

Community Health Centers Supplemental – FTCA Deemed Application

I. APPLICANT INFORMATION

1.1	Applicant Name:	
1.2	Website(s):	

II. UNDERWRITING QUESTIONS

2.1	Do the applicant provide any other medical services that are outside your deeming status? If YES , please provide details:	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
_____ _____ _____																						
2.2	Does the applicant have a formalized employee verification program including background checks?	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
2.3	Please detail the medical services that the applicant provides:																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 60%;">Type of Clinic Services</th> <th colspan="2" style="text-align: center;"># of Annual Patient Visits</th> </tr> <tr> <th style="text-align: center;">Projected Policy Period</th> <th style="text-align: center;">Current Policy Period</th> </tr> </thead> <tbody> <tr> <td>Preventive Care (flu shots, occupational medicine, physicals):</td> <td></td> <td></td> </tr> <tr> <td>Family Practice or Internal Medicine:</td> <td></td> <td></td> </tr> <tr> <td>Pre Natal / Post Natal Care:</td> <td></td> <td></td> </tr> <tr> <td>Rehabilitation (Occupational / Home Health or Physical Speech):</td> <td></td> <td></td> </tr> <tr> <td>Other: please describe in space:</td> <td colspan="2"></td> </tr> </tbody> </table>			Type of Clinic Services	# of Annual Patient Visits		Projected Policy Period	Current Policy Period	Preventive Care (flu shots, occupational medicine, physicals):			Family Practice or Internal Medicine:			Pre Natal / Post Natal Care:			Rehabilitation (Occupational / Home Health or Physical Speech):			Other: please describe in space:		
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2.4	Please provide the projected age of the applicant's clients: Adult (18 and older): ____% Pediatric (under 18): ____%																					
2.5	Does the applicant have a formalized patient complaint review committee?	<input type="checkbox"/> Yes <input type="checkbox"/> No																				
2.6	Please provide any past or current accreditations for your organization: <input type="checkbox"/> AAAHC <input type="checkbox"/> AAAASF <input type="checkbox"/> JCAHO <input type="checkbox"/> Other:																					

III. RATING INFORMATION AND PROECDURAL MIX

3.1	Please provide the most recent date that you were deemed an FTCA Clinic:								
3.2	Please provide a current roster of your deemed AND non-deemed Licensed Independent Practitioners (LIP), past and present, including NP's and PA's.								
3.3	Please provide the type and amount of annual staffing positions:								
		# of EMPLOYEES		# of CONTRACTORS		# of VOLUNTEERS		# that carry their own insurance coverage	
		F/T	P/T	F/T	P/T	F/T	P/T	Yes	No
Case Manager:									
Chiropractor:									
CNA:									
Counselor:									
CRNA:									
Dentist:									
Home Health Aid:									
Medical Director (Admin Only):									
Nurse (RN):									
Nurse (NP):									
Nurse Midwife:									
Optometrist:									
Pharmacist:									
Physician (MD, DO):									

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Physician Assistant:								
Psychiatrist:								
Psychologist:								
Social Worker:								
Teacher:								
Therapist – (PT/OT/ST):								
Other (specify):								
Totals:								

IV. CLAIMS

4.1	Within the past five (5) years, has the Applicant given written notice under the provisions of the Federal Tort Claims Act or any current or prior policy providing similar insurance of any claim or regulator/licensure action or of any specific fact or circumstances which might give rise to a claim or regulatory/licensure action against the applicant? If YES , please provide details: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.2	With respect to the coverage applied for, upon inquiry of any person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim or regulatory/licensure action under the coverage(s) to which the applicant is applying? If YES , please provide details: _____ _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

IMPORTANT NOTICE

I DECLARE THAT THE STATEMENTS MADE IN THIS SUPPLEMENTAL APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.** (As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

Signature of authorized representative of Applicant	Title
Type / Print name of authorized representative	Date
Producer Signature	Date

IV. FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 that person to criminal and civil penalties.

(Not applicable in AL, AR, CO, DC, FL, KY, KS, LA, ME, MD, NJ, NM, NY, OH, OK, OR, PA, RI, TN, VA, WA and WV).

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

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APPLICABLE IN CO

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.

APPLICABLE IN FL AND OK

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)*. *Applies in FL only.

APPLICABLE IN KS

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.

APPLICABLE IN KY, NY, OH AND PA

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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

APPLICABLE IN ME, TN, VA AND WA

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.

APPLICABLE IN NJ

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

APPLICABLE IN OR

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.