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NORCAL MUTUAL INSURANCE COMPANY

APPLICATION FOR COVERAGE

HEALTH CARE GENERAL LIABILITY INSURANCE, NON-OWNED AUTO AND HIRED AUTO LIABILITY INSURANCE, AND ADMINISTRATION OF YOUR EMPLOYEE BENEFITS PROGRAM LIABILITY INSURANCE

This application is subject to review and acceptance by The Company and does not bind coverage.
Additional information may be requested by The Company.

Agency Name:
Agency Location:
Producer Name and License Number:

REQUESTING ADDITION TO A CURRENT NORCAL MUTUAL POLICY

Name of Entity/Organization or Physician	Policy Number

APPLICATION CHECKLIST

Please complete the entire application, sign, and date. Indicate not applicable (n/a) where appropriate.

- ☐ Answer all questions fully and completely. Alternatively, you may attach a credentialing application or application for another insurer that you have completed within the past 90 days and complete this application beginning with Section V, Supplemental and Claims History Questions.
- ☐ A copy of the Declarations page and endorsements from your most recent insurance policy. If an extended reporting endorsement (tail) has been purchased, please provide a copy as well.
- ☐ Loss runs for the past 10 years.
- ☐ Please download and print the NORCAL Mutual Business Associate Agreement at http://www.norcalmutual.com/resources and file with your other HIPAA compliance documents. Revised regulations in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended the Privacy, Security, Enforcement and Breach Notification Rules, requiring NORCAL Mutual to enter into a revised Business Associate Agreement with all business associates who manage or distribute protected health information.

SECTION I: GENERAL INFORMATION

GENERAL INFORMATION

1. Identify the type of coverage(s) for which the organization is applying:
   Note: Medical Professional Liability Insurance must be provided by NORCAL Mutual before any other coverage is available.

   ☐ Health Care General Liability Insurance – Occurrence-based
   ☐ Non-owned Auto and Hired Auto Liability Insurance – Occurrence-based
   ☐ Administration of Your Employee Benefits Program Liability Insurance – Claims-Made

2. Identify the requested limit of coverage for which the Entity/Organization is applying:
   Note: Please contact NORCAL Mutual or your broker for an indication of the limits of coverage available. The limits of coverage for Health Care General Liability Insurance are shared with the Non-Owned Auto and Hired Auto Liability Insurance, if that coverage is provided. The limits of coverage for Administration of Your Employee Benefits Program Liability Insurance are $1,000,000 each claim/$1,000,000 aggregate per endorsement period.

   Requested Effective Date:

   General Liability Limit: $ each occurrence or offense Limit $ aggregate Limit

SECTION II: HEALTH CARE GENERAL LIABILITY INSURANCE

PREMISES

1. Complete the following regarding all premises (excluding vacant land) owned, occupied, rented, leased, used, or controlled by the Entity/Organization. Use the Remarks section if more space is needed.

Premises Name and Address (street, city, state, and zip code)	**Description of Operations**	**Interest**	**Year Built**	**Construction Type***	**Square Footage and Floors***	**Fire Protection***
				☐ W ☐ C ☐ M ☐ O	Sq. Ft.: Floors:	☐ A ☐ SC ☐ S
				☐ W ☐ C ☐ M ☐ O	Sq. Ft.: Floors:	☐ A ☐ SC ☐ S
				☐ W ☐ C ☐ M ☐ O	Sq. Ft.: Floors:	☐ A ☐ SC ☐ S

*** Notes and Codes:**

Construction Type: W = Wood/Frame; C = Concrete/Brick; M = Metal/Steel; O = Other (specify in Remarks section)

Square Footage and Floors: If the Entity/Organization owns the premises, identify the total square footage and number of floors of the premises. If the Entity/Organization does not own the premises, identify the square footage and number of floors of the premises that the Entity/Organization occupies.

Fire Protection: A = Automatic Sprinkler; SC = Smoke Detector w/Central Monitoring; S = Smoke Detector w/o Central Monitoring

2. Are all premises identified in question 1 in compliance with current building codes? ☐ Yes ☐ No

   If no, identify the location(s) and explain:

3. Does the Entity/Organization own premises that it rents or leases, in whole or in part, to others? ☐ Yes ☐ No

   If yes, identify each location and whether occupancy is commercial or residential:

4. Do any of the premises identified in question 1 have a heliport? ☐ Yes ☐ No

   If yes, please describe each location:

Premises	Ownership Type	# Landings	Separate Helipad Liability Coverage in Place?
	☐ Leased ☐ Owned		☐ Yes ☐ No
	☐ Leased ☐ Owned		☐ Yes ☐ No
	☐ Leased ☐ Owned		☐ Yes ☐ No

5. Does the Entity/Organization own vacant land? ☐ Yes ☐ No

   If yes, complete the following for all vacant land owned by the Entity/Organization. Use the Remarks section if more space is needed.

