



Worldwide Facilities, Inc.

www.WWFI.com

Miscellaneous Medical Professional Liability Application (Claims Made Form)

1. Full Name of Applicant (Including all dba's and subsidiaries seeking coverage under the policy for which you are applying):

2. Mailing and Location Address: (If multiple addresses include an attachment with a complete schedule of all locations)

3. Internet Address:

4. Date Established:

5. Type of Entity:

- Corporation
- Partnership
- Individual
- Other :

6. Is this entity owned by, associated with or controlled by any other entity?

YES

NO

If Yes, please give details:

7. Professional Activities and Specialty:

- Ambulance Service Ground Air
- Cosmetic Aesthetics Clinic (Medi-Spa)
- Dental Practice
- Drug and Alcohol Treatment
- Home Healthcare Agency
- Kidney Dialysis Center
- Laser Vision Correction Center
- Medical Clinic
- Medical Staffing
- Methadone Clinic

- Mental Health Services
- Nurses Registry
- Pharmacy
- Radiology (Teleradiology YES NO)
- Residential Care Facility
- Social Services
- Surgery Center
- Other (Please Provide Details)



8. State the approximate division of patients :

% Substance Abuse - Drug or Alcohol

% Cosmetic or Elective

% Counseling

% Communicable Diseases

% Dental

% Dialysis

% Family Planning

% Holistic or Alternative Medicine

% General Medical

% Developmentally Disabled

% Obstetric

% Pediatric

% Psychiatric

% Research or Experimental

% Geriatric

% Surgical

% Other (Please provide details):

9. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

	Employees or Volunteer	Independent Contractors	Insured On Own Med Mal Policy		Employees or Volunteer	Independent Contractors	Insured On Own Med Mal Policy
Physicians (no surgery)	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Occupational Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Physicians (surgical)	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Physical Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Physician Assistants	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Speech Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Surgical Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Other <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO
Certified Nurse Anesthetists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	Total Staff:	<input type="text"/>		
Nurse Practitioners	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	** Please attach copies of declarations pages on all individuals that carry their own medical malpractice.			
Registered Nurses	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	If you have a Medical Director, provide name, speciality and C.V.:			
LPN's or Nurse Aides	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>			
X-Ray Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	a) Are Medical Director's duties administrative only?			
Medical Assistants	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO			
Optometrists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	b) Does Medical Director provide direct patient care?			
Opticians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO			
Pharmacists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	c) What medical malpractice limits is Medical Director required to carry?			
Pharmacy Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO	<input type="text"/>			
Chiropractors	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Massage Therapists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Laboratory Technicians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Paramedics	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
EMT's	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Social Workers	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Aestheticians	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				
Perfusionists	<input type="text"/>	<input type="text"/>	<input type="radio"/> YES <input type="radio"/> NO				



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10. Are all of the above individuals licensed in accordance with applicable state and federal regulations? YES NO
If No, Please attach a detailed explanation.

11. Has the applicant or any of the above employees and/or independent contractors:

Please attach explanation for any of the questions below answered "YES":

- a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? YES NO
- b) Ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? YES NO
- c) Ever been treated for alcoholism or drug addiction? YES NO
- d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? YES NO

12. Does the applicant perform any of the following non-surgical procedures or treatment?

- a) Acid or chemical peels YES NO
Solution Strength If over 30%, is this done by licensed MD YES NO
- b) Acupuncture YES NO
- c) Angiography, Arteriography, Venography YES NO
- d) Botox Injections YES NO
- e) Catheterization (other than urinary or umbilical) YES NO
- f) Closed reduction of compound fractures YES NO
- g) Collagen injections YES NO
- h) Electrolysis YES NO
- i) Laser Treatments (non-surgical) If Yes, which of the following: YES NO
 - Hair Removal
 - Skin Resurfacing
 - Tattoo Removal
 - Other:
- j) Lipodissolve YES NO
- k) Mesotherapy YES NO
- l) Microdermabrasion YES NO
- m) Pain management (non-surgical) YES NO
- n) Permanent Makeup Application YES NO



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- o) Psychiatric shock therapy YES NO
- p) Radiation Therapy and/or Chemotherapy YES NO
- q) Sclerotherapy YES NO
- r) Silicone Injections YES NO

