



## Allied Healthcare Services Renewal Application

### Applicant Information

1. Applicant name:
  
2. Principal business address (attach separate sheet if more than one location):  
 Street:  County:   
 City:  State:  Zip:   
 Phone:  Website:
  
3. Date established:  (if applicant is a facility/entity)  
 Date of birth:  (if applicant is an individual)
  
4. Please describe in detail the nature of the applicant's operation and types of services rendered:

5. Please state sources and amounts of total revenue:

	in last 12 months	for next 12 months
Charitable contributions	\$	\$
Government funding	\$	\$
Fee for services	\$	\$
Other – specify: <input style="width: 20%;" type="text"/>	\$	\$
<b>Total gross revenue:</b>	<b>\$</b>	<b>\$</b>

### Operations and Activities

6. Please indicate the number of:
  - a. patient/client encounters in the **last** 12 months:
  - b. tests performed in the **last** 12 months:

*(encounters refers to number of visits – not number of patients/clients)*

7. Please indicate the number of:
  - a. estimated patient/client encounters in the **next** 12 months:
  - b. estimated tests performed in the **next** 12 months:

8. a. If applicant has a training school, complete the following:

Profession for which students are being trained	Max no. of students per session	Number of sessions per year	Number of faculty per session	Qualification of faculty (e.g. MD RN)

- b. What is the total number of faculty members?
- c. What is the total annual number of students enrolled?



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9. Does the applicant perform:
- |   |                              |                             |
|---|------------------------------|-----------------------------|
| a. acupuncture or acupuncture anesthesia?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| b. angiography/arteriography/venography?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| c. catheterization (other than urinary or umbilical)?                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| d. radiation therapy and/or chemotherapy?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| e. psychiatric shock therapy?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| f. Botox or dermal filler injections?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| g. laser treatments?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| h. hypnosis?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| i. spinal anesthesia (other than saddle blocks or caudals)?                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| j. surgery other than incision of superficial boils or suturing superficial fascia? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| k. obstetric procedures?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| l. cosmetic plastic surgery?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| m. excision of large cysts and/or I&D of deep-seated boils or carbuncles?           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| n. hysterectomies?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| o. open reduction of fractures?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| p. biopsies and/or endoscopies?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If Yes to any of the above, please provide a full description:

10. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes  No

If Yes, please explain in the comments section.

11. Does the applicant maintain any beds for overnight occupancy? Yes  No

If Yes, please give total number:

12. Does the applicant (wholly or in part) operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes  No

If Yes, please give details, including name, location, size, and number of beds:



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**Staffing Information**

13. a. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted		Profession	Employed	Contracted
Acupuncturists				Opticians		
Chiropractors				Optometrists		
Hearing aid fitters				Paramedics/EMT's		
Inhalation/respiratory therapists				Perfusionists		
Inhalation therapist				Pharmacists		
Laboratory technicians				Physicians – minor surgery		
Nurse anesthetists				Physicians – no surgery		
Nurse midwives				Physiotherapists		
Nurse practitioner				Prosthetic device fitters		
Nurses, licensed practical				Social workers		
Nutritionists				Speech therapists		
Nurses registered				Other – (specify below)		
				specify:		

- b. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes  No   
 If No, please explain in the comments section.
- c. Do you require contracted staff to carry their own professional liability insurance? Yes  No
- d. Do you maintain Certificates of Insurance to confirm such coverage? Yes  No

14. Provide the name of the applicant's Medical Director and attach a copy of his/her Curriculum Vitae (CV).

**Insurance and Claims History**

15. Has the applicant notified Hiscox Inc. of all matters that may result in a potential claim including any litigation, administrative proceedings, demand letters, formal or informal investigations or inquiries which have occurred within the expiring policy period?  
 Yes  No  None to Report   
 If No, please attach a detailed explanation or explain in the Comments Section.



**Allied Healthcare Services**  
Renewal Application

Comments Section

**Notice to New York 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 material thereto, commits a fraudulent insurance act, which is a crime.**

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

**A copy of this application should be retained for your records.**