



HEALTHCARE PROFESSIONALS
ADDITIONAL INFORMATION REQUEST

Answer each question on behalf of all entities seeking insurance coverage, unless specifically requested otherwise.

*NOTE – coverage is not offered for Medical Doctors (including Dentists), Advanced Practice Registered Nurses (including Nurse Practitioners, Clinical Nurse Specialists or any other type of nurse that prescribes medications, or provides diagnoses or treatment) or Physician’s Assistants.

An Additional Information section is provided at the end of this document for any information that exceeds the space provided.

GENERAL INFORMATION

Proposed First Named Insured & Other Named Insured(s):		Today's Date:
Proposed Effective Date (mm/dd/yyyy):	Proposed Expiration Date (mm/dd/yyyy):	

CORONER/EMT/NURSES/SOCIAL SERVICES WORK INFORMATION

POSITION HELD	FULL-TIME	PART-TIME		VOLUNTEERS	
	Employee Count	Employee Count	Total Hours**	Volunteer Count	Total Hours**
Coroner (Other than Medical Doctors)					
EMT Only					
Firefighter w/EMT Certification					
Firefighters including First Response not EMT Certified					
Jail Nurses					
Nurses (Other than Advanced Practice Registered Nurses*)					
Social Workers/Case Workers/Foster Care Workers/ Counselors/Therapists					
Other					

* An advanced practice registered nurse is a nurse practitioner, clinical nurse specialist, or any other type of nurse who prescribes medications, or provides diagnoses or treatment

** Total Hours equals the number of hours worked for all Part-Time and/or Volunteer workers in an average week

1. Describe any licenses held: _____

- a. Do you verify license or certification status?..... Yes No
- b. Do you check for any pending license suspensions or revocations or any pending disciplinary action?..... Yes No
- c. Do you conduct local and federal background checks?..... Yes No
- d. Do all departments have an established policies and procedures manual?..... Yes No

If “No” is selected for any of the above, please provide details: _____

2. If you have a coroner and coverage is requested, does the coroner conduct autopsies? Yes No
3. Has the insured or organization been involved in any claims, suits, or incidents arising out of counseling services? Yes No
4. Has insurance been canceled, declined or non-renewed for any reason during the last 3 years or is cancellation or non-renewal pending? **(Not Applicable in Missouri)** Yes No

INSURANCE REQUIREMENTS INFORMATION

5. Do you require the contracted health care service providers or professionals providing services to your organization to carry their own professional liability insurance? Yes No
6. Are certificates of insurance obtained? Yes No
7. Are you named as an additional insured under the contracted professional's policy? Yes No

EMT / FIRE DEPARTMENT / PARAMEDIC INFORMATION

8. Are mutual aid agreements in place with neighboring communities? Yes No
9. Is Entity responsible for transporting injured persons? Yes No
10. Are all volunteers fully trained and certified according to minimum state requirements? Yes No
11. Is a substance abuse testing program in place, including volunteers? Yes No
12. Are EMTs / Paramedics in contact with the hospital/doctors at all times when responding to a call? Yes No
13. Are response times monitored and problems investigated? Yes No
14. Are written records kept of all calls, with a description of treatment and patient delivery to the hospital for medical response? Yes No
 How long are the records kept? _____

NURSE/JAIL NURSE ADDITIONAL INFORMATION

15. Describe services provided: _____
16. Do you have any advanced practice registered nurses* (e.g., nurse practitioners, clinical nurse specialists)? Yes No
- If yes, describe services: _____

SOCIAL SERVICES INFORMATION

17. Indicate whether you provide the following services *check all that apply*:
- Adoption
 - Alternative incarceration home
 - Foster care placement
 - General psychological counseling
 - Home care, home nursing, or similar type operation

- Marriage and family counseling
- Pastoral counseling
- Specialized counseling services (drug abuse, depression, stress management, etc.) describe: _____
- Substance abuse detoxification services
- Suicide or crisis hotline
- Vocation rehabilitation
- Other, describe: _____

FRAUD STATEMENTS – ATTENTION APPLICANTS IN THE FOLLOWING JURISDICTIONS

ALABAMA, ARKANSAS, DISTRICT OF COLUMBIA, MARYLAND, NEW MEXICO, AND RHODE ISLAND: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who 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: 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.

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 insurance 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, NEW YORK, 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. (In New York, the civil penalty is not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each such violation.)

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

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 include imprisonment, fines, and denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

SIGNATURES

Producer information only required in Florida and Iowa.

Authorized Representative Signature*: X	Authorized Representative Name – Printed:	Date (mm/dd/yyyy):
Producer Signature*: X	State Producer License No (required in FL):	Date (mm/dd/yyyy):
Agency:	Agency Contact:	Agency Phone Number:

* If you are electronically submitting this document, apply your electronic signature to this form by checking the Electronic Signature and Acceptance box below. By doing so, you agree that your use of a key pad, mouse, or other device to check the Electronic Signature and Acceptance box constitutes your signature, acceptance, and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

- Electronic Signature and Acceptance – Authorized Representative
- Electronic Signature and Acceptance – Producer

ADDITIONAL INFORMATION

This area may be used to provide additional information to any question. Please reference the question number.