EVOLUTION INSURANCE BROKERS

8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-678-7342 • Fax 80-478-9880

BIRTHING CENTERS

General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: ( )_____ Fax: ( )_____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____

Producer No.: _____ Producer's Name: _____

Producer's E-mail: _____

Detailed description of business activities (specifically, and by location): _____

_____

_____

Is this a new business? **o** Yes **o** No If no, how many years have you been in business? _____

Applicant is: **o** Individual **o** Corporation **o** Partnership **o** Joint Venture

o Other (please describe): _____

Annual Payroll: $ _____

Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? **o** Yes **o** No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: ( )_____

Fax: ( )_____ Years with Company: _____

Employee's Responsibilities: _____

1. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	$	$	$

Has the Applicant or any predecessor or related person or entity ever had a claim? **o** Yes **o** No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? **o** Yes **o** No

If yes, please explain: _____

_____

_____

_____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets?

o Yes **o** No

If the standard markets are declining placement, please explain why: _____

_____

2. Desired Insurance

Limit of Liability - Professional Liability Coverage:

	Per Act/Aggregate		Per Person/Per Act/Aggregate
o	$50,000/$100,000	**o**	$25,000/$50,000/$100,000
o	$150,000/$300,000	**o**	$75,000/$150,000/$300,000
o	$250,000/$1,000,000	**o**	$100,000/$250,000/$1,000,000
o	$500,000/$1,000,000	**o**	$250,000/$500,000/$1,000,000
o	Other: _____	**o**	Other: _____

Identify all contracted medical professional services performed for you and the minimum medical professional liability limits required.

Pharmacy $_____

Respiratory Therapy $_____

Physical Therapy $_____

Other $_____

Self-Insured Retention (SIR): **o** $1,000 (Minimum) **o** $1,500 **o** $2,500 **o** $5,000 **o** $10,000

3. Business Activities

1. Person providing accounting and tax services:
   a. Name: _____
   b. Mailing Address: _____
   c. City: _____ State: _____ Zip: _____
   d. E-Mail: _____
   e. Business Telephone Number: ( )_____ Fax: ( )_____
2. The applicant has been:
   a. Licensed or approved by State Board of Health ☐ Yes ☐ No

b. Accredited by JCAHO ☐ Yes ☐ No

If no, please explain on another sheet of paper.

3. Number of years that this facility has been operating: _____
4. Number of years with the present owner: _____
5. Number of years with the current management: _____
6. Please provide copies of all licenses held by your facility.
7. Has your license been suspended, revoked or placed on probation within the last 5 years: ☐ Yes ☐ No
8. Annual income for the past 12 months, and estimated for the next 12 months:

	BIRTHING CENTERS	HOMES	HOSPITALS
Past 12 mo.	$	$	$
Next 12 mo.	$	$	$

9. Number of births during the past 12 months:

BIRTHING CENTERS	HOMES	HOSPITALS

10. Number of births estimated for the next 12 months:

BIRTHING CENTERS	HOMES	HOSPITALS

11. Facility Classification:

TYPE OF SERVICE AND/OR BEDS AVAILABLE	SERVICE FEE CHARGED	NUMBER OF BEDS	NUMBER OF BEDS OCCUPIED

12. Recreation Facilities:

☐ None ☐ Swimming Pool ☐ Exercise/Weight Room ☐ Sauna/Hot Tub

☐ Tennis/Racquetball ☐ Other: _____

13. What is the maximum length of stay: _____ days
14. Indicate the name of the Administrator and provide a brief summary of administrative experience: _____

_____

_____

15. Do you employ a medical director? ☐ Yes ☐ No
16. If yes, briefly describe the director's medical qualifications._____
17. Does the medical director also act as the attending physician for any residents? ☐ Yes ☐ No

If yes, how many: _____

18. If a medical director isn't employed, who is responsible for overseeing the medical services provided?

_____

19. Employee Profile (please indicate the number of each kind of employee):

EMPLOYEE CLASSIFICATION	1ST SHIFT	2ND SHIFT	3RD SHIFT
Physicians			
Midwives			
RNs			
LPNs			
Nurse's Aides			
Other			
Non Medical			
Total			

20. Give a summary of the procedures you use when hiring a medical professional at your facility.
21. If an individual has had a previous medical professional claim, how would it affect your hiring of that person?
22. Do you require evidence of acceptable health for all new patients to your facility? ☐ Yes ☐ No
23. Do you have a written emergency evacuation plan? ☐ Yes ☐ No

    If yes, please include a copy.
24. Do all patients have their own attending physician? ☐ Yes ☐ No

    If no, who performs this role?_____
25. Are written orders from an attending physician required for:
    a. All drugs or medicines? ☐ Yes ☐ No
    b. Special dietary requirements? ☐ Yes ☐ No
    c. Any other specific therapy/treatment? ☐ Yes ☐ No
26. Is nursing assessment conducted for new patients? ☐ Yes ☐ No
27. Do you require a physician on-site or on-call on a 24 hour basis? ☐ Yes ☐ No
28. Who determines if a patient must be transferred to another facility for further medical diagnosis or treatment?

_____

29. Is smoking permitted in patient rooms? ☐ Yes ☐ No

    If yes, explain the rules applicable to smoking in your facility._____
30. Smoke Detectors are located:
    - ☐ None
    - ☐ Entire Facility
    - ☐ Common Areas
    - ☐ Hallways
    - ☐ Patient or Resident Rooms
    - ☐ Other:

    Areas protected by approved automatic sprinkler system:
    - ☐ None
    - ☐ Entire Facility
    - ☐ Common Areas
    - ☐ Hallways
    - ☐ Patient or Resident Rooms
    - ☐ Other:

31. When was the last time that this building's electric, heating, and plumbing systems were last inspected or updated?

	ELECTRIC	HEATING	PLUMBING
Qualified Inspection			
Replaced or Updated			

32. When was this building last inspected by the:

    Local fire authorities: _____ State Department of Health: _____

    (If the inspection was completed in the last three years, please include a copy)

33. Are there at least two exits on every floor? ☐ Yes ☐ No

34. Are handrails provided in hallways and bathrooms? ☐ Yes ☐ No

35. Are bathtubs and showers equipped with non-slip surfaces? ☐ Yes ☐ No

36. Are all skilled and intermediate beds equipped with side rails? ☐ Yes ☐ No

37. Have you had any professional or general liability claims made in the last five years? ☐ Yes ☐ No

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.

2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.

3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.

4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____

Applicant:

_____
Signature

_____
Print Name

Dated: _____

Agent/Broker:

_____
Signature

_____
Print Name

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STAFF RECAP

General Information Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: ( )_____ Fax: ( )_____

NAME	AGE	YEARS OF EXPERIENCE	TYPE OF TRAINING	CERTIFICATIONS HELD	OUTSTANDING COMPLAINTS