/ SUPPLEMENTAL APPLICATION

Allied Health & Medical Professional Supplemental

Outpatient, allied-health, and miscellaneous medical professional risk.

> Please complete this supplement in full and return it with a signed ACORD application. Submit to submissions@hedgespecialty.com or through the Hedge broker portal. Answer every question — incomplete applications delay quoting.

GENERAL INFORMATION

NAMED INSURED / APPLICANT

DBA / TRADE NAME

BROKERAGE / BROKER

AGENCY / AGENT

PROPOSED EFFECTIVE DATE

NEW OR RENEWAL?

POLICY / QUOTE NUMBER

FEIN

ENTITY TYPE (LLC, CORP, ETC.)

YEARS IN BUSINESS

YEARS UNDER CURRENT MGMT

EMPLOYEES (FT / PT)

TYPE OF PRACTICE / FACILITY

WEBSITE

MAILING & RISK ADDRESS

MAILING ADDRESS

CITY

STATE

ZIP

COUNTY

OF LOCATIONS

PRIMARY RISK / PREMISE ADDRESS (IF DIFFERENT)

CITY

STATE

ZIP

COUNTY

CONTACTS

PRIMARY CONTACT NAME

TITLE

EMAIL

PHONE

AUDIT / INSPECTION CONTACT

INSPECTION PHONE

INSPECTION EMAIL

CURRENT / EXPIRING CARRIER INFORMATION

CURRENT / EXPIRING CARRIER

POLICY NUMBER

ANNUAL PREMIUM $

LIMIT(S) OF INSURANCE

DEDUCTIBLE / SIR

RETROACTIVE DATE (IF ANY)

Is the current carrier offering renewal? ☐ YES ☐ NO

Is the expiring / current coverage written on a claims-made basis? ☐ YES ☐ NO

OPERATIONS & ENTITY

Describe the applicant's operations. If more than one entity or subsidiary, attach a description and ownership % for each.

Type of practice / facility (check all that apply)

- ☐ Physician / medical group
- ☐ Nurse practitioner / PA practice
- ☐ Chiropractor
- ☐ Physical / occupational therapy
- ☐ Speech therapy
- ☐ Home health care provider
- ☐ Visiting nurse agency
- ☐ Hospice
- ☐ Medical / supplemental staffing
- ☐ Nurse registry
- ☐ Companion / homemaker agency
- ☐ Infusion therapy
- ☐ Dialysis
- ☐ Adult day care
- ☐ Ambulatory surgery center
- ☐ Urgent care / clinic
- ☐ Med spa / aesthetics
- ☐ Behavioral / mental health
- ☐ Substance abuse / rehab
- ☐ Optometry / vision
- ☐ Podiatry
- ☐ Dental / oral
- ☐ Audiology
- ☐ Dietary / nutrition
- ☐ Medical equipment supplier (DME)
- ☐ Pharmacy (retail / closed / compounding)
- ☐ Laboratory / diagnostics
- ☐ Imaging / radiology
- ☐ Other

DESCRIPTION OF OPERATIONS (SPECIALTY, SCOPE, PATIENT MIX)

NAICS / SIC

ENTERPRISE TYPE (FOR-PROFIT / NOT-FOR-PROFIT)

TAX-EXEMPT? (Y/N)

DATE BUSINESS ESTABLISHED

TOTAL # EMPLOYEES (FT / PT)

ACCREDITED? (JOINT COMMISSION / CHAP / ACHC / OTHER)

ACCREDITING BODY & STATUS

1. Is the applicant owned by, associated with, or controlled by any other entity? ☐ YES ☐ NO
   IF YES, NAME AND % OWNED FOR EACH
2. Is the applicant licensed in all states in which it operates? ☐ YES ☐ NO
3. Has the applicant sold, acquired, merged, or discontinued any operations in the past 5 years? ☐ YES ☐ NO
   IF YES, DESCRIBE
4. Does the applicant use a formal written Quality Improvement / Risk Management program? ☐ YES ☐ NO
5. Is overall responsibility for risk management assigned to one individual? ☐ YES ☐ NO
   IF YES, NAME AND TITLE
6. Does the applicant maintain written job descriptions and a formal training / education program? ☐ YES ☐ NO

