LAMMICO

SUPPLEMENTAL ENTITY APPLICATION
PROFESSIONAL LIABILITY COVERAGE FOR PROFESSIONAL CORPORATIONS, PROFESSIONAL ASSOCIATIONS AND OTHER ORGANIZATIONS

(Complete one supplement for each entity)

Attach copy of Articles of Incorporation, Partnership Agreement or documents setting up entity listed in #1.

1. Legal Name of Entity: Entity's Tax I.D. #:

2. Entity business address (Street, City, State, Zip Code) 3. Parish

4. Desired Effective Date of Coverage? 5. Current form of insurance for entity (Check one)
☐ **Claims-Made** ☐ **Occurrence** ☐ **None**

6. Current Carrier for entity If claims-made, was reporting endorsement purchased from current carrier?
☐ **Yes** ☐ **No**

7. Are you requesting separate limits of liability from LAMMICO for the entity? (Additional premium charge applies)
☐ **Yes** ☐ **No**

7a. Are you requesting prior acts coverage from LAMMICO for the entity? Retroactive date used by current carrier:_____
☐ **Yes** ☐ **No** If yes, please attach entity certificate of insurance from current carrier

8. Are all entities and health care providers currently enrolled in the Louisiana Patient's Compensation Fund?
☐ **Yes** ☐ **No** If no, give details on non enrolled entities and/or providers in comments section of this application.

9. Type of Practice:
☐ Professional Corporation ☐ Partnership ☐ LLC ☐ Corporation ☐ Joint Venture ☐ Professional Assn. ☐ Other (describe):

10. Description of Operations:

☐ Private doctor's office ☐ Doctor's office with diagnostic equipment (describe in comments section) ☐ Urgent Care Facility

☐ Physician owned and operated lab--owner use only ☐ Physician owned and operated lab--used by other than doctor/owner patients

☐ Pain Clinic ☐ Medical Spa ☐ Out patient surgery ☐ Other—Describe _____

ADDITIONAL APPLICATIONS MAY BE NEEDED, DEPENDING ON THE OPERATIONS.

10a. Is the entity/facility used by anyone other than the owner(s), members, or employees? (If yes, please describe) ☐ **Yes** ☐ **No**

10b. Are there any services or business operations conducted outside of Louisiana? ☐ **Yes** ☐ **No** If yes, describe in comments section.

11. Number of owners: Number of partners: Are all owners and partners insured with LAMMICO?
☐ **Yes** ☐ **No**

11a. List the names of all **owners**, partners or members of the entity named in Item #1, above. (Attach separate sheet, if necessary):

Name	**Check if NOT insured by LAMMICO**	**Carrier if NOT insured by LAMMICO***	**Specialty**
	☐		
	☐		
	☐		

12. Employed or contracted physicians/surgeons with the above named entity (exclude owner/partners) Attach a separate sheet, if necessary.

Name	**Check if NOT insured by LAMMICO**	**Carrier if NOT insured by LAMMICO***	**Specialty**
	☐		
	☐		
	☐		

*Attach current certificate of insurance from professional liability carrier, if not insured by LAMMICO.

Are all insured with LAMMICO? *

13. No. of employed or contracted licensed physician assistants and surgeon assistants:_____ ☐ Yes ☐ No

Number of employed or contracted nurse anesthetists: _____ ☐ Yes ☐ No

Number of employed or contracted nurse midwives: _____ ☐ Yes ☐ No

Number of employed or contracted nurse practitioners:_____ ☐ Yes ☐ No

Number of other employees of this entity (not listed or counted above):_____

*Attach current certificate of insurance from professional liability carrier, if not insured by LAMMICO.

14. Are there any subsidiaries that provide health care related services? (If yes, list subsidiary name, description of operations, % of ownership and date acquired, below): ☐ **Yes** ☐ **No**

15. Are these subsidiaries to be included in this coverage? ☐ **Yes** ☐ **No**

Subsidiary Name	**Description of operations**	**Date Acquired**	**%**

16. If subsidiaries are not 100% owned by the parent, provide details of other owners and the percentage owned by each.

17. Does this entity perform utilization review for a fee for others? (If yes, please describe) ☐ **Yes** ☐ **No**

18. Is this entity currently under contact to supervise or administer any departments within a hospital or other facility, for an HMO or PPO or any government agency program? (If yes, please describe) ☐ **Yes** ☐ **No**

19. Is the entity required to be licensed to provide medical professional services? (If yes, by whom?) ☐ **Yes** ☐ **No** Has a license been granted for the entity? ☐ **Yes** ☐ **No**

20. Is the entity eligible to be JCAHO certified? ☐ **Yes** ☐ **No** If yes, is it certified? ☐ **Yes** ☐ **No** Date of certification:

21. Has this entity's license ever been suspended, restricted, revoked or surrendered or has probation ever been invoked? (If yes, please explain): ☐ **Yes** ☐ **No**

22. Have any claims or suits ever been made or brought against this entity? (Give dates, allegation and disposition of each claim made.) ☐ **Yes** ☐ **No**

23. Do you have knowledge of any claims which might be made against this entity or activities that might give rise to a claim or suit in the future? (Include any requests for medical records.) ☐ **Yes** ☐ **No** (Please include a description of each claim or activity.)

24. Comments (Attach separate sheet if necessary):

SIGNING THIS INFORMATION SUPPLEMENT DOES NOT BIND THE COMPANY TO ISSUE A POLICY OF INSURANCE. ALL INFORMATION REQUESTED IN THIS SUPPLEMENT IS CONSIDERED MATERIAL AND IMPORTANT. IF THE COMPANY AGREES TO BE BOUND UNDER THE TERMS OF THIS SUPPLEMENT, THE INSURANCE POLICY IS VOID IF THE INSURED HIDES ANY IMPORTANT INFORMATION FROM THE COMPANY, MISLEADS THE COMPANY, OR ATTEMPTS TO DEFRAUD OR LIE TO THE COMPANY ABOUT ANY MATTER CONTAINED IN THIS SUPPLEMENT.

_____ _____

Signature of Authorized Representative | Title

_____ _____

Printed or Typed Name | Date Signed