement or policy language.

What are the current Abuse limits on your policy? _____

B. Are you aware of any type of abuse (physical, emotional, financial, sexual, etc.) that has occurred in your facility? ☐ Yes ☐ No

C. Do background checks of prospective employees and volunteers include information on all criminal convictions, abuse registry / sex related or child-abuse related offenses? ☐ Yes ☐ No

D. Are employment-related references verified during hiring? ☐ Yes ☐ No

E. Is there a written policy outlining management's commitment to sexual abuse prevention? *(If 'Yes', please attach a copy)* ☐ Yes ☐ No

F. Are all staff and volunteers trained in policies and procedures related to sexual abuse prevention and the consequences of non-adherence at all locations? *(If 'No', please explain in Comments Section)* ☐ Yes ☐ No

PART II – LOSS HISTORY

A. Are you aware of any facts, incidents, circumstances, or allegations that may result in an abuse or molestation claim against you? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

B. Have you, any employee, counselor, independent contractor, sub-contractor, volunteer, 'others' or officers currently seeking coverage been involved in an allegation or claim relating to abuse or molestation? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

C. In the past 5 years, have any employees, counselors, independent contractors, sub-contractors, volunteers, 'others' or officers been disciplined, terminated or transferred due to their suspected or actual involvement in abusive behavior? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

PART III – POLICIES & PROCEDURES

A. Are the below items included in the code of conduct handbook for all employees, contractors and volunteers?

i. Zero tolerance statement for abuse perpetrated on children or other persons in the applicant's care. *(Please attach a copy)* ☐ Yes ☐ No

ii. Written policy that defines appropriate and inappropriate displays of affection. *(Please attach a copy)* ☐ Yes ☐ No

iii. Written procedure governing interactions between employees, contractors and volunteers when alone with children or other persons in your care. *(Please attach a copy)* ☐ Yes ☐ No

iv. Written policy / procedure governing the use of chaperones during patient examinations. *(Please attach a copy)* ☐ Yes ☐ No

B. Do you have a written procedure for responding to reports of suspicious or inappropriate behavior or allegations of abuse? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

C. Do you have a designated investigator with specialized training in charge of handling sexual misconduct investigations? ☐ Yes ☐ No

D. Do you use a standardized incident reporting form across all locations and programs? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

E. Are management / staff and volunteers trained in policies and procedures relating to abuse and molestation and the consequences of non-adherence at all locations? *(If 'No', please explain in Comments Section)* ☐ Yes ☐ No

F. Are complete records maintained documenting adherence to all applicable policies and procedures (e.g., hiring & screening, code of conduct, training, incident & follow up, etc.)? ☐ Yes ☐ No

G. Is there a formal procedure concerning when appropriate law enforcement authorities are called when there is a suspected incident of abuse or molestation? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

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SECTION 6: APPLICANT NOTICE AND DECLARATION

The Applicant expressly represents and warrants that the above statements and facts are true and correct and that no material facts have been suppressed or misstated. Applicant specifically acknowledges that LAMMICO has relied on statements contained in this application to issue coverage, particularly as to claims made and prior acts or retro coverage as to disclosing all incidents occurring in the last ten (10) years where Applicant knows or has reason to believe a claim may be made in the future. Any failure to disclose material facts affecting coverage, losses and premiums, including incidents that have occurred at the time of this application, but not made until after coverage is instituted may constitute a material misrepresentation or fraud causing the denial of coverage.

I understand the submission of this application does not bind LAMMICO to issue me, or our institution to purchase, this insurance. By signing below, I grant permission (1) to LAMMICO to contact third parties and (2) for third parties to release to LAMMICO information which relates to the issuance and continuation of this coverage. I also understand that knowingly providing false, incomplete or misleading information to LAMMICO for the purpose of defrauding LAMMICO may constitute a crime punishable by imprisonment, fines, and/or a denial of insurance benefits.

I represent the information provided in this application (and attachments) is true. I understand (1) that this application and any previous applications are the basis of and will become a part of the coverage contract with LAMMICO; (2) that the application information I provided is material to LAMMICO; (3) that LAMMICO is relying on this information in determining whether to issue a coverage contract and in establishing the premium to charge for the contract; and (4) that LAMMICO may rescind or void the coverage contract if this application or any previous application contains any misrepresentations or omission. Furthermore, I understand that my failure to disclose to LAMMICO any material fact that I become aware of subsequent to the completion of this application but prior to the effective date of the coverage may also void the contract.

Applicant Signature	Title	Date

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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COMMENTS SECTION