1800 Northern Blvd., P.O. Box 9009
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(833) 774-6625
www.MyEmPRO.com

General Liability Insurance Application

Requested Effective Date: _____

Section 1 - Applicant Information

Name of Facility:		d/b/a (If Applicable):	
Main Location:	City:	State:	Zip:
Number of Years in Business:	Number of Years Under Current Management:	Facility Tax I.D. Number:	
Contact Person Name:		Contact Person Email Address:	

Type of Facility (Check all that apply)

- ☐ For Profit
- ☐ Not For Profit
- ☐ Surgery Center
- ☐ Hospital
- ☐ Nursing Home
- ☐ Healthcare Clinic
- ☐ Home Health Care Agency
- ☐ Laboratory
- ☐ Other: _____

List all states where the Applicant is operating and providing services: _____

_____

Named Insureds: List all subsidiaries, date acquired, description of operation, ownership in percentage, and if coverage is requested for the subsidiary.

Subsidiaries	Date Acquired	Description Of Operation	% of Ownership	Coverage Requested?

Section 2 - Coverage Options

☐ Primary ☐ Excess ***(Only Available in New York)***

Coverage Type

☐ Claims-Made ***(Not Available in New York)*** ☐ Occurrence

Requested Liability Limits:

Per Location Aggregate	$ _____
General Aggregate (Other Than Products-Completed Operations)	$ _____
Products-Completed Operations Aggregate	$ _____
Personal & Advertising Injury	$ _____
Each Occurrence	$ _____
Fire Damage Legal Liability (Any One Fire)	$ _____
Medical Expense (Any One Person)	$ _____
Other (Hired and Non Owned Auto, Employee Benefits, etc.)	$ _____

Section 2 - Continued

Requested Deductible (Check Only One):

☐ No Deductible ☐ $10,000 ☐ $25,000 ☐ $100,000

☐ $2,500 ☐ $20,000 ☐ $50,000 ☐ Other: ____________________

Section 3 - General Liability Insurance History

Primary General Liability Coverage

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims-Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability?	Premium
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$

Excess General Liability Coverage

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims-Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability?	Premium
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$
			☐ Ded ☐ SIR	☐ CM ☐ Occ		☐ Yes ☐ No	$

Has the Applicant’s policy or coverage ever been declined, canceled, or non-renewed during the past three (3) years?

If “Yes,” please explain: ____

Section 4 - Schedule of Exposures

Please list all properties owned, controlled, or occupied by the Applicant (including leased properties and parking areas). If needed, please attach a current Statement of Values.

Location #	Description	# of Stories	Owned/Leased	Area Sq. Ft.

Please list any construction, alteration, or additions which have been proposed, are currently being performed, or have been newly completed.

Location #	Description	# of Stories	Owned/Leased	Area Sq. Ft.

Section 5 - General Information (All questions must be answered)

Where applicable, provide a copy of each agreement.

1. Is there a formal safety program in operation? ☐ **Yes** ☐ **No**
2. Is there sufficient lighting in the stairwells, hallways, and operating areas? ☐ **Yes** ☐ **No**
3. Is the facility wheelchair accessible? ☐ **Yes** ☐ **No**
4. Are protocols in place to address emergency situations? ☐ **Yes** ☐ **No**
5. Are the premises designed to minimize hazards? ☐ **Yes** ☐ **No**
6. Is the infrastructure in proper working condition? ☐ **Yes** ☐ **No**
7. Are corridors properly ventilated? ☐ **Yes** ☐ **No**
8. Are there sprinkler systems and fire extinguishers throughout the facility? ☐ **Yes** ☐ **No**
9. Is any equipment loaned/rented to others? ☐ **Yes** ☐ **No**
10. Are employees leased to or from other employers? ☐ **Yes** ☐ **No**
11. Are employees subject to training? ☐ **Yes** ☐ **No**
12. Are respective employees vetted for aptitude and ability? ☐ **Yes** ☐ **No**
13. Does the Applicant have a management contract to provide management services to other facilities? ☐ **Yes** ☐ **No**