Address (street, city, state, and zip code)	Square Footage	Planned Use and When

6. Is Health Care General Liability Insurance with NORCAL Mutual desired for all premises and vacant land identified in questions 1 and 5 above? ☐ Yes ☐ No

   If no, identify each location for which coverage is not desired and explain why coverage is not desired:

7. Is the Entity/Organization engaged in, or does it plan to engage in, any new construction? ☐ Yes ☐ No

   If yes, explain and identify when the construction began or will begin:

PRODUCTS

1. Does the Entity/Organization or any of its members sell, lease, or rent any products to others? ☐ Yes ☐ No

   If yes, please describe:

Product	Distribution	Total Revenue
	☐ Sell ☐ Lease ☐ Rent	
	☐ Sell ☐ Lease ☐ Rent	
	☐ Sell ☐ Lease ☐ Rent	

2. Does the Entity/Organization maintain its own products liability insurance, or is it named as an insured or additional insured under the products liability insurance of any third party? ☐ Yes ☐ No

   If yes, please identify the following for each product:

Product	Insurance Company	Limit	Coverage Type
			☐ Own policy ☐ Named Insured (on 3rd-party policy) ☐ Additional Insured (on 3rd-party policy)
			☐ Own policy ☐ Named Insured (on 3rd-party policy) ☐ Additional Insured (on 3rd-party policy)
			☐ Own policy ☐ Named Insured (on 3rd-party policy) ☐ Additional Insured (on 3rd-party policy)

3. Do any of the Entity's/Organization's members modify the design or function (other than as part of regular maintenance) of any products that were purchased for use on behalf of the organization? ☐ Yes ☐ No

   If yes, identify the products and describe the procedure in place to monitor who is making the changes and what changes are made:

4. Does the Entity/Organization have a legal review process for all of its publications and advertising material? ☐ Yes ☐ No

   If no, explain:

5. Is the Entity/Organization or any of its members engaged in the business of manufacturing, distributing, selling, serving, or furnishing alcoholic beverages? ☐ Yes ☐ No

   If yes, explain:

SECTION III: NON-OWNED AUTO AND HIRED AUTO LIABLITY INSURANCE

Note: Complete this section only if the Entity/Organization is applying for Non-Owned Auto and Hired Auto Liability Insurance.

1. Do the Entity's/Organization's executive officers, partners, members, employees, independent contractors, volunteers, and/or students use their owned autos in the course of the Entity/Organization's business? ☐ Yes ☐ No

   If yes:

   a. How often does this occur monthly?

   b. When it occurs, what percentage of the time does it involve transporting the Entity's/Organization's clients? %

   c. Does the Entity/Organization require such personnel to maintain personal auto liability insurance with limits equal to or greater than the applicable state's minimum financial responsibility law? ☐ Yes ☐ No

2. How often per month does the Entity/Organization or its members lease, hire, rent, or borrow an auto?

SECTION IV: ADMINISTRATION OF YOUR EMPLOYEE BENEFITS PROGRAM LIABILITY INSURANCE

Note: Complete this section only if the Entity/Organization is applying for Administration of Your Employee Benefits Program Liability Insurance.

1. How many employees are currently covered by the Entity's/Organization's employee benefits program?

2. Does the Entity/Organization currently maintain insurance to cover the administration of its employee benefits program? ☐ Yes ☐ No

   If yes, specify the type of coverage provided: ☐ Claims-made ☐ Occurrence

   If claims-made, do you wish to apply for prior acts coverage with NORCAL Mutual? ☐ Yes ☐ No

   If yes, please specify the retroactive date and provide a copy of the Declarations page from your current policy.

   Retroactive Date (mm/dd/yyyy):

SECTION V: SUPPLEMENTAL AND CLAIMS HISTORY QUESTIONS

Note to Missouri Applicants: Skip question 1 and begin with question 2.

1. Has the Entity/Organization ever had an insurance company cancel, nonrenew, decline to offer, or modify with special terms, or been notified by an insurance company that it intends to pursue such action, for any of the following coverages:
   Note: Use "N/A" if the Entity/Organization is not applying for the coverage.

