OneBeacon HEALTHCARE GROUP onebeacon.com	877.701.0171 t | 888.777.3719 f 199 Scott Swamp Road, Farmington, CT 06032	Brown & Brown INSURANCE of Garden City Inc. d/b/a Sobel Affiliates
	Homeland Insurance Company of New York | Homeland Insurance Company of Delaware Stock companies owned by the OneBeacon Insurance Group (hereinafter referred to as the "Underwriter")	
Application (New Business)	MEDICAL PROFESSIONAL AND GENERAL LIABILITY INSURANCE FOR FEDERALLY QUALIFIED COMMUNITY HEALTH CENTERS	

PORTIONS OF THE POLICY FOR WHICH THIS APPLICATION IS MADE PROVIDE CLAIMS MADE AND REPORTED COVERAGE, WHICH APPLIES ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD OR AN APPLICABLE EXTENDED REPORTING PERIOD AND REPORTED IN ACCORDANCE WITH THE POLICY'S REPORTING PROVISIONS. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING AND CONTACT YOUR PRODUCER WITH ANY QUESTIONS.

Instructions:
Whenever used in this Application, the term "Applicant" shall mean the organization identified in response to question 1.

A. ACCOUNT INFORMATION

1. Applicant Name	
Doing Business As	
Federal Employee I.D. # (FEIN)	
Principle State of Operations	
2. Mailing Address	Street:
	City: State: Zip:
	County: Website Address:
3. Risk Manager or Contact Person	Name/Title:
	Email Address:
	Telephone Number:
4. Applicant's Legal Structure	☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ LLC ☐ Other (describe): _____
5. Tax Status	☐ For Profit – Private ☐ For Profit - Publicly Traded ☐ Not For Profit ☐ Governmental ☐ Other (describe): _____
6. Number of years in operation: _____	
7. Number of continuous years with "deemed" status: _____	

8. Licensed as a:

☐ Federally Qualified Health Center
☐ Other Health Center (please describe):

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

10. Is the Applicant owned, controlled or managed by another entity? ☐ Yes ☐ No

If "Yes," please provide details:

11. Within the past twelve (12) months or within the next twelve (12) months, has the Applicant or does the Applicant expect to:

a. merge, acquire or consolidate with another entity? ☐ Yes ☐ No

b. sell or divest another entity or facility? ☐ Yes ☐ No

c. discontinue any operations or services? ☐ Yes ☐ No

d. enter into any new business activities or services (including new procedures or products being offered)? ☐ Yes ☐ No

If "Yes," please attach a supplemental sheet which describes the essential terms of each transaction. For each transaction, please be sure to include the name of the entity, date of transaction and indicate if liabilities were assumed.

12. List below all entities, subsidiaries and joint ventures requested to be included for coverage under the proposed insurance including a description of operations, relationship to the Applicant, date acquired, ownership and tax status:

Name: _____
Address: _____

Description of Operations	Relationship to Applicant	Date Acquired	Ownership %	Tax Status

Name: _____
Address: _____

Description of Operations	Relationship to Applicant	Date Acquired	Ownership %	Tax Status

Name: _____
Address: _____

Description of Operations	Relationship to Applicant	Date Acquired	Ownership %	Tax Status

(Please note that coverage for these entities is not automatically included. The policy, if issued, will determine coverage.)

13. Does the Applicant own, operate or manage any business or facilities other than the operations described in this Application? ☐ Yes ☐ No

If "Yes," please attach details to this Application.

B. CURRENT AND REQUESTED COVERAGE Please note that requested coverage is not automatically provided. The policy, if issued, will determine actual coverage.

14. Please indicate below which coverage, limits and deductibles/SIRs are being requested:

Coverage Requested	Check if the Applicant Currently Purchases	Limits of Liability Requested (Per Claim/Aggregate)	Deductible/SIR Requested
☐ Healthcare Professional Liability	☐	$_____	$_____
☐ General Liability	☐	$_____	$_____
☐ Employee Benefit Liability	☐	$_____	$_____
☐ Hired and Non-owned Auto Liability	☐	$_____	$_____

15. Please provide current insurance information:

Coverage: _____
Insurance carrier: _____

Limit of Liability	Deductible/SIR	Policy Period MM/DD/YYYY – MM/DD/YYYY	Retroactive Date	Premium