13. Does the applicant perform any of the following surgical procedures?

- a) Abortions If Yes, please answer the following: YES NO
 - What is the maximum trimester
 - What methods
 - How many per month
- b) Bariatric Surgery If Yes, attach a list of types performed YES NO
- c) Biopsies YES NO
- d) Circumcisions YES NO
- e) Colonoscopies or Endoscopies YES NO
- f) Cosmetic Plastic Surgery If Yes, what percentage of Practice? YES NO
- g) Cryosurgery YES NO
- h) Deliveries YES NO If Yes, C Sections? YES NO
- i) Dilation and curettage YES NO
- j) Hysterectomies YES NO
- k) Minor surgical procedures only YES NO
- l) Major surgical procedures YES NO
- m) Mastectomies or lumpectomies YES NO
- n) Neurosurgery YES NO
- o) Organ transplant surgery YES NO
- p) Orthopedic surgery other than spinal YES NO
- q) Penile lengthening or enhancement surgery YES NO
- r) Sex change operations or sexual reassignment surgery YES NO
- s) Spinal surgery YES NO
- t) Surgical podiatry YES NO
- u) Vasectomies YES NO
- v) Other

14. Does the applicant administer methadone treatment? YES NO
 If yes, how many slots?

15. Does the applicant administer detoxification treatment? YES NO
 How many patients annually?



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16. Does the applicant maintain any beds for overnight occupancy? YES NO
If Yes, what is the total number of beds?

17. Does the applicant provide services to Nursing Homes or Assisted Living Centers? YES NO
If Yes, please provide description of the services, and the percentage (%) of total revenue derived from these services:

18. Is anesthesia (other than topical or by means of local infiltration) administered at the applicant's facility? YES NO
If Yes, what percentage of procedures require general anesthesia?

19. Does the applicant sell any products? YES NO
If Yes, please include product brochures.
a) What kind of products?
b) Do any of these products require a physicians prescription? YES NO
c) Do you re-label these products in your own name? YES NO

20. State sources and amounts of total revenue:	Last 12 months	Estimate for next 12 months
Charitable Contributions	<input type="text"/>	<input type="text"/>
Government Funding	<input type="text"/>	<input type="text"/>
Fee for service	<input type="text"/>	<input type="text"/>
Other income: <input type="text"/>	<input type="text"/>	<input type="text"/>
Total Gross Revenues	<input type="text"/>	<input type="text"/>

21. Please provide the number of annual patients encounters or client visits:	Last 12 months	Estimate for next 12 months
Outpatient Visits (Non-Surgical)	<input type="text"/>	<input type="text"/>
Surgical Procedures (not included in above)	<input type="text"/>	<input type="text"/>
Other <input type="text"/>	<input type="text"/>	<input type="text"/>

22. If the applicant has or is a training school, please provide the following: (attach separate sheet if more room needed)

Profession for which students are being trained.	Max # students per session.	# of sessions per year	% of time in clinical settings	Qualifications of Facility (MD, RN,PHD)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



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23. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If None, state NONE)

Carrier	Limit	Deductible	Premium	Policy Term

24. What is the retroactive date on your current policy?

25. Is the applicant currently insured under a Commercial General Liability policy? YES NO

If Yes, please attach copies of declaration page.

26. Does the applicant own, operate or manage any business other than the one (s) described in this application for which you are applying for coverage? YES NO

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

27. Has any application for professional liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? YES NO

If Yes, please provide details including name of carrier and dates.

28. Has any claim ever been made against the Applicant or any of its employees? YES NO

If Yes, please complete the Supplemental Claim Information Form with your submission of this application. [Form Link](#)

29. Is the applicant aware of any circumstances which may result in any claim against them or their employees? YES NO

If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.



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30. Does the Applicant have a Risk Management and Risk Control Program in place? YES NO

a. Who is responsible for that Program?

Title: Contact E-mail:

Phone Number

I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

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 for any contract of insurance issued by the Company in response to it.

Signature of
Applicant or Authorized
Representative:

Current Date

Title

Please attach the following documents to this application:

- * Resumes or CV's on principals and partners
- * Copies of brochures, marketing or advertising materials
- * Five years of currently valued company loss runs.
- * Information on disciplinary actions, license revocations, etc.
- * Copy of most current declarations page