Louisiana Medical Mutual Insurance Company
One Galleria Blvd., Suite 700 ♦ Metairie ♦ Louisiana ♦ 70001
Phone: 504-831-3756 ♦ 800-452-2120
Fax: 504-841-5300 ♦ 504-841-5205
www.lammico.com

GENERAL LIABILITY INSURANCE

☐ New Application ☐ Renewal Application – Expiring Policy Number: _____

Please complete a separate application for EACH location if multiple locations exist. If additional space is needed to answer any questions fully, use the Comments Section (Part IX) or attach a separate page.

NOTE: THIS IS OCCURRENCE COVERAGE ONLY

Agency Name (If using Agent):	Agency Address: *(City, State, Zip)*	Producer:

PART I – APPLICANT

Complete Legal Name of Applicant:	Doing Business As:

Applicant Mailing Address: *(Street, City, State, Zip)*	Website Address:

Primary Contact Person:	Primary Contact Title:	Primary Contact Phone:	Primary Contact Fax:	Primary Contact Email:

Requested Coverage Effective Date:
From: To:

PART II – APPLICANT FACILITIES

A. Complete the following information for each location you occupy. Location No. 1 should be the business address for the primary facility.

Location Number	Business Name & Address *(Street, City, State, Zip)*	Description of Operations	Interest	Is coverage desired for this location?
			☐ Own ☐ Rent ☐ Occupy	☐ Yes ☐ No

B. Please complete the following for each location:

	Location 1	Location 2	Location 3	Location 4
i. Year Built				
ii. Year Remodeled				
iii. Number of Stories				
iv. Total Square Footage of Building				
v. Construction Type*				
vi. Number of Apartment Units (if applicable)				
vii. Square Footage Occupied By Insured**				
viii. Square Footage Occupied By Your Employees**				
ix. Square Footage of Parking Lots**				
x. Square Footage Leased to Other Occupant(s)**				
xi. Square Footage of Medical Offices**				
xii. Square Footage of Vacant Space**				

**** Frame, Combustible, Non-Combustible, Fire Resistive, Modified Fire Resistive, etc.***
***** May differ from Total Square Footage of Building***

C. Is the Building Equipped With: *(Please indicate for each location as necessary)*

i. Complete Sprinkler System? ☐ Yes ☐ No
ii. At Least Two Clearly Marked Exits on Each Floor? ☐ Yes ☐ No
iii. Self-Closing Fire Doors on Each Floor? ☐ Yes ☐ No
iv. Automatic Fire Alarm System Connected to Local Fire Department? ☐ Yes ☐ No
v. Smoke Detectors? ☐ Yes ☐ No
vi. Emergency Electrical System? ☐ Yes ☐ No
vii. Heat Sensors? ☐ Yes ☐ No
viii. Fire Escapes? ☐ Yes ☐ No
ix. Posted Emergency Evacuation Procedures? ☐ Yes ☐ No
x. Properly Maintained Fire Extinguishers? ☐ Yes ☐ No

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PART III – APPLICANT OPERATIONS

Do any of the facilities listed in Part II above have: *(Explain all "Yes" answers in the Comments Section, Part IX)*

A. An exposure to flammables, explosives, chemicals? ☐ Yes ☐ No

B. A catastrophe exposure? ☐ Yes ☐ No

C. An exposure to radioactive materials? ☐ Yes ☐ No

D. Any operations involving the storage, treatment, discharge, application, disposal or transport of hazardous materials? ☐ Yes ☐ No

E. Any elevators or escalators that are owned by you? ☐ Yes ☐ No

(If "Yes", please indicate the model and if the elevator and /or escalator is serviced by you under a maintenance contract)

_____

F. Parking facilities? ☐ Yes ☐ No

(If "Yes", please indicate if the parking facilities are owned or rented) ☐ Owned ☐ Rented ☐ Maintained

G. Recreation Facilities / Health Club? ☐ Yes ☐ No

(If "Yes", please indicate the annual number of members / users of the facility) _____