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

PATIENTS, VOLUME & GEOGRAPHY

PATIENT VISITS / ENCOUNTERS PER YEAR

AVG WEEKLY PATIENT ENCOUNTERS

BEDS (IF APPLICABLE)

STATE(S) OF OPERATION | # LOCATIONS | PRIMARY PATIENT POPULATION (ADULT / PEDIATRIC / GERIATRIC)

Gross Revenue — Five-Year History (by source)

GROSS REVENUE SOURCE	UPCOMING YR (EST.) $	LAST 12 MONTHS $	1 YEAR PRIOR $	2 YEARS PRIOR $	3 YEARS PRIOR $
Fee for Services / Patient Revenue					
Government Funding (Medicare / Medicaid)					
Equipment / Product Sales					
Equipment Rental / Lease					
Pharmacy					
Charitable Contributions / Grants					
TOTAL					

SERVICES PROVIDED

Check all services provided and, where requested, give the approximate % of operations. Service percentages should total 100%.

Clinical & support services (check all)

- ☐ Personal care / chore / companion
- ☐ Homemaker
- ☐ Skilled nursing care
- ☐ Private-duty nursing
- ☐ Rehabilitation (PT / OT / Speech)
- ☐ Respiratory therapy
- ☐ Infusion therapy
- ☐ IV / chemotherapy
- ☐ Radiation therapy
- ☐ Wound / skin / bedsore care
- ☐ Pain management
- ☐ Pediatric / infant care
- ☐ Obstetrical / labor & delivery
- ☐ Cardiac care
- ☐ In-home dialysis
- ☐ Hospice
- ☐ Palliative care
- ☐ Surgical nursing / OR techs
- ☐ Blood transfusion
- ☐ Diagnostic / laboratory
- ☐ Imaging / X-ray
- ☐ Behavioral / mental health
- ☐ Substance abuse treatment
- ☐ Social services
- ☐ Meals / nutrition
- ☐ Supplemental staffing (medical)
- ☐ Supplemental staffing (non-medical)
- ☐ Permanent placement
- ☐ Medical equipment / DME
- ☐ Telehealth / telemedicine
- ☐ Other

% PERSONAL CARE / COMPANION | % SKILLED NURSING | % REHABILITATION | % INFUSION / IV THERAPY

% HOSPICE / PALLIATIVE | % SUPPLEMENTAL STAFFING | % EQUIPMENT / DME | % OTHER (DESCRIBE)

Locations where services are provided (must total 100%)

% PRIVATE HOMES | % ASSISTED / INDEPENDENT LIVING | % NURSING HOMES | % HOSPITALS | % CLINICS

% PHYSICIAN OFFICES | % AMBULATORY SURGERY CENTER | % SCHOOLS | % CORRECTIONAL FACILITIES | % OTHER

If hospital staffing, % by unit

% OPERATING ROOM | % EMERGENCY ROOM | % LABOR & DELIVERY | % NICU | % ICU (ADULT / PEDS)

7. Does the applicant provide overnight bed / board facilities? ☐ YES ☐ NO

8. Does the applicant perform any treatment or services on its own premises? ☐ YES ☐ NO

9. Does the applicant care for ventilator or tracheotomy patients? ☐ YES ☐ NO

IF YES, % OF SERVICES

10. Does the applicant perform permanent placements of staff? ☐ YES ☐ NO

IF YES, % PERMANENT VS. TEMPORARY

11. Does the applicant offer training / certification programs? ☐ YES ☐ NO

IF YES, OPEN TO THE GENERAL PUBLIC?

12. Does the applicant provide telehealth or remote-monitoring services? ☐ YES ☐ NO

PROVIDER & STAFF SCHEDULE

List each provider / clinician class. Give license type, count, FT/PT split, specialty, and years of experience. Attach a separate schedule with individual licensed providers (name, license #, specialty) if requested.

