The Hanover Insurance Group™

SURPLUS LINES
HEALTHCARE FACILITY

Community Health Centers and Free Clinics – Supplemental Application

Underwritten by The Hanover Atlantic Insurance Company, Ltd.

Instructions:

- This application must be completed *in conjunction* with our Healthcare Facility Common Application.
- Provide a copy of Deeming documents (if applicable).
- Complete a separate supplemental application for each state you perform services in or provide the breakout of the requested information by state in an attachment.

Name of Applicant: _____

These operations are conducted in what state? _____ If multi-state, please complete a ***separate*** supplemental for each state or provide the breakout of the requested information by state in an attachment.

1. **Which best describes your operation:**
   ☐ FQHC ☐ Look-Alike ☐ FTCA Community Health Center ☐ FTCA Free Clinic ☐ Tribal Clinic
   ☐ Health Department ☐ Other – Describe: _____
2. **Visit Count:**

Total Projected Visit Count	Total Prior Year Visit Count

3. **What is the breakout of patients that you service? (Total of all should equal 100%.)**

Patient Type	Percentage (%)
Elderly	%
School Based	%
Migrant	%
Homeless	%
Other: Describe	%

4. **Current number of patients: _____ of which _____% is pediatric.**
5. **Is the applicant deemed under the Federal Tort Claims Act?** ☐Yes ☐No
   IF YES, PROVIDE A COPY of the following, if applicable:
   - ✓ A copy of your Original Deeming Letter (not required on renewals)
   - ✓ A copy of your most recent FTCA application, form 5 parts A-C
   - ✓ A copy of the most recent UDS report or Provider Schedule for FTCA Free Clinics

   a. **Has there been any lapse in deemed status for the entity or individual providers?** ☐Yes ☐No
      If Yes, please provide dates and details: _____
   b. **Are any sites at which services are provided non-deemed locations?** ☐Yes ☐No
      If Yes, please provide details: _____

6. **Are you providing any non-deemed services?** ☐Yes ☐No **If Yes, complete the table below:**

Services Provided	**# of Non-Deemed Visits Annually**
Adult Primary Health Care	
Substance Abuse Counseling	
Mental Health Counseling	
Chronic Disease Management (asthma, obesity, diabetes…)	
Dental Care	
Emergency Care	
Eye Care	
Food bank/Meals	
Home Health Care	
Immunizations	
Insurance Eligibility Screening	
Invasive Procedures – describe:	
Medical Referral Services	
Medical Social Services	
Medication Assisted Detox	
Nutritional Counseling	
Pediatric Primary Care	
Pre-employment Physical	
Psychiatric	
Social Services	
TB Testing	
Other – describe:	
Women's Care	**# of Non-Deemed Visits Annually**
Abortions	
Breast Examination	
Dilation and Curettage	
Family Planning Services	
Mammography Referral	
Deliveries	
Post-Partum Care	
Prenatal Care	
Other – describe:	
Other Services Provided	**Annual Revenues from Non-Deemed Operations**
Clinical Trials – describe:	$
Imaging – describe:	$
Lab Testing – describe:	$
Other – describe:	$

7. **Are any providers including volunteers, interns/residents, or contractors/sub-contractors non-deemed?** ☐Yes ☐No
   a. If Yes, does the applicant require individuals to carry Professional Liability insurance? ☐Yes ☐No
      If Yes, what limits do you require? $_____ each claim / $_____ aggregate
   b. Are background checks conducted for volunteers? ☐Yes ☐No
   c. **If applicant does *not* require individuals that are not covered by the FTCA to carry Professional Liability insurance or you are seeking coverage for them under this policy, please complete the table below** or provide detail in an attachment if additional room is required:

Provider Name/Type	Indicate: Volunteer, Intern, Resident, Contractor, etc.	Average hours worked per work	Retro Date	Services/Duties Performed

   1) **Has any of the above had claims in the past 5 years?** ☐Yes ☐No
      If Yes, please provide details: _____
   2) **Has any of the above operated under a restricted license?** ☐Yes ☐No

8. **Do you arrange with local community providers to provide after hour coverage to your patients?** ☐Yes ☐No
   a. If Yes, is this arrangement covered by the FTCA/deemed? ☐Yes ☐No
   b. If No, do you require them to maintain insurance at minimum of $1M/3M? ☐Yes ☐No

9. **Do you provide recuperative/medical respite care, inpatient substance abuse, or other inpatient exposures?**
   a. If Yes, what type of care model do you follow?
      ☐ Coordinated Care ☐ Coordinated Clinical Care ☐ Integrated Clinical Care
      ☐ Comprehensive Clinical Care
   b. Provide the number beds: _____ Average Occupancy: _____
   c. What is the average length of stay? _____
   d. What is the average patient population mix for this exposure?
      _____% Adult _____% Geriatric _____% Adolescent & Child
   e. Types of individuals: ☐ Male ☐ Female ☐ Both
   f. How are patients separated? ☐ Gender ☐ Age ☐ Other: _____
   g. Are patients required to notify the facility when leaving and returning? ☐Yes ☐No
   h. Do you require signed release forms to release records to other individuals or entities? ☐Yes ☐No

i. Are patients primarily responsible for their own basic personal care including bathing, dressing, eating and restroom functions? ☐Yes ☐No

j. Is 24-hour "awake" staff supervision provided? ☐Yes ☐No

k. The ratio of patients to staff is: # _____ patients to # _____ staff.

l. Do you staff or have access to an infection preventionist? ☐Yes ☐No

m. How are individuals screened? _____

n. What type of security is provided? _____

o. Are all above services covered by the FTCA/deemed? ☐Yes ☐No

If No, please explain: _____

10. **Do you operate a pharmacy?**

a. If Yes, are these services covered by the FTCA/deemed? ☐Yes ☐No

b. Annual revenues from pharmacy exposures: $_____

c. Indicate full time equivalent for Pharmacists: (FTE equals total # of annual hours worked divided by 2,080) _____

11. **Medically Assisted Treatment – Complete below or check N/A** ☐

a. Are the MAT services covered by the FTCA/deemed? ☐Yes ☐No

b. What percentage of your overall services are Medication Assisted Treatment? _____%

c. What is the number and percentage of clients annually for the following medications?

Treatment	# of Clients	% of Clients	N/A
Methadone			
Buprenorphine			
Naltrexone			
Other:			

d. Do you allow take home privileges? ☐Yes ☐No

If Yes, how many clients have this privilege? _____

e. Do you have formal policies and procedures in place to guard against the diversion/theft of medication by employees and/or clients? ☐Yes ☐No

AUTHORIZATION

I have answered the questions in this Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

GENERAL FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly provides false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MARYLAND, NEW MEXICO, RHODE ISLAND AND WEST VIRGINIA: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FLORIDA AND OKLAHOMA: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree in FL).

KANSAS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY, OHIO AND PENNSYLVANIA: 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.

MAINE, TENNESSEE, VIRGINIA, AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME Only.

NEW HAMPSHIRE AND NEW JERSEY: Any person who includes any false or misleading information to the best of her/his knowledge on an application for an insurance policy is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a

fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

NEW YORK: 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 civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF APPLICANT'S AUTHORIZED REPRESENTATIVE

SIGNATURE IN FULL: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

THE APPLICATION MUST BE COMPLETED IN FULL, SIGNED AND DATED BY A PRINCIPAL OF THE BUSINESS.