Coverage: _____
Insurance carrier: _____

Limit of Liability	Deductible/SIR	Policy Period MM/DD/YYYY – MM/DD/YYYY	Retroactive Date	Premium

16. Does the Applicant have any other general liability, professional liability or social services professional liability coverage in place? ☐ Yes ☐ No

If "Yes," please describe the operations covered by such policy and provide the limits of liability and evidence of coverage for each such policy:

17. Does the Applicant have an obligation to include anyone other than its landlord, lessors or funding sources as additional insureds? ☐ Yes ☐ No

If "Yes," please describe any additional insureds to be included, their interest and requested coverage.

Name: _____ Address: _____

Description of Operations	Interest	Coverage Desired
		☐ PL ☐ GL

Name: _____ Address: _____

Description of Operations	Interest	Coverage Desired
		☐ PL ☐ GL

Name: _____ Address: _____

Description of Operations	Interest	Coverage Desired
		☐ PL ☐ GL

18. **MISSOURI RESIDENTS: DO NOT ANSWER THIS QUESTION.** Has any professional liability insurer ever cancelled, declined or reduced coverage (i.e. reduced limits, restricted coverage, surcharged rates or refused renewal) for the Applicant or any facility for which coverage is requested? ☐ Yes ☐ No

If "Yes," please provide details:

C. EXPOSURE DETAILS

19. Please complete the following exposure information:

	Last 12 Months	Next 12 Months (Projected)
Total budget	$	$

Deemed Services:

20. List the number of visits/procedures for the following "deemed" services:

	Last 12 Months	Next 12 Months
Outpatient Medical visits		
Dental visits		
Outpatient Mental Health visits		
Other (describe):		
Total number of visits/procedures		

21. Does the Applicant or any of its staff provide any services/care in hospitals? ☐ Yes ☐ No

If "Yes," are patients other than patients of Applicant's facility(ies) treated? ☐ Yes ☐ No

If "Yes," please describe the services/care provided to such patients:

22. Please provide information requested below for each employed physician or dentist providing services at the Applicant's facility(ies):

Physician/Dentist Name	Specialty	Carries own Malpractice Insurance? (Yes or No)	If "Yes," Policy Limits Carried	Policy Period MM/DD/YY – MM/DD/YY	Hours Worked Per Week

23. Please provide information requested below for each non-employed physician or dentist providing services at the Applicant's facility(ies): ☐ Yes ☐ No
(If additional space is required, please attach a separate sheet to this Application)

Does the Applicant wish to include these individuals as insureds? ☐ Yes ☐ No

Physician/Dentist name: ____
Insurance carrier: ____

Specialty	Policy Number	Policy Period MM/DD/YYYY – MM/DD/YYYY	Status (check one)	Hours worked per week
			☐ Contractor ☐ Volunteer	

Physician/Dentist name: ____
Insurance carrier: ____

Specialty	Policy Number	Policy Period MM/DD/YYYY – MM/DD/YYYY	Status (check one)	Hours worked per week
			☐ Contractor ☐ Volunteer	

Physician/Dentist name: ____
Insurance carrier: ____

Specialty	Policy Number	Policy Period MM/DD/YYYY – MM/DD/YYYY	Status (check one)	Hours worked per week
			☐ Contractor ☐ Volunteer	

Physician/Dentist name: _____
Insurance carrier: _____

Specialty	Policy Number	Policy Period MM/DD/YYYY – MM/DD/YYYY	Status (check one)	Hours worked per week
			☐ Contractor ☐ Volunteer	

Physician/Dentist name: _____
Insurance carrier: _____

Specialty	Policy Number	Policy Period MM/DD/YYYY – MM/DD/YYYY	Status (check one)	Hours worked per week
			☐ Contractor ☐ Volunteer	