Provider Schedule

PROVIDER NAME / CLASS	LICENSE / CERT TYPE	LICENSE #	SPECIALTY	FT / PT	# EMPLOYEES	# CONTRACTORS (1099)	YEARS EXPERIENCE

Staffing summary — annual counts & hours

Staff Census

PROVIDER / STAFF TYPE	# FT	# PT	# 1099 / IC	ANNUAL HOURS	ANNUAL PAYROLL $
Physician / MD / DO					
Nurse Practitioner					
Physician Assistant					
CRNA					
Nurse Midwife					
Registered Nurse (RN)					
LPN / LVN					
CNA / Home Health Aide					
Physical Therapist					
Occupational Therapist					
Speech Therapist					
Respiratory Therapist					
Social Worker					
Pharmacist					
Pharmacy Tech / Assistant					
Medical Technician / Tech					

PROVIDER / STAFF TYPE	# FT	# PT	# 1099 / IC	ANNUAL HOURS	ANNUAL PAYROLL $
X-Ray / Imaging Tech					
Lab Technician					
Chiropractor					
Massage Therapist					
Counselor / Behavioral					
Companion / Homemaker / Sitter					
Doula					
Medical Director					

TOTAL # PROVIDERS / CLINICIANS

TOTAL # NURSES

TOTAL # AIDES / SUPPORT STAFF

TOTAL # ADMINISTRATIVE

CREDENTIALING, HIRING & VERIFICATION

Describe how clinical staff and independent contractors are screened, credentialed, and verified before hire or placement.

Pre-hire / pre-placement screening performed (check all)

- ☐ Reference checks (prior employers)
- ☐ References in writing
- ☐ References by telephone
- ☐ Education / residency verification
- ☐ Criminal background — state
- ☐ Criminal background — federal
- ☐ OIG / SAM / GSA exclusion check
- ☐ Sex-offender registry check
- ☐ Drug & alcohol screening
- ☐ License / certification verification
- ☐ License sanction / suspension check
- ☐ NPDB query
- ☐ Prior malpractice / claims inquiry
- ☐ Motor vehicle record (if driving)
- ☐ Competency / skills assessment
- ☐ Immunization / health screening

13. Are all individuals licensed / certified in accordance with applicable state regulations before hire or placement? ☐ YES ☐ NO

14. Are credentials, licenses, and exclusion checks re-verified on a documented periodic basis? ☐ YES ☐ NO

15. Are references and criminal background screening completed for ALL clinical employees and contractors prior to hire/placement? ☐ YES ☐ NO

16. Has the applicant formalized a drug & alcohol screening program (pre-hire and for-cause)? ☐ YES ☐ NO

DESCRIBE

17. Who reviews and retains credentialing files, and for how long? ☐ YES ☐ NO

REVIEWER / RETENTION PERIOD

IF “YES” TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

PROFESSIONAL / INDEPENDENT-CONTRACTOR LIABILITY

18. Do ALL employed providers carry their own professional liability (malpractice) insurance? ☐ YES ☐ NO

19. Do ALL independent contractors / 1099 staff carry their own professional liability insurance? ☐ YES ☐ NO

20. Are contractors required to name the applicant as additional insured and provide a current COI? ☐ YES ☐ NO

REQUIRED LIMITS

21. Is the applicant requesting that the policy provide direct coverage for independently-contracted staff? ☐ YES ☐ NO

22. Are 1099 / contracted staff verified for active, unimpaired licensure at each placement? ☐ YES ☐ NO

REQUIRED IC MALPRACTICE — EACH CLAIM $	REQUIRED IC MALPRACTICE — AGGREGATE $	EMPLOYED-PROVIDER MALPRACTICE — EACH CLAIM $	AGGREGATE $

PROCEDURES & TREATMENT EXPOSURES

Indicate procedures performed and any higher-hazard treatment exposures.

