BusinessRisk PARTNERS

# MISCELLANEOUS PROFESSIONAL LIABILITY APPLICATION

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www.businessriskpartners.com

Please complete the application by either entering the required information directly from your keyboard, or printing the application and entering the information by hand. You will need Adobe Acrobat Reader Version 4.0 (at minimum). If you are using version 3.0, you can upgrade it for free at www.adobe.com. Fax or e-mail the completed application to Business Risk Partners at the address noted above.

## GENERAL INFORMATION

1. Company Name (Applicant) _____

   Street _____

   _____

   City _____ State _____ Zip _____

   Telephone _____ Fax _____
   E-mail Address _____
   Website _____

2. Please list the states in which the Applicant provides services.

   _____

   _____

3. Please provide a brief description of the professional services for which coverage is desired.

   _____

   _____

   _____

   _____

   _____

## REVENUE BREAKDOWN

4. Please list the professional services that the Applicant provides and the % of revenue generated by each service.

| Professional Service | Percentage of Revenue |
|---|---|
| _____ | _____% |
| _____ | _____% |
| _____ | _____% |
| _____ | _____% |

## DESCRIPTION OF BUSINESS

5. Please indicate the total revenue for the following fiscal years for both the Applicant and any subsidiaries performing professional services sought to be covered under this policy.

   Current Year: _____

   Last Year: _____
   Next Year (projected): _____

6. How many years has the Applicant been in business? _____

7. Please indicate the Applicant's total number of employees. _____

8. How many of these employees provide professional services directly to clients? _____

9. Does the Applicant provide professional services to any client/customer that represents more than 20% of the Applicant's gross annual revenue? ☐ No ☐ Yes

10. Is the Applicant controlled or owned by, or associated or affiliated with, or does it own any other firm business enterprise? If yes, please explain: ☐ No ☐ Yes

    _____

    _____

11. Does the Applicant have a contract in place with clients?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ Never

12. Do the Applicant's contracts contain indemnification/hold-harmless clauses running in its favor?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ Never

13. Does the Applicant do business through independent contractors?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ Never

14. Does the Applicant contractually require independent contractors to maintain E&O insurance?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ Never

15. Have any of the Applicant's owners, principals, directors, officers or employees ever been the subject of an investigation, disciplinary or criminal action as a result of their professional activities?

☐ No ☐ Yes

If you answered "yes" to the above question, please describe:

| |
|---|
| |

16. Have any professional liability claims ever been made against the Applicant, Applicant's owners, principals, directors, officers or employees?

☐ No ☐ Yes

If you answered “yes” to the above question, please describe including name of claimant; type of service provided and allegation made; date claim was made; demand amount and final disposition including indemnity and expense amounts:

.

17. Does the Applicant or do the Applicant’s owners, principals, directors, officers or employees have any knowledge or information of any act, error or omission which might reasonably give rise to a claim against any potential insured or its predecessors in business?

☐ No ☐ Yes

If you answered “yes” to the above question, please describe:

It is understood and agreed that if the answer to the previous three queries is “yes”, any such claim or potential claim is specifically excluded from this proposed coverage.

18. List any industry associations/memberships with which the Applicant is affiliated.

_____

19. Please indicate desired coverage terms.

Limit _____

Retention _____

Retro-Date _____

*If no retroactive date is selected, proposed coverage will begin on the policy effective date.*

20. Please attach any additional information we may find helpful in evaluating your risk.

In addition, please attach any special coverage requests.

21. OPTIONAL: In order to best meet your coverage needs, please provide the following information about the Applicant’s current policy.

Carrier _____

Limit _____

Retention _____

Premium _____

Retro Date _____

Expiration _____

## NOTICE TO APPLICANT: PLEASE READ CAREFULLY

**Warranty:** The undersigned warrants that the information contained herein is true as of the date this application is executed and understands that it shall be the basis of the policy of insurance and deemed incorporated herein if the Insurers accept this application by issuance of a policy. It is understood and agreed that this warranty constitutes a continuing obligation to report to the Insurers, as soon as possible, any material change in the circumstances of the Applicant's business including, but not limited to the size of the firm, the area of business engaged in by the firm and the information contained on each Supplemental application submitted by the Applicant.

Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance 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.

SIGNATURE: _____

TITLE: _____

DATE: _____

BSR

**Return to submit@bsrins.com**

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# MEDICAL BILLING SUPPLEMENTAL APPLICATION

1. Estimate the percentage of business derived/referred from the following services which the Applicant performs on behalf of health care providers:

   _____% Coding of claims

   _____% Accounts receivable

   _____% Processing of claims

   _____% Bad debt collections

   _____% Other, Please describe:

   _____

   How many clients do you currently service? _____

   Please identify these clients:

   _____

   _____

2. What percentage of your billings are for Medicare/Medicaid? _____%

3. For what types of medical services do you provide services?

   _____

   _____

   _____

4. Is your compensation related to the dollar amount billed or collected? ❒ Yes ❒ No
   If Yes, please explain:

   _____

   _____

5. Are you currently and have you always been in compliance with existing statutes and regulations? ❒ Yes ❒ No
   If No, please explain:

   _____

   _____

6. Do you have written policies and procedures for standards of conduct? ❒ Yes ❒ No

   a. Do you have a compliance officer and compliance committee? ❒ Yes ❒ No

   b. Do you conduct training and education for all your employees? ❒ Yes ❒ No

   c. Do you have documented standards that are enforced? ❒ Yes ❒ No

   d. Do you conduct internal monitoring and auditing? ❒ Yes ❒ No

**It is understood and agreed that this supplemental application shall become a part of the application for Professional Liability Errors & Omissions Insurance.**
**THE APPLICATION MUST BE SIGNED AND DATED BY AN OWNER, OFFICER OR PARTNER.**

Applicant Signature: _____ Date (Mo-Day-Yr): _____

Name and Title (Please Print): _____