H. A swimming pool on the premises? ☐ Yes ☐ No

I. Any sponsored sporting or social events? ☐ Yes ☐ No

(If "Yes", please indicate the annual number of events) _____ *(Is alcohol served at any of these events?)* ☐ Yes ☐ No

J. Any off-site events such as health fairs or screenings? ☐ Yes ☐ No

K. An Ambulance service? ☐ Yes ☐ No

(If "Yes", please indicate the following) Number of Vehicles: _____ Number of Annual Runs: _____

L. A Blood Bank? ☐ Yes ☐ No

(If "No", please indicate your supplier(s)) _____

(If "Yes", please indicate the following):

Total units collected annually: _____ Total units sold in the last 12 months: _____ Any crossover to stock blood? ☐ Yes ☐ No

M. An Organ Tissue Bank? ☐ Yes ☐ No

(If "Yes", please indicate the following) Number of annual organ/tissue donations: _____ Number of donors: _____

N. Day Care Services that are either operated, controlled or contracted by you? ☐ Yes ☐ No

(If "Yes", you will be required to complete the Day Care Services supplement and provide copies of any contract agreements)

O. A Heliport? ☐ Yes ☐ No

(If "Yes", state by location where each pad is located (e.g., parking lot, top of building, etc)):

_____

Please describe the type of construction: _____

Is the heliport separately insured? ☐ Yes ☐ No

Is the heliport: ☐ Owned? ☐ Leased? *(Please check one)* What is the number of annual landings? _____

P. A Gift Shop? ☐ Yes ☐ No

Q. A Cafeteria? ☐ Yes ☐ No

R. Security Guards? ☐ Yes ☐ No

If "Yes", are the Security Guards armed? ☐ Yes ☐ No

(If the Security services are contracted, please provide a copy of any contract agreements)

PART IV – PRODUCT / SERVICES INDEMNIFICATION

A. Estimated annual sales of medical equipment supplies: $ _____

B. Estimated annual receipts from any Retail Pharmacy operation $ _____

C. Estimated annual rental receipts of medical equipment: $ _____

D. Estimated annual receipts from servicing equipment of others: $ _____

E. Do you obtain revenue from contracting with others for services (i.e., laundry, food, maintenance)? ☐ Yes ☐ No

If yes, sales from service contract: $ _____

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F. Do you modify the design or function of any medical equipment? ..... ☐ Yes ☐ No

If yes, please explain:

G. Describe any other products or services _____

PART V – ADDITIONAL INTEREST / CERTIFICATE RECIPIENT

A. Does your facility have any signed contracts which require your facility to name another party as an additional insured or extend contractual indemnity coverage? *(If "Yes", please include a copy of contract)*..... ☐ Yes ☐ No

PART VI – APPLICANT HISTORY

A. Please list prior general liability insurance carried for each of the past ten years. If none, state "NONE".

Insurance Carrier	Limits of Liability	Deductible (If any)	Premium	Inception (MM/DD/YY)	Expiration (MM/DD/YY)	Was this Claims Made?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

B. Ten Year Loss History *(Attach 10 year loss history from current or previous carriers)*

C. Is any claim above subject to a deductible or self insured retention? ..... ☐ Yes ☐ No

If "Yes", are the amounts shown above inclusive or exclusive of the deductible or self-insured retention?

If "inclusive", what is the amount of the deductible or self insured retention? ..... $

D. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you? ..... ☐ Yes ☐ No

(If "Yes", please attach an explanation)

E. Has any insurer cancelled, declined to issue, or non-renewed your General Liability Insurance coverage? ..... ☐ Yes ☐ No

(If "Yes", please attach an explanation including the name of the carrier, the date and the reason)

PART VII – LIMITS AND REIMBURSEMENT AMOUNTS*

A. PRIMARY GENERAL LIABILITY LIMITS

☐ $100,000 Per Claim / $300,000 Total Annual Aggregate	☐ $1,000,000 Per Claim / $3,000,000 Total Annual Aggregate
☐ $500,000 Per Claim / $500,000 Total Annual Aggregate	☐ $2,000,000 Per Claim / $2,000,000 Total Annual Aggregate
	☐ Higher Limits (refer to company)