23. Does the applicant prescribe or dispense prescription drugs? ☐ YES ☐ NO

DESCRIBE

24. Does the applicant dispense or recommend vitamins, supplements, or herbal products? ☐ YES ☐ NO

DESCRIBE

25. Are any experimental, investigational, off-label, or clinical-trial procedures performed? ☐ YES ☐ NO

DESCRIBE

26. Are X-rays or diagnostic imaging used in determining treatment? ☐ YES ☐ NO

ARE IMAGES READ BY A RADIOLOGIST?

27. Are skin-penetration, injection, or invasive procedures performed? ☐ YES ☐ NO

DESCRIBE

28. Is manipulation or treatment performed under anesthesia? ☐ YES ☐ NO

DESCRIBE

29. Are pain-management injections, nerve blocks, or epidurals performed? ☐ YES ☐ NO

DESCRIBE / # PER YEAR

30. Is acupuncture or dry-needling performed? ☐ YES ☐ NO

DISPOSABLE SINGLE-USE NEEDLES ONLY?

31. Is the applicant a covered entity under HIPAA, and are HIPAA privacy/security procedures implemented? ☐ YES ☐ NO

32. Are differential diagnoses made and unusual findings referred out? ☐ YES ☐ NO

DESCRIBE REFERRAL PROTOCOL

33. Does the applicant treat animals (veterinary / animal chiropractic)? ☐ YES ☐ NO

DESCRIBE

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

CONTROLLED SUBSTANCES & PHARMACY

34. Does the applicant prescribe, administer, store, or dispense controlled substances (Schedule II–V)? ☐ YES ☐ NO

DEA REGISTRATION #

35. Are controlled substances stored in a locked, access-controlled, and inventory-logged manner? ☐ YES ☐ NO

36. Is a prescription-drug-monitoring-program (PDMP) check performed before prescribing? ☐ YES ☐ NO

37. Does the applicant operate a pharmacy or perform compounding / repackaging / relabeling? ☐ YES ☐ NO

RETAIL / CLOSED / MAIL-ORDER / COMPOUNDING

38. Is there a written controlled-substance diversion-prevention and reconciliation policy? ☐ YES ☐ NO

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

SEDATION & ANESTHESIA

39. Is any sedation or anesthesia administered (local, minimal, moderate, deep, or general)? ☐ YES ☐ NO

LEVELS ADMINISTERED & BY WHOM

40. Is a licensed anesthesiologist or CRNA present for moderate/deep sedation or general anesthesia? ☐ YES ☐ NO

DESCRIBE

41. Is patient monitoring (pulse-ox, capnography, EKG) and resuscitation equipment / crash cart on site? ☐ YES ☐ NO

42. Are pre-anesthesia assessment, ASA classification, and recovery / discharge protocols documented? ☐ YES ☐ NO

43. Is malignant-hyperthermia / emergency-transfer protocol and a transfer agreement in place? ☐ YES ☐ NO

DESCRIBE

IF “YES” TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

COSMETIC, LASER & INJECTABLE PROCEDURES

44. Are any cosmetic, aesthetic, or med-spa procedures performed? ☐ YES ☐ NO

LIST PROCEDURES AND % OF REVENUE

45. Are lasers, IPL, or energy-based devices used? ☐ YES ☐ NO

LIST DEVICES AND INDICATIONS

46. Are injectables (Botox, dermal fillers, neuromodulators, sclerotherapy) administered? ☐ YES ☐ NO

BY WHOM (MD / NP / PA / RN) AND UNDER WHAT SUPERVISION

47. Are chemical peels, microneedling, microdermabrasion, or body-contouring performed? ☐ YES ☐ NO

DESCRIBE

48. Is a supervising physician's standing order / good-faith exam required before treatment, and is informed consent obtained? ☐ YES ☐ NO

IF “YES” TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

STAFFING & PLACEMENT CONTROLS

Complete if the applicant performs medical staffing, supplemental staffing, nurse-registry, or placement operations.

