Custom Assurance

PLACEMENTS, LTD.

A SPECIALTY LINES INSURANCE BROKER

PO Box 5736, Columbia, SC 29250-5736
Phone: (803) 799-1770 Fax: (803) 799-1817

Medical Tourism Facilitator Professional Liability

General Information Effective date desired: _____

Name of Company _____

(if other than parent firm, supply full details of ownership entity):

Address:_____ Country:_____

City: _____ State:_____ Zip: _____

Contact Name: _____ Title: _____

E-mail Address: _____ Phone: (____)_____

Website: _____ Fax: (___)_____

2. State in which the applicant is domiciled: _____

Other Locations: _____

3. Applicant is a/an: (please check)

a.) [ ] Individual [ ] Partnership [ ] Corporation [ ] Professional Association

[ ] Other (describe): _____

b.) [ ] Non-Profit [ ] For profit [ ] Both

4. Date of establishment: _____(MM/DD/YY)

5. List all that apply:

a.) states where the applicant operates: _____

b.) destination countries your patients/employees may select: _____

_____

c.) do you maintain records on types of procedures performed, destination countries, specific care providers (hospitals, etc.), gender, age and results of patients?

[ ] Yes [ ] No

6. Is the Applicant a member of Trade Association? [ ] Yes [ ]No

If, Yes, please list all: _____

7. Is the applicant engaged in, owned by or associate with or controlled by any other business?
[ ] Yes [ ] No

If yes, provide details (use an additional sheet if necessary): _____

_____

8. Please list the individual shareholders or partners of the company:_____

_____

_____

9. Please list the procedures for which you provide medical tourism services: (i.e, dental, orthopedics, cosmetics, cardiology and provide list of procedures for each category)

_____

_____

_____

_____

_____

_____

_____

_____

10. Does the Applicant manage its internet services?
[ ] Yes [ ] No

11. Does the Applicant anticipate adding any new services within the next year?
[ ] Yes [ ] No

If yes, please describe: _____

12. Does the Applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered?
[ ] Yes [ ] No

If yes, provide details:_____

13. Does the Applicant advertise its professional services in any manner (other than a standard telephone directory listing or Internet link)?
[ ] Yes [ ] No
(*If yes, please attach a copy of ALL of the advertisements and web addresses)*

14. Does the Applicant participate in any activity, e.g. newspaper columns, broadcasts, etc. whereby professional advice is offered to the public?
[ ] Yes [ ] No

15. Hold Harmless (Indemnification) Agreements: [ ] Yes [ ] No
[ ] In favor of the Applicant: if the Applicant has obtained any written indemnification agreements holding the Applicant harmless, please describe, indicated if certificates of insurance are obtained & attach a sample copy:
_____
_____
_____
[ ] In favor of others: the Applicant agrees to hold harmless others under written contract – attach copies.

16. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountably Act of 1996 (HIPPA) Privacy Rule?
[ ] Yes [ ] No

If yes:
a.) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule?
[ ] Yes [ ] No
b.) Provide the name and title of the Applicant's Privacy Officer:_____

17. Please state the number of client medical trips you arranged in the last 12 months and estimate the next 12 months:

Type of Encounters	# for Last 12 Months	Estimated # for Next 12 Months
Client or Employee Medial Trips		

18. State Projected gross revenue:

Source	Amount this Fiscal Year	Amount Next Fiscal Year
Fee for Service	$	$

19. Please Provide the number of case mangers you employ: _____

a. Are any of your employees required to be licensed by state regulations?
[ ] Yes [ ] No

b. Are any of your case managers medically credentialed?
[ ] Yes [ ] No

c. Do you have any independent contractors?
[ ] Yes [ ] No
If yes, list the number and type of independent contracts who provide professional services on your behalf.

Number	Type

d. Is continuing education or staff development required for your employees?
[ ] Yes [ ] No

e. Name of medical director or affiliated physician or physician's practice (if any).
_____

I. Is coverage provided for the medical director under any other insurance policy?
[ ] Yes [ ] No

If yes, please provide type of policy and name of carrier:_____
_____

II. Are