   General liability or similar insurance? ☐ Yes ☐ No ☐ N/A
   Non-Owned auto and hired auto liability or similar insurance? ☐ Yes ☐ No ☐ N/A
   Administration of employee benefits liability or similar insurance? ☐ Yes ☐ No ☐ N/A

   If yes applies to any of the above questions, explain:

2. Within the past 10 years, has a claim or suit been brought against the Entity/Organization, or has the Entity/Organization been notified of its involvement in a claim or suit, directly or indirectly, for any of the following coverages?
   Note: Use "N/A" if the organization is not applying for the coverage.

   General liability or similar insurance? ☐ Yes ☐ No ☐ N/A
   Non-Owned auto and hired auto liability or similar insurance? ☐ Yes ☐ No ☐ N/A
   Administration of employee benefits liability or similar insurance? ☐ Yes ☐ No ☐ N/A

3. Are you aware of any incident or accident, conduct, circumstance, offense, or occurrence that might reasonably be expected to give rise to a claim or suit against the Entity/Organization, directly or indirectly, under any of the following coverages, even if you believe the claim or suit would be without merit?
   Note: Use "N/A" if the Entity/Organization is not applying for the coverage.

   General liability or similar insurance? ☐ Yes ☐ No ☐ N/A
   Non-Owned auto and hired auto liability or similar insurance? ☐ Yes ☐ No ☐ N/A
   Administration of employee benefits liability or similar insurance? ☐ Yes ☐ No ☐ N/A

If you answered yes to question 2 or 3, complete the attached Claim/Suit/Incident Supplemental Form for each applicable claim, suit, incident, conduct, etc.

REMARKS SECTION

Please provide any additional information/explanations for your application below.

AGREEMENTS AND NOTICES

I understand that any claims whose circumstances were known before the effective date of coverage are specifically excluded from coverage under any policy of insurance that may be issued by NORCAL Mutual (The Company).

I understand that, as a condition precedent to approval for coverage, The Company may perform a detailed inquiry and investigation of the applicant's background, competence, and qualifications. I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to The Company and its duly authorized agents and representatives. I further expressly authorize all individuals and entities to whom such legal inquiry is made by The Company and its duly authorized agents and representatives to provide the same with all information within their possession or under their control that pertains to the applicant's background, competence, and qualifications. I expressly release and discharge the aforesaid entities and individuals and their agents and representatives from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation, as well as in the evaluation of information so received from whatever source.

All information requested in this application is considered material and important. I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of The Company in considering this application for insurance. I understand that any material misrepresentation in this application that The Company relies on to its detriment could void coverage. I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to me by The Company.

I understand that I must notify The Company immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf and that The Company may withdraw or modify any outstanding quotations or authorization or agreement to bind insurance.

I understand that this application is subject to acceptance by The Company and does not bind coverage.

Florida Applicants: 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.

Applicant Signature

Date (mm/dd/yyyy)

Printed Name

Title

This application is not valid without your complete signature.

CLAIM | SUIT | INCIDENT SUPPLEMENTAL FORM

Attach a detailed narrative, which includes at least the information requested below, or complete this form, for each claim, suit, or incident within the past 10 years. Provide adequate detail to allow proper evaluation. Additional information may be requested.

Claimant Name	Age	☐ Male ☐ Female
Date of Incident (mm/dd/yyyy)	Location of Incident	
Name of Insurer	Date Reported to Insurer (mm/dd/yyyy)	

Type: ☐ Suit ☐ Demand for Money ☐ Incident Only ☐ Notice of Intent to Sue
☐ Request for Records ☐ Other:

1. Allegations:

2. Other persons and entities involved:

3. Status/Disposition:

☐ Open Describe current status and defense strategy:

☐ Closed without indemnity payment ☐ Settled ☐ Judgment/Verdict for defense ☐ Judgment/Verdict for plaintiff

If closed, date closed (mm/dd/yyyy):

Amount reserved for you:	Indemnity: $	Defense: $
Amount reserved for other defendants:	Indemnity: $	Defense: $
Amount paid on your behalf:	Indemnity: $	Defense: $
Amount paid on behalf of other defendants:	Indemnity: $	Defense: $

4. Has there been a change in operations as a result of this claim, suit, or incident? ☐ Yes ☐ No

If yes, explain below:

I understand this information is part of my Application.

Signature Printed Name Date (mm/dd/yyyy)

Save Print Submit Form