24. Indicate the number of allied health care professionals and annual hours worked in each applicable category:

	Employees		Contractors		Volunteers	
	Number of:	Annual Hours:	Number of:	Annual Hours:	Number of:	Annual Hours:
Addiction Counselor						
Case Worker/Case Manager						
Chiropractor						
EMT/Paramedic						
Home Health Aide/Caregiver						
Lab Technician						
Mental Health Counselor						
Nurse - RN						
Nurse – LPN/LVN						
Nurse Aide or Assistant						
Nurse Anesthetist						
Nurse Practitioner/ Advance Practice Nurse						
Occupational/Speech Therapist						
Optometrist						
Pharmacist						
Physical Therapist						
Physician Assistant						
Podiatrist						
Psychologist						
Respiratory Therapist						
Social Worker						
Surgical Technician						
Other (describe):						

Non-Deemed Services:

25. Does the Applicant have any programs or services not included within the scope of its HRSA project? ☐ Yes ☐ No

If "Yes," provide details for each program/service:

26. Are medical or surgical abortions performed?

If "Yes," please provide information requested below for the provider(s) of these services:

Provider Name	Specialty	Board Certified in OB/GYN or Family Practice ?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

27. Does the Applicant have any locations that are not currently approved under its scope of project? ☐ Yes ☐ No

If "Yes," provide the following information:

Name of Location/Program: _____
Address: _____

Description of Operations/Services	Type of Professionals Providing Services	Date Program Services Incepted

Name of Location/Program: _____
Address: _____

Description of Operations/Services	Type of Professionals Providing Services	Date Program Services Incepted

Name of Location/Program: _____
Address: _____

Description of Operations/Services	Type of Professionals Providing Services	Date Program Services Incepted

28. Does the Applicant employ or contract with any physicians who bill for services performed on behalf of the Applicant under the physician's own name or provider number? ☐ Yes ☐ No

If "Yes," provide the following information for each such physician:

Physician Name	Specialty	Hours Worked Per Week	Services Performed

29. Does the Applicant have any physicians that it employs under a contract with the physician's professional corporation and not with the physician individually? ☐ Yes ☐ No

If "Yes," provide the following information for each such physician:

Physician Name	Specialty	Hours Worked Per Week	Services Performed

30. Does the Applicant have mid-level practitioners/contractors who work less than 32.5 hours per week? ☐ Yes ☐ No

If "Yes," provide the following information for each such provider:

Physician Name	Specialty	Hours Worked Per Week	Services Performed

31. Have any of the Applicant's locations or services, or any physician employed by the Applicant, had their "deemed" status revoked during the current or prior policy period? ☐ Yes ☐ No

If "Yes," please provide details:

32. Does the Applicant:

a. maintain any beds for overnight occupancy? ☐ Yes ☐ No

if "Yes," please provide the number of beds: _____

b. provide inpatient care for any patients? ☐ Yes ☐ No

c. own, operate or administer any facility that provides inpatient care services? ☐ Yes ☐ No

If "Yes" to any of the above, please provide details:

General Liability Exposures: Complete this section (Questions 33 – 34) if General Liability Coverage is requested.

33. Does the Applicant operate any of the below?

a. Homeless Shelters ☐ Yes ☐ No

b. Section 8 housing ☐ Yes ☐ No

c. Migrant camps ☐ Yes ☐ No

d. Thrift stores ☐ Yes ☐ No

e. Social services activities such as Meals on Wheels, youth camps, adoption / foster services, etc. ☐ Yes ☐ No

If "Yes" to any of the above, provide the location and services provided:

Location Name	Services Provided

34. If coverage for Hired and Non-Owned Auto Liability is requested:

a. Are MVRs checked prior to hire? ☐ Yes ☐ No

b. Are MVRs rechecked? ☐ Yes ☐ No

If "Yes," how often are MVRs updated? _____

c. Does the Applicant transport patients? ☐ Yes ☐ No

d. Does the Applicant have a commercial auto policy in place? ☐ Yes ☐ No

e. What are the required minimum personal auto liability limits for those drivers who use their own personal vehicles for business purposes? _____

35. List of Locations:

Please list all locations associated with the Applicant and provide corresponding premises information. If additional space is required, please attach a separate sheet to this Application.

