LAMMICO

SUPPLEMENTAL ENTITY APPLICATION

PROFESSIONAL LIABILITY COVERAGE FOR PROFESSIONAL CORPORATIONS, ASSOCIATIONS AND OTHER ORGANIZATIONS

*** Complete one supplement for each entity ***

Attach copy of Articles of Incorporation, Partnership Agreement or documents setting up entity listed below

A. General Information

Legal Name of Entity		DBA	Entity TIN #
Entity Business Address			Administrator / Contact Person
Phone Number	Fax Number	Email Address	Website Address

B. Coverage Information

Requested Effective Date: _____ / _____ / _____
MM DD YYYY

1. Current form of insurance for entity: ☐ Claims-Made ☐ Occurrence ☐ None
2. If claims-made, was a reporting endorsement purchased from current carrier? ☐ Yes ☐ No
3. Are you requesting separate limits of liability from LAMMICO for the entity? (additional premium charge applies) ☐ Yes ☐ No
4. Are you requesting prior acts coverage from LAMMICO for the entity? ☐ Yes ☐ No
   If yes, please attach entity certificate of insurance from current carrier
5. Retroactive date used by current carrier: _____

C. Practice and Operations Information

1. Are all entities and health care providers currently enrolled in a state Patient Compensation Fund? ☐ Yes ☐ No ☐ N/A
2. Type of Practice:
   ☐ Professional Corporation ☐ Partnership ☐ LLC ☐ LLP ☐ Joint Venture ☐ Professional Association
   ☐ Other- describe: _____
3. Description of Operations:
   ☐ Private doctor's office ☐ Urgent Care Facility ☐ Pain Clinic ☐ Medical Spa ☐ Outpatient surgery
   ☐ Physician owned and operated lab – owner use only ☐ Physician owned and operated lab – used by other than doctor/owner patients
   ☐ Doctor's office with diagnostic equipment – describe: _____
   ☐ Other- describe: _____

ADDITIONAL APPLICATIONS MAY BE NEEDED, DEPENDING ON THE OPERATIONS

4. Is the entity/facility used by anyone other than the owner(s), members, or employees? ☐ Yes ☐ No
   If yes, please describe: _____
5. Are there any services or business operations conducted outside of your primary state? ☐ Yes ☐ No
   If yes, please describe: _____

6. Number of owners: _____ Number of partners: _____ Are all owners and partners insured with LAMMICO? ☐ Yes ☐ No

7. List the names of all **owners**, partners or members of the entity listed above. (Attach separate sheet, if necessary)

Name / Specialty	Check if NOT insured by LAMMICO	Carrier if NOT insured by LAMMICO *
	☐	
	☐	
	☐	

8. Employed or contracted physicians/surgeons with the above named entity (exclude owners/partners)
   (Attach separate sheet, if necessary)

Name / Specialty	Check if NOT insured by LAMMICO	Carrier if NOT insured by LAMMICO *
	☐	
	☐	
	☐	

***Attach current certificate of insurance from professional liability carrier, if NOT insured by LAMMICO.**

fax 504.841.5205
call 800.452.2120
One Galleria Blvd., Suite 700
Metairie, LA 70001

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LAMMICO

9. Number of employed or contracted:

	How many?	Are all insured with LAMMICO?
☐ Physician Assistants	_____	☐ Yes ☐ No
☐ Surgeon Assistants	_____	☐ Yes ☐ No
☐ Nurse Anesthetists	_____	☐ Yes ☐ No
☐ Nurse Midwives	_____	☐ Yes ☐ No
☐ Nurse Practitioners	_____	☐ Yes ☐ No
☐ Other employees of this entity (not listed or counted above)	_____	

*** Attach current certificate of insurance from professional liability carrier, if not insured by LAMMICO.**

10. Are there any subsidiaries that provide health care related services? ☐ Yes ☐ No
    If yes, list below the subsidiary name, description of operations, % of ownership and date acquired)

Subsidiary Name	Description of Operations	Ownership %	Date Acquired

11. If subsidiaries are not 100% owned by the parent, provide details of other owners and the percentage owned by each.
    _____
    _____

12. Does this entity perform utilization review for a fee for others? ☐ Yes ☐ No
    If yes, please describe: _____
13. Is this entity currently under contract to supervise or administer any departments within a hospital or other facility, for an HMO or PPO or any government agency program? ☐ Yes ☐ No
    If yes, please describe: _____
14. Is the entity required to be licensed to provide medical professional services? ☐ Yes ☐ No
    If yes, by whom? _____
    Has a license been granted for the entity? If no, please explain in comments. ☐ Yes ☐ No
15. Is the entity eligible to be JCAHO certified? ☐ Yes ☐ No
    If yes, is it certified? ☐ Yes ☐ No
    Date of certification: _____
16. Has this entity's license ever been suspended, restricted, revoked, surrendered or has probation ever been invoked? ☐ Yes ☐ No
    If yes, please explain: _____
17. Have any claims or suits ever been made or brought against this entity? ☐ Yes ☐ No
    Give dates, allegation and disposition of each claim made.
    _____
    _____
18. Do you have knowledge of any claims which might be made against this entity or activities that might give rise to a claim or suit in the future? (include any requests for medical records) ☐ Yes ☐ No
    Include a description of each claim or activity.
    _____
    _____
19. Comments (attach a separate sheet if necessary):
    _____
    _____

Signing this application does not bind the company to issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 of insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____ Signature of Authorized Representative

_____ Title

_____ Printed or Typed Name

_____ Date Signed

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