49. Does the applicant function as a staffing / supplemental-staffing agency or nurse registry? ☐ YES ☐ NO

50. Is a written staffing agreement (with hold-harmless / indemnification) in place with each client facility? ☐ YES ☐ NO

51. Does the applicant verify the receiving facility's supervision, orientation, and scope-of-practice controls before placement? ☐ YES ☐ NO

52. Are placed staff matched to client requirements by skill, license level, and competency assessment? ☐ YES ☐ NO

53. Who is responsible for workers' compensation on placed / leased / temporary staff? ☐ YES ☐ NO

RESPONSIBLE PARTY

54. Does the applicant carry workers' compensation on its own employees? ☐ YES ☐ NO

55. Are placed staff supervised or evaluated by the applicant during assignment? ☐ YES ☐ NO

IF “YES” TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

MEDICAL DIRECTOR

MEDICAL DIRECTOR NAME | SPECIALTY | FT / PT | LICENSE #

56. Does the Medical Director provide direct patient care? ☐ YES ☐ NO

57. Does the Medical Director carry their own professional liability insurance? ☐ YES ☐ NO

58. Is there a written Medical-Director / collaborating-physician agreement? ☐ YES ☐ NO

DESCRIBE SCOPE

ABUSE, MOLESTATION & EXCLUSION

59. Are background and OIG/SAM exclusion checks completed and documented for all staff with patient contact? ☐ YES ☐ NO

60. Is there a written abuse / molestation / patient-safety prevention and reporting policy? ☐ YES ☐ NO

61. Are two-person / supervision protocols used for vulnerable-patient (pediatric, geriatric, disabled) care? ☐ YES ☐ NO

62. Has the applicant or any staff ever been the subject of an abuse, molestation, or exclusion allegation? ☐ YES ☐ NO

DESCRIBE

63. Are mandatory-reporter and incident-reporting procedures trained and documented? ☐ YES ☐ NO

IF “YES” TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

PREMISES & HAZARDS

64. Are any services provided on the applicant's own premises (clinic, day care, infusion suite, etc.)? ☐ YES ☐ NO

65. Is there exposure to flammables, explosives, or hazardous chemicals? ☐ YES ☐ NO

66. Is there exposure to radioactive or nuclear materials? ☐ YES ☐ NO

67. Is there any catastrophe (flood / quake / wind) exposure at the premises? ☐ YES ☐ NO

68. Does the applicant store, transfill, or distribute oxygen or compressed medical gases? ☐ YES ☐ NO

DESCRIBE

69. Are EPA-approved contractors used for hazardous / medical waste disposal? ☐ YES ☐ NO

MEDICAL EQUIPMENT / PRODUCTS (IF APPLICABLE)

Complete if the applicant sells, rents, leases, repairs, or distributes medical equipment or supplies. Total sales/rental across categories must reconcile to the revenue history above.

Equipment by Category

EQUIPMENT CATEGORY	ANNUAL SALES $	ANNUAL RENTAL / LEASE $
Category I — Expendable items (one-time use)		
Category II — Non-expendable (beds, lifts, ambulatory aids)		
Category III — Diagnostic / treatment devices		
Category IV — Life-sustaining / critical-monitoring devices		

70. Does the applicant repair or perform maintenance on medical equipment? ☐ YES ☐ NO

ANNUAL REPAIR REVENUE $

71. Is preventative maintenance performed on a written schedule, and is condition documented before release? ☐ YES ☐ NO

72. Does the applicant manufacture, modify, repackage, or relabel any product? ☐ YES ☐ NO

DESCRIBE

73. Is the applicant named as additional insured / vendor on the manufacturer's policy (required for Category IV)? ☐ YES ☐ NO

74. Are certificates of insurance obtained from all product suppliers? ☐ YES ☐ NO

75. Has the applicant distributed or imported products from a foreign manufacturer? ☐ YES ☐ NO

DOES THE FOREIGN MANUFACTURER HAVE A U.S. LOCATION?

