CapSpecialty

Capitol Specialty Insurance Corporation
A Stock Company

P. O. Box 5900
Madison, WI 53705-0900

CapSpecialty.com

Urgent Care Clinics / Convenience Care Centers Supplemental Application

I. APPLICANT INFORMATION

1.1	Applicant Name:	
1.2	Applicant Business Address:	
1.3	Applicant Contact	
	Name:	
	Email Address:	
1.4	Website(s):	

II. BUSINESS INFORMATION

2.1	Does the Applicant provide any other services, including other medical services, that are not directly related to your Urgent Care Clinics or Convenience Care Centers?	☐ Yes ☐ No
	If yes, please provide details (use a separate sheet If needed): _____	
2.2	Does the Applicant have a formalized employee verification program, including background checks performed prior to hire?	☐ Yes ☐ No
	If yes, are any negative findings discovered in this process investigated and duly considered in the hiring process?	☐ Yes ☐ No
2.3	Has the Applicant organization or any medical professional working on its behalf ever been under investigation by a regulatory agency for professional misconduct?	☐ Yes ☐ No
	If yes, please provide details: _____	
2.4	Does the Applicant have a formalized credentialing / peer review committee and procedure?	☐ Yes ☐ No
	If yes, are any negative findings discovered in this process investigated, property documented and duly considered in the credentialing process?	☐ Yes ☐ No
2.5	Does the Applicant provide any services in any prisons or correctional facilities, or to any prisoners, inmates or incarcerated persons? If yes, please provide details on a separate sheet of paper.	☐ Yes ☐ No
2.6	Is the Applicant requesting separate limits of liability for each Allied Health Professional / Physician?	☐ Yes ☐ No
	If yes, please provide a list of such professionals and their respective specialties in a separate attachment, and CV for each.	

III. PROFESSIONAL SERVICES AND STAFFING

Please conduct due diligence prior to completing the information below to ensure that it is accurate. The following information is critical to make an accurate assessment of the Applicant's exposure.

3.1	Please indicate the number of Annual Patient Visits for each type of Clinic Service listed below for the current policy period, and for the next projected policy period:

Type of Clinic Services	# of Annual Patient Visits	
	Current Policy Period	Projected Policy Period
Emergent Care Services (allergic reactions, chest pain, moderate to severe burns, or pressure):		
Non-Emergent Care Services (abrasions, cold symptoms, minor burns / fractures / lacerations, sprains, and occupational medicine):		
Pain Management Services **(Please ALSO complete Pain Management Supplemental Application if these services are being provided.):**		
Preventative Services (allergy, blood pressure screenings, flu shots, and physicals):		
Prescriptions (including Over the Counter (OTC) prescriptions):		
Stem Cell-Based – Adipose Tissue (Fat):		
Stem Cell-Based – Bone Marrow:		
Stem Cell-Based – Engineered:		
Stem Cell-Based – Umbilical Cord / Placenta:		
Telemedicine Services:		
Other, describe: _____		

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3.2	Please indicate if the Applicant organization has the following accreditations:	
	☐ AAAASF ☐ AAUCM ☐ AAAHC ☐ JCAHO ☐ NAFAC ☐ UCAOA ☐ Other: _____	
3.3	Please provide a roster of the Applicant's Licensed Independent Practitioners (LIPs), including past and present, for which coverage is being requested. This should include Mid-Level Providers (such as NPs and PAs).	
	Please include roster as a separate attachment.	
3.4	Do all patients of the Applicant sign informed consent forms, in advance, which is specific to the services provided/procedures being performed?	☐ Yes ☐ No
	If no, please explain: _____	
3.5	If services or procedures are to be performed on a minor, is a signed parental consent form obtained, in advance, which is specific to the services provided/ procedures being performed?	☐ Yes ☐ No
	If no, please explain: _____	
3.6	Does the Applicant make any promises or guarantees relating to any treatment, procedure or therapy?	☐ Yes ☐ No
3.7	Specifically, in the Applicant's marketing, advertising, website or informed consent forms, does the Applicant make any promises or guarantees, relating to any treatment, procedure or therapy involving the use of stem cells, including but not limited to its safety or effectiveness, its status as approved or not approved by the U.S. Food and Drug Agency (FDA), or whether or not it has any proven medically beneficial use?	☐ Yes ☐ No
3.8	Does the Applicant disclose and sufficiently warn patients about the potential dangers or side-effects of any stem-cell treatment, procedure or therapy?	☐ Yes ☐ No

IV. CLAIMS AND INCIDENTS

Please respond to the following questions to the best of your knowledge and belief, after conducting due diligence and inquiry with <u>any</u> individuals who may have knowledge or information about the matters described below.

