

# Market Finders Insurance Corp.

## QUICK CLINIC HEALTHCARE COMPREHENSIVE COVERAGE FOR IN-STORE NON-EMERGENCY CLINICS

PLEASE TYPE OR PRINT IN INK

Effective date desired: \_\_\_\_\_

1. Complete name of facility (applicant) (if other than parent firm, supply full details of ownership entity)  
**(use an additional sheet of paper if necessary):** \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Contact name: \_\_\_\_\_ Title: \_\_\_\_\_ Email address: \_\_\_\_\_

Phone: \_\_\_\_\_ Web site Address: \_\_\_\_\_ Fax: \_\_\_\_\_

List all other locations **(use an additional sheet of paper if necessary):**

\_\_\_\_\_

2. In what state is the facility domiciled? \_\_\_\_\_

3. Applicant is: a.  Individual  Partnership  Corporation  Professional Association  Other: \_\_\_\_\_  
b.  Not-for-profit  For-profit  Both

4. Date established: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

5. List all states where you are licensed to practice:

\_\_\_\_\_

6. Current accreditations or associations:  NAHC  TAHC  JCAHO  CHAP  NHPCO  Other: \_\_\_\_\_

7. Is the firm engaged in, owned by or associated with or controlled by any other business? \_\_\_\_\_  Yes  No  
If yes, give details (use an additional sheet of paper if necessary): \_\_\_\_\_

8. Please list the individual shareholders or partners of the facility:

\_\_\_\_\_

9. Are any services provided outside of the United States? \_\_\_\_\_  Yes  No

If yes, please explain, including what countries, what type of services are provided and what percentage of your revenues are derived from these services: \_\_\_\_\_

10. Do you provide any internet services? \_\_\_\_\_  Yes  No  
If yes, please attach an explanation, including confirmation of licensing in all states in which services are provided.

\_\_\_\_\_

11. Does the applicant anticipate any facility expansions within the next year? \_\_\_\_\_  Yes  No  
 If yes, please describe: \_\_\_\_\_  
 Number of facilities to be added: \_\_\_\_\_ States: \_\_\_\_\_

12. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? \_\_\_\_\_  Yes  No  
 If yes, give details: \_\_\_\_\_

13. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? \_\_\_\_\_  Yes  No  
 If yes, please attach a copy of ALL of the advertisements.

14. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? \_\_\_\_\_  Yes  No

15. Hold Harmless (Indemnification) Agreements: -  
 (a) In favor of the applicant: - if the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained: \_\_\_\_\_  
 (b) In favor of others: - has the applicant agreed to indemnity (hold harmless) others under written contract? \_\_\_\_\_  Yes  No  
 If yes, please submit a copy of the agreement.

16. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule? \_\_\_\_\_  Yes  No  
 If yes,

(i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? \_\_\_\_\_  Yes  No  
 (II) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_

17. State the number of patient encounters and/or patient tests carried out as follows (patient encounters refer to number of visits—not number of patients):

Type of Encounters	Number for Last 12 Months	Estimated Number for Next 12 Months
Patient Encounters		
Patient Tests		

18. State projected gross revenue:

Source	Amount this Fiscal Year	Amount Next Fiscal Year
Fee for Service		

19. Please provide the number of nurse practitioners and medical assistants per location: NP's \_\_\_\_\_  
 MA's \_\_\_\_\_

a. Are all the above individuals licensed in accordance with applicable state and federal regulations?  Yes  No  
 If no, attach an explanation.

b. Does the applicant have any independent contractors? \_\_\_\_\_  Yes  No  
 If yes, list the number and type of independent contractors who provide professional services on behalf of the applicant: \_\_\_\_\_

- c. Is continuing education or staff development required for your employees? \_\_\_\_\_  Yes  No
- d. Name of medical director or referring physician, if any: \_\_\_\_\_
  - (i) Is coverage provided for the medical director under any other insurance policy? \_\_\_\_\_  Yes  No
  - (ii) If yes, please provide type of policy and name of carrier: \_\_\_\_\_

**HIRING PRACTICES**

- 20. a. Do you conduct a criminal background check? \_\_\_\_\_  Yes  No
- b. Do you require signed applications on all prospective employees? \_\_\_\_\_  Yes  No
- c. Do you verify all professional qualifications, licenses and certifications? \_\_\_\_\_  Yes  No
- d. Do you require professional and personal references on each employee? \_\_\_\_\_  Yes  No
- e. Do you provide training and orientation for new employees? \_\_\_\_\_  Yes  No
- f. Do you verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities? \_\_\_\_\_  Yes  No
- g. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? \_\_\_\_\_  Yes  No
- h. Do you have written job descriptions? \_\_\_\_\_  Yes  No
- i. Do you require drug/alcohol screening? \_\_\_\_\_  Yes  No

**RISK MANAGEMENT/LOSS CONTROL**

- 21. a. Is there a written, formalized Quality Assurance Program? \_\_\_\_\_  Yes  No
- b. Is there a written, formalized Risk Management Program? \_\_\_\_\_  Yes  No
- c. Do you have a standard system to handle a patient's complaints or suggestions? \_\_\_\_\_  Yes  No
- d. Do qualified personnel inspect and maintain the equipment on a regular basis? \_\_\_\_\_  Yes  No
- e. Do you have a Quality Assurance Department? \_\_\_\_\_  Yes  No
- f. In case of an emergency, is management available 7 days a week, 24 hours a day? \_\_\_\_\_  Yes  No

**INSURANCE AND CLAIM INFORMATION**

- 22. Do you currently carry the following:
  - a. Professional Liability Insurance? \_\_\_\_\_  Yes  No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

If claims made, what is the **retroactive date/prior acts date** on your current policy? \_\_\_\_\_

b. **Commercial General Liability Insurance?** .....  Yes  No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made or Occurrence?	Premium

If claims made, what is the **retroactive date/prior acts date** on your current policy? \_\_\_\_\_

23. Please state the average value per location for the following:

- a. Business Personal Property: \_\_\_\_\_  
(Includes tables, chairs, computers, phones and other property necessary to operate the clinic).
- b. Improvements and Betterments: \_\_\_\_\_  
(The replacement value of any construction to return your space to its required operating condition).

**24. CLAIMS HISTORY:**

- a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance?  Yes  No

**ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS  
IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT**

- b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? \_\_\_\_\_  Yes  No  
If yes, provide full details. \_\_\_\_\_
- c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?  Yes  No  
If yes, fully describe the circumstances and follow up action taken: \_\_\_\_\_

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD 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 CONTAINING 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.

\*Notice applicable in most states:  
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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

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**Applicant's Signature**

/

**Title**

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**Date**

**PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:**

1. COPY OF 5 YEAR CURRENTLY VALUED HARD COPY COMPANY LOSS RUNS
2. COPY OF THE DECLARATION PAGE OF YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY
3. IF A START UP FIRM, COPY OF THE PROFORMA BUSINESS PLAN
4. COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS
5. COPY OF A SAMPLE CLIENT CONTRACT
6. RESUMES/CV'S FOR ALL KEY PERSONNEL, PRINCIPALS, EXECUTIVES, MEDICAL DIRECTORS AND/OR ADMINISTRATORS

**YOU SHOULD SECURE PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS, DENTISTS, SURGEONS AND NURSE ANESTHETISTS**