IF "YES" TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

NON-OWNED & HIRED AUTO / CLIENT TRANSPORTATION

76. Do employees or contractors drive their own vehicles in the course of business? ☐ YES ☐ NO

HOW MANY DRIVERS

77. Are employees / contractors required to carry personal auto liability and provide annual proof? ☐ YES ☐ NO

78. Are MVRs ordered and reviewed prior to hire and annually? ☐ YES ☐ NO

79. Do employees or contractors provide client transportation, or ever drive a client's vehicle? ☐ YES ☐ NO

% OF SERVICES INVOLVING TRANSPORTATION

80. Are drivers prohibited from driving on a suspended/revoked license or with serious violations? ☐ YES ☐ NO

COVERAGE REQUESTED

Indicate each line requested with limits. Professional Liability is typically claims-made; confirm retro dates.

Lines requested (check all)

- ☐ General Liability
- ☐ Professional Liability (Med-Mal)
- ☐ Abuse & Molestation
- ☐ Employee Benefits Liability
- ☐ Non-Owned / Hired Auto
- ☐ Products / Completed Ops
- ☐ Excess / Umbrella

GL EACH-OCCURRENCE $

GL GENERAL AGGREGATE $

GL PRODUCTS/COMPLETED-OPS AGGREGATE $

PROFESSIONAL LIABILITY — EACH CLAIM $

PROFESSIONAL LIABILITY — AGGREGATE $

PL BASIS (CLAIMS-MADE / OCCURRENCE)

PROFESSIONAL LIABILITY RETROACTIVE DATE

ABUSE & MOLESTATION LIMIT / SUBLIMIT $

ABUSE RETROACTIVE DATE

DEDUCTIBLE / SIR $

NON-OWNED AUTO LIMIT $

EXCESS / UMBRELLA LIMIT $

REQUESTED EFFECTIVE DATE

PRIOR COVERAGE & REGULATORY HISTORY

List up to five years of prior Professional Liability and General Liability coverage. Attach currently-valued (within 90 days) loss runs for all desired lines.

Professional & General Liability — Prior Coverage

YEAR	CARRIER	LIMITS (EACH / AGG)	DEDUCTIBLE $	PREMIUM $	CLAIMS-MADE / OCC	RETRO DATE
PL — Yr 1						
PL — Yr 2						
PL — Yr 3						
GL — Yr 1						
GL — Yr 2						
GL — Yr 3						

81. Has any license, certification, or registration ever been limited, suspended, revoked, denied, or investigated (applicant or any staff)? ☐ YES ☐ NO

82. Has the applicant or any employee ever been charged with or convicted of a crime? ☐ YES ☐ NO

83. Has any insurer or Lloyd's ever declined, cancelled, or refused to renew the applicant's coverage? ☐ YES ☐ NO

84. Has any state or federal agency (Medicare/Medicaid, DEA, OIG, licensing board) taken action against the applicant? ☐ YES ☐ NO

85. Is the applicant aware of any circumstance, incident, or request for records that may result in a claim? ☐ YES ☐ NO

86. Are there any known unreported claims or incidents against the applicant? ☐ YES ☐ NO

IF “YES” TO ANY OF THE ABOVE, EXPLAIN (REFERENCE QUESTION NUMBER)

LOSS HISTORY

List all claims and losses for the past 5 years, regardless of fault or payment. Attach currently-valued (within 90 days) loss runs for all lines.

87. Has the applicant had any claims, losses, or incidents in the past 5 years? ☐ YES ☐ NO

88. Are there any known incidents, facts, or circumstances that may result in a claim? ☐ YES ☐ NO

89. Has any coverage been declined, cancelled, or non-renewed in the past 5 years? ☐ YES ☐ NO

Loss Detail

DATE OF LOSS	LINE / COVERAGE	CLAIMANT	DESCRIPTION	PAID $	RESERVED $	STATUS (O/C)

APPLICANT STATEMENT & SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (in some states a fine and/or imprisonment). The applicant represents that the statements and answers given are true, complete, and accurate to the best of their knowledge and will be relied upon by the insurer. Completion of this application does not bind coverage.

SIGN

SIGNATURE OF APPLICANT

DATE

PRINTED NAME

TITLE

PRODUCER / AGENCY

HEDGE SUBMISSION #