The term "Applicant" as used below, means any proposed insured, including any individual or entity for whom coverage is sought.

4.1	During the past five (5) years, has the Applicant received notice of any claim, suit, legal proceeding or regulatory/licensure action against any proposed insured relating to professional services, or for which coverage may be sought under the Policy applied for?	☐ Yes ☐ No
4.2	Within the past five (5) years, has the Applicant given written notice to its any current or prior professional or general liability insurance carrier of any claim, suit, legal proceeding or regulatory/licensure action, or of any facts, circumstances or situations which might give rise to a claim, suit, legal proceeding or regulatory/licensure action against any proposed insured relating to professional services?	☐ Yes ☐ No
4.3	Is the Applicant or any proposed insured aware of any facts, circumstances, situations, transactions, events, acts, errors or omissions which could reasonably be expected to give rise to a claim, suit, legal proceeding or regulatory/licensure action against any proposed insured relating to professional services, or for which coverage may be sought under the Policy applied for?	☐ Yes ☐ No
4.4	In the past five (5) years, has any proposed insured entity, or professional employee of Applicant, or other proposed insured, had their professional licenses or certifications suspended or revoked, or been investigated for professional misconduct?	☐ Yes ☐ No
4.5	During the past three (3) years, has any professional or general liability insurance carrier cancelled or nonrenewed Applicant's insurance coverage, declined any application for coverage or refused to issue any policy to Applicant?	☐ Yes ☐ No

The policy for which the Applicant is applying, if issued, <u>will not insure</u>: any claim, suit, proceeding or regulatory/licensure action disclosed, or which should have been disclosed, in response to the above; or any claim, suit, proceeding or other regulatory/licensure action that arises from any fact, circumstance, situation, transaction, event, act, error or omission disclosed, or which should have been disclosed, in response to the above.

IF YOU REPLY "YES" TO ANY OF THE QUESTIONS IN IV. CLAIMS AND INCIDENTS ABOVE, PLEASE PROVIDE DETAILS IN A SEPARATE ATTACHEMENT AND ATTACH CURRENT LOSS RUNS.

V. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or 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 and subjects that person to criminal and civil penalties.

(Not applicable in AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, VT, WA and WV).

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

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APPLICABLE IN CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN FL AND OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL only.

APPLICABLE IN KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KY, NY, OH AND PA

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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

APPLICABLE IN ME, TN, VA AND WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN NJ

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

APPLICABLE IN OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

APPLICABLE IN VT

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

VI. REPRESENTATIONS

This Application must be signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application. By signing this Application, the undersigned represents, on behalf of the Applicant and all proposed insureds, the following:	
a.	***After conducting due diligence, the statements in the Application and Supplemental Application furnished to the Company are accurate and complete;***
b.	***Those statements furnished to the Company are representations Applicant makes on behalf of all proposed Insureds;***
c.	***Those representations are a material inducement to the Company to provide a premium proposal;***
d.	***If a policy is issued, the Company will have issued this Policy in reliance upon those representations;***
e.	***If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report such material change to the Company in writing; and***
f.	***The Company reserves the right, upon receipt of such notice, to change or rescind any proposal previously offered by the Company.***

As used above, the term "Company" refers to Capitol Specialty Insurance Corporation.

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NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED OR THAT ANY ITEMS REFERENCED IN QUESTIONS OR ANSWERS TO QUESTIONS WILL BE COVERED EVEN IF COVERAGE IS OFFERED AND BOUND.

SOME RESPONSES MAY REQUIRE MORE SPACE THAN THAT PROVIDED IN THE APPLICATION ITSELF. PLEASE PROVIDE THOSE RESPONSES ON A SEPARATE PAGE AND ATTACH IT TO THIS APPLICATION.

Signature of authorized representative of Applicant	**Title**
Type / Print name of authorized representative	**Date**
E-mail address of authorized representative	