RESET SAVE PRINT

Supplemental Application

Submission requirements:

5 years of company loss runs, current financials, brochure.

APPLICANT INFORMATION

Name:_____

(If more than one entity/subsidiary, please attach description and % owned for each)

Address:_____

Website:_____ Requested effective date: _____

Type of entity:_____

1. Has any applicant had a change in ownership or management in the past 12 months? ☐ Yes ☐ No
   If yes, describe: _____
2. Description of services:_____
3. Will any new services be offered in the next 12 months? ☐ Yes ☐ No
   If yes, describe: _____
4. Will any services be discontinued in the next 12 months? ☐ Yes ☐ No
   If yes, describe: _____
5. Licensed specialty: _____ Licensing agency (ies): _____
6. Applicant accreditation: _____ Date surveyed: _____
7. Has your license/certification ever been, revoked or canceled ? ☐ Yes ☐ No
   If yes, describe: _____
8. Have there been any claims alleging negligence/failure to comply with any regulatory/licensing guidelines? ☐ Yes ☐ No
   If yes, explain: _____

OPERATIONS

Check the appropriate medical office/facility that best describes your operation.

Medical offices: – available coverage: GL, abuse, auto, umbrella

- ☐ Audiologist
- ☐ Dermatology
- ☐ Neurological
- ☐ Oncology
- ☐ Orthopedics
- ☐ Ophthalmologist
- ☐ Primary care physicians office
- ☐ Dieticians offices
- ☐ Dental offices
- ☐ Urologists

Medical facilities: – available coverage: property and auto

- ☐ Ambulatory surgery center
- ☐ Cancer treatment center
- ☐ Community health center
- ☐ Convenience care clinic
- ☐ Diagnostic testing/imaging
- ☐ Dialysis center
- ☐ Hospice home
- ☐ Medical laboratory
- ☐ Physical/speech/occupational therapy or rehabilitation
- ☐ Sleep center
- ☐ Urgent center

☐ Other:_____

Operations continued: Provide details on a separate page for all yes responses

1. Do you provide general anesthesia? ☐ Yes ☐ No
2. Do you have a mobile facility? ☐ Yes ☐ No
3. Do you provide any in home services? ☐ Yes ☐ No
4. Do you offer 24-hour emergency service? ☐ Yes ☐ No
5. Do you have a lab(s)? ☐ Yes ☐ No
6. Do you sell, rent or lease medical supplies and/or equipment? ☐ Yes ☐ No
7. Do you repackage, re-label any items obtained from suppliers? ☐ Yes ☐ No
8. Do you sell products under your own label? ☐ Yes ☐ No
9. Do you sell/provide nutraceuticals or dietary supplements? ☐ Yes ☐ No
10. Do you administer or distribute non-FDA approved pharmaceuticals (experimental drugs)? ☐ Yes ☐ No

    If yes, describe: _____

11. Does any applicant distribute oxygen cylinders? ☐ Yes ☐ No

    If yes, are the cylinders pre-filled? ☐ Yes ☐ No

    If yes, does any applicant fill oxygen cylinders at the applicants' premises? ☐ Yes ☐ No
12. Do you arrange transportation for patients through livery or 3rd party transportation? ☐ Yes ☐ No

    If yes, please explain: _____

Other Coverage

1. Do you have medical professional insurance in place? ☐ Yes ☐ No
2. Provide the limits of liability of your medical professional insurance coverage: $_____

   (Attach evidence of medical professional insurance with your submission)

Risk Management

1. Are patient records protected in accordance with HIPPA (Health Insurance Portability and Accountability Act of 1996)? ☐ Yes ☐ No

   If no, please explain:_____
2. Is an informed consent process in place? ☐ Yes ☐ No

   Are copies of informed consent forms maintained in patient files? ☐ Yes ☐ No
3. Is a formal written quality assurance and risk management program in place? ☐ Yes ☐ No
4. If you contract for services, do you require the contractors to sign a hold harmless or indemnification agreement?If yes, attach a copy of the standard agreement. ☐ Yes ☐ No
5. Are certificates of Insurance required and kept in file for those contractors? ☐ Yes ☐ No

   Required limits: $_____
6. Do you obtain certificates of insurance granting yo u additional insured status from your subcontractors? ☐ Yes ☐ No

   If yes, attach a copy.

