



## 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		Entity TIN #
DBA (if applicable)		Administrator/Contact Person
Entity Business Address		Phone Number
Email Address	Website Address	Fax Number

### B. Coverage Information

Requested Effective Date: \_\_\_ / \_\_\_ / \_\_\_  
MM DD YYYY

- Current form of insurance for entity:  Claims-Made  Occurrence  Self-Insured  None
- If claims-made, was a reporting endorsement purchased from current carrier?  Yes  No
- Are you requesting **separate limits of liability** from LAMMICO for the entity? (add'l premium charge applies)  Yes  No
- Are you requesting prior acts coverage from LAMMICO for the entity?  
If yes, please attach entity certificate of insurance from current carrier.  Yes  No
- Retroactive date used by current carrier: \_\_\_\_\_

### C. Practice and Operations Information

- Are all entities and health care providers currently enrolled in a state Patient Compensation Fund?  N/A  Yes  No
- Type of Practice:  
 Professional Corporation  Partnership  LLC  LLP  Joint Venture  Professional Association  
 Other- describe: \_\_\_\_\_
- 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**

- Is the entity/facility used by anyone other than the owner(s), members, or employees?  
If yes, please describe: \_\_\_\_\_  Yes  No
- Are there any services or business operations conducted outside of your primary state?  
If yes, please describe: \_\_\_\_\_  Yes  No
- 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 LAMMICO Insured and list carrier
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

8. Employed or contracted physicians/surgeons, **non-owners/partners**, of entity listed above. (Attach separate sheet, if necessary)

Name	Specialty	Check if NOT LAMMICO Insured and list carrier
		<input type="checkbox"/>
		<input type="checkbox"/>
		<input type="checkbox"/>

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

9. Do you (or does your partnership/association/corporation/joint venture) employ or contract with any of the following:  Yes  No

**Indicate the number of personnel in each applicable category.**

Professional Type:	Employed	**Contract	Professional Type:	Employed	Contract
*Certified Nurse Midwife (CNM)			Aesthetician		
*Chiropractor			*Orthotist		
*Clinical Nurse Specialist (CNS)			*Perfusionist		
*Nurse Anesthetist (CRNA)			Physical Therapist		
*Nurse Practitioner			*Prosthetist		
*Optometrist			RN First Assistant		
*Pharmacist			Surgical Assistant		
*Physician Assistant			Specify type:		
*Podiatrist			Other:		
*Psychologist					
<b>*Separate LAMMICO application is required for coverage.</b>					

**NOTE: If you answered "yes" to any part of question 9, please list all names in the "Remarks" section. If you want to apply for insurance for these medical professionals through LAMMICO, please indicate in the "Remarks" section.**

10. Are there any subsidiaries that provide health care related services? If yes, please list below:  Yes  No

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.**

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Printed or Typed Name**

\_\_\_\_\_  
**Date Signed**

**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.