Section 5 - Continued

14. Are there any services provided by contractors/subcontractors? ☐ Yes ☐ No
15. Are certificates of insurance required from all subcontractors? ☐ Yes ☐ No
16. Are parking facilities owned? ☐ Yes ☐ No
17. Are parking facilities leased? ☐ Yes ☐ No
18. Are there any elevators on-premises? ☐ Yes ☐ No

    If "Yes", do you require elevator collision coverage? ☐ Yes ☐ No

    If "Yes," indicate number of elevators: _____

19. Does the Applicant have a heliport/helipad? ☐ Yes ☐ No
20. Does the Applicant own and/or operate a daycare service? ☐ Yes ☐ No

    If "Yes," is the daycare open to the public? ☐ Yes ☐ No
21. Does the Applicant own a pharmacy? ☐ Yes ☐ No

    If "Yes," are prescriptions dispensed to persons other than patients? ☐ Yes ☐ No
22. Are management services provided by another facility? ☐ Yes ☐ No
23. Are employees supervised? ☐ Yes ☐ No

Section 6 - Quality Assurance/Risk Management

Risk Management Contact Information:

Name: _____ Title: _____

Telephone #: _____ Email Address: _____

Years of Experience: _____ Reports to: _____

Section 7 - Additional Information Required

1. Copies of any hold harmless agreements.
2. Copy of loss runs for the last ten (10) years.
3. List of entities to be covered under the policy and the relationship to the Applicant.

READ CAREFULLY BEFORE SIGNING.

The statements in this application, together with any supplemental applications, attachments, and any other information submitted to the Company in connection with this application will be referred to as the "Policy Application."

REPRESENTATIONS AS TO THE ACCURACY OF THIS APPLICATION, THE AUTHORITY OF PERSON SIGNING, AND APPLICANT'S OBLIGATION TO SUPPLEMENT INFORMATION

By signing below, I represent and certify: (i) that the information contained in this Policy Application is true and accurate; (ii) that I have made all reasonable efforts to investigate the accuracy of the information provided in this Policy Application and to obtain such information from all persons and entities to be insured by the requested policy as is necessary to provide true and accurate information in the policy application; (iii) that I am duly authorized to sign this Policy Application on behalf of all persons and entities to be insured by the requested insurance; and (iv) that I have carefully read this Policy Application.

I acknowledge that obtaining the requested insurance, including any renewals of the requested insurance, is conditioned upon providing true and accurate information in this Policy Application, and any such insurance that may be issued will be based upon the Company's reliance on the information provided in this Policy Application. I also agree and understand that this Policy Application shall be the basis of the contract should a policy be issued, and that this Policy Application will be deemed to be attached to and part of such policy and any renewals of such policy, if issued.

Additionally, I agree that in the event there is any change in the information provided in this Policy Application before the effective date of the requested insurance or before any renewal of the requested insurance, I will immediately notify the Company in writing. I understand that if there is a change in the information provided in this Policy Application the Company, in its sole discretion, may modify or withdraw any quotation or agreement to bind insurance.

NO OBLIGATION TO ISSUE OR PURCHASE INSURANCE

I understand that this Policy Application is not a binder of insurance. Accepting this Policy Application does not bind the Company to issue, or me to purchase, the requested insurance.

AUTHORIZATION TO OBTAIN INFORMATION

The Company is hereby authorized to obtain full information from any liability insurer, healthcare insurer, hospital, healthcare provider, medical association or society, board of medical examiners, governmental agency, attorney, or other person or entity concerning: (i) any medical malpractice claim, suit, licensing board proceeding, credentialing proceeding, disciplinary action, or any other civil or criminal action asserted against or relating to the professional conduct of any person or entity to be covered by the requested insurance; (ii) the qualifications of any person or entity to be covered by the requested insurance to perform professional healthcare services; and (iii) such other information which, in the sole judgment of the Company, may have a bearing on whether to issue the requested insurance.

I agree to hold harmless any person or entity providing such information to the Company and the Company, its directors, officers, employees, and agents from any liability arising out of the disclosure of such information, including any liability arising out of errors and omissions in the information disclosed.

This application shall be deemed appended to and a part of any policy of insurance issued to you based on this Policy Application.

PENNSYLVANIA APPLICANTS: 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 subjects such person to criminal and civil penalties.

NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK APPLICANTS: 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.

Signature of Applicant: _____ Title: _____

Printed Name: _____ Date: ____/____/____