B. REIMBURSEMENT AMOUNT*

(Reimbursement amount applies separately to Professional and General Liability)

☐ None	☐ $5,000	☐ $10,000	☐ $25,000	☐ $50,000	☐ $100,000	☐ Indemnity Only ☐ Indemnity & Expense

**Reimbursement amount means the amount you would reimburse LAMMICO following a loss and / or loss adjustment expense payment on your behalf.*

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PART VIII – EXCESS COVERAGES (APPLICABLE TO HOSPITAL RISKS ONLY)

Excess coverages may provide additional limits excess of $1,000,000 above your underlying policy limits. Please complete the following sections if you require any of these coverages.

1. EXCESS AUTOMOBILE COVERAGE

A. Number of hospital owned autos / emergency vehicles..... _____

B. Name of primary insurance co. on those owned vehicles: _____

C. Policy Number: _____ D. Expiring Limits:

E. Expiration Date: _____ F. Uninsured Motorists (yes or no) ..... ☐ Yes ☐ No

VEHICLE INFORMATION – COMPLETE OR ATTACH SEPARATE LISTING:

Vehicle Type	# of Vehicles	Use / Purpose
A. Private Passenger		
B. Light Truck / Van (non-patient transport)		
C. Van / Small Bus (non-emergency transport)		
D. Bus (include # of passengers in "Use / Purpose)		
E. Emergency Ambulance		
F. Hired & Non-owned Autos		
G. Other		

In the past five years, have you had any automobile losses that exceeded $100,000? ..... ☐ Yes ☐ No

Please provide a copy of your automobile loss runs for the last five years

2. EXCESS EMPLOYERS LIABILITY

A. Name of Workers' Compensation Carrier: _____

B. Policy Number: _____ C. Expiring Limits: _____ D. Expiration Date: _____ E. No. of Employees: _____

3. Employee Benefits Liability (primary limits available)

A. Name of Employee Benefits Carrier: _____

B. Policy Number: _____ C. Expiring Limits: _____ D. Expiration Date: _____ E. No. of Employees: _____

F. Are Employee Benefits Self-Administered? ..... ☐ Yes ☐ No

If "Yes", what is the name of the vendor? _____

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PART IX – APPLICANT NOTICE AND DECLARATION

The Applicant expressly represents and warrants that the above statements and facts are true and correct and that no material facts have been suppressed or misstated. Applicant specifically acknowledges that LAMMICO has relied on statements contained in this application to issue coverage, particularly as to claims made and prior acts or retro coverage as to disclosing all incidents occurring in the last ten (10) years where Applicant knows or has reason to believe a claim may be made in the future. Any failure to disclose material facts affecting coverage, losses and premiums, including incidents that have occurred at the time of this application, but not made until after coverage is instituted may constitute a material misrepresentation or fraud causing the denial of coverage.

I understand the submission of this application does not bind LAMMICO to issue me, or our institution to purchase, this insurance. By signing below, I grant permission (1) to LAMMICO to contact third parties and (2) for third parties to release to LAMMICO information which relates to the issuance and continuation of this coverage. I also understand that knowingly providing false, incomplete or misleading information to LAMMICO the purpose of defrauding LAMMICO may constitute a crime punishable by imprisonment, fines, and/or a denial of insurance benefits.

I represent the information provided in this application (and attachments) is true. I understand (1) that this application and any previous applications are the basis of and will become a part of the coverage contract with LAMMICO; (2) that the application information I provided is material to LAMMICO; (3) that LAMMICO is relying on this information in determining whether to issue a coverage contract and in establishing the premium to charge for the contract; and (4) that LAMMICO may rescind or void the coverage contract if this application or any previous application contains any misrepresentations or omission. Furthermore, I understand that my failure to disclose to LAMMICO any material fact that I become aware of subsequent to the completion of this application but prior to the effective date of the coverage may also void the contract.

Applicant Signature	Title	Date

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PART X – COMMENTS SECTION