AUTOMOBILE

1. Are all vehicles listed on the ACORD application titled to the applicant? ☐ Yes ☐ No
2. Do you provide emergency transportation? ☐ Yes ☐ No
3. Do you transport clients/others? ☐ Yes ☐ No

   If yes, please explain: _____
4. Do you have mobile medical vehicles? ☐ Yes ☐ No
5. Is there a formal accident analysis program in place? ☐ Yes ☐ No

6. Do you obtain MVR's upon hire? ☐ Yes ☐ No

   If yes, please describe your protocol for monitoring MVR's: _____

7. Do you require drug tests on all drivers? ☐ Yes ☐ No

   If yes: ☐ Before hiring ☐ After hiring ☐ Random

8. Do you allow personal use of your owned vehicles? ☐ Yes ☐ No

   If yes, by whom and for what reasons? _____

9. Is training provided for new employees? ☐ Yes ☐ No
10. Do you have a vehicle maintenance program in place that complies with OEM standards? ☐ Yes ☐ No
11. Do you have rules governing the use of cell phones while driving? ☐ Yes ☐ No

Hired and non-owned automobile:

1. Are any vehicles leased or hired? ☐ Yes ☐ No

   If yes, describe what types, what uses and how often: _____

2. Do you hire from a transportation company? ☐ Yes ☐ No

   If yes, with drivers? ☐ Yes ☐ No

3. Total number of hired vehicles: _____ Annual cost of hire: $_____
4. How many drive personal vehicles for business use regularly? Full time: _____ Part time: _____
5. How many drive personal vehicles for business use occasionally? Full time: _____ Part time: _____
6. Do you require your employees that use their own autos to carry and provide evidence of personal auto insurance? ☐ Yes ☐ No

   If yes, indicate minimum limits of personal auto limits: _____

7. Is proof of personal auto insurance required on a renewal basis? ☐ Yes ☐ No

INLAND MARINE Provide a separate schedule of all mobile medical and medical diagnostic equipment

1. Do you have mobile medical equipment? ☐ Yes ☐ No

   Value: $_____

2. Do you have medical diagnostic equipment? ☐ Yes ☐ No

   Value: $_____

PANDEMIC AND COMMUNICABLE DISEASE

1. Do you have formal procedures in place to handle pandemic or other communicable diseases? ☐ Yes ☐ No

   a. Do your procedures address:

      i. Staffing ☐ Yes ☐ No
      ii. Training ☐ Yes ☐ No
      iii. Personal protective equipment ☐ Yes ☐ No
      iv. Client care ☐ Yes ☐ No
      v. Vendors/visitors ☐ Yes ☐ No
      vi. Internal & external communication ☐ Yes ☐ No
      vii. Maintenance of premises and vehicles ☐ Yes ☐ No
      viii. CDC guidelines and recommendations ☐ Yes ☐ No

   b. Please provide a copy of your written procedures

2. Have you ever had to implement those procedures? ☐ Yes ☐ No

   a. If yes, please provide details. _____

DECLARATION AND SIGNATURE

Authorized entity representative designation

The person named herein is authorized and designated to give and receive any and all notices on behalf of the entity and all Insureds from the entity or their authorized representative(s) concerning this insurance.

Named individual: _____

Title or position: _____ Date: _____

Attestation

The authorized signer of this application represents to the best of his/her knowledge and belief that the statements and information set forth herein are true and include all material information. The authorized signer also represents that any fact, circumstance or situation indicating the probability of a claim or legal action now known to any entity official or employee has been declared, and it is agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. Signing of this application does not bind The Hanover Insurance Group, Inc. to offer, nor the authorized signer to accept insurance, but it is agreed this application and any attachments hereto shall be the basis of the insurance and will be incorporated by reference and made part of the policy should a policy be issued.

Signature of authorized entity representative

_____ Date _____

The Hanover Insurance Group®

The Hanover Insurance Company
440 Lincoln Street, Worcester, MA 01653

hanover.com
The Agency Place (TAP)—https://tap.hanover.com

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