Address/Occupancy	Square Footage	Age	Type of Construction	Number of Floors	Type of Fire Protection: AS = Auto. Sprinkler; H = Heat Detector; S = Smoke Detector; A = Auto Alarm

D. OPERATIONS AND ADMINISTRATION

36. Please indicate the professional or industry association(s) of which the Applicant is a member in good standing:

☐ JCAHO ☐ NAHC ☐ NACHC ☐ Other: _____

37. Has any physician or dentist (whether employed, contracted or volunteer) who provides services on the Applicant's behalf:

a. been investigated, disciplined, censured or reprimanded by any government agency, medical society, professional review board or licensing entity or board? ☐ Yes ☐ No

b. been treated for any alcohol, narcotics or any substance abuse? ☐ Yes ☐ No

c. had hospital privileges reduced, suspended or revoked? ☐ Yes ☐ No

d. had a license to practice denied, revoked, suspended, placed on probation or limited in any way? ☐ Yes ☐ No

If "Yes" to any of the above, please list each such physician or dentist below and provide a separate Federally Qualified Community Health Centers Physician Application or Dentist Application for each such physician or dentist.

Physician/Dentist name: _____

38. Has the Applicant or any facility had an incident or investigation with any provider of alleged sexual misconduct or molestation? ☐ Yes ☐ No

39. Does the Applicant have a written policy that requires staff to report and document all incidents, accidents, adverse events or complaints? ☐ Yes ☐ No

If "Yes," are records of such reports kept on file with the Applicant? ☐ Yes ☐ No

E. CLAIMS / PRIOR KNOWLEDGE

40. During the past five (5) years, has any claim that may fall within the scope of the proposed insurance been made against the Applicant or against any entity or individual proposed for coverage under this insurance? ☐ Yes ☐ No

If "Yes," please provide the following information for all such claims as an attachment to this Application: date of loss, claimant name, all defense and indemnity payments, all defense and indemnity reserves (if claims are open), and claim status (open/closed).

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 40 IS EXCLUDED FROM THE PROPOSED INSURANCE.

41. Is the Applicant or any entity or individual proposed for coverage under this insurance aware of any fact, circumstance, situation, transaction, event, act, error or omission that the Applicant, any such entity, or any such individual has reason to believe may, or could reasonably be foreseen to, give rise to a claim or loss that may fall within the scope of the proposed insurance? ☐ Yes ☐ No

If "Yes," please attach details to this Application.

NOTE:WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM OR LOSS ARISING FROM ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 41 IS EXCLUDED FROM THE PROPOSED INSURANCE.

F. ATTACHMENTS

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.

- Currently valued loss runs from the last (5) years
- Deeming Notification Letter

Please complete a Federally Qualified Community Health Centers Physician Application or Dentist Application as applicable for each physician or dentist requesting coverage for non-"deemed" services under the proposed insurance or as required by question 37 of this Application.

G. FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of committing a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ALABAMA AND MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who 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.

ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime.

COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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.

DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA APPLICANTS: 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.

KANSAS APPLICANTS: 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 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.

KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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, or a denial of insurance benefits.

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.

OKLAHOMA APPLICANTS: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON AND TEXAS APPLICANTS: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

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.

PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) nor more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

H. SIGNATURE AND AUTHORIZATION

The undersigned, as the authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. For Florida and New Hampshire Applicants, the preceding sentence is replaced with the following sentence: The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The information in this Application is material to the risk accepted by the Underwriter. If a policy is issued it will be in reliance upon the Application, and the Application will be the basis of the contract.

The Underwriter will maintain the information contained in and submitted with this Application on file and along with the Application will be considered physically attached to, part of, and incorporated into the policy, if issued. For North Carolina, Utah and Wisconsin accounts, this Application and the materials submitted with it shall become part of the policy, if issued, if attached to the policy at issuance.

The Underwriter is authorized to make any inquiry in connection with this Application. The Underwriter's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Underwriter to complete the insurance or issue a policy.

The information provided in this Application is for underwriting purposes only and does not constitute notice to the Underwriter under any policy of a Claim or potential Claim.

If the information in this Application materially changes prior to the effective date of the policy, the Applicant must notify the Underwriter immediately and the Underwriter may modify or withdraw any quotation or agreement to bind insurance.

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.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICAT ION MUST BE SIGNED BY A PARTNER, PRINCIPAL, DIRECTOR OR OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.

Produced By (Insurance Agent)	
Insurance Agency	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip:
Email Address	

Submitted By (Insurance Agency)	
Insurance Agency Taxpayer ID	
Agent License No. or Surplus Lines No.	
Address	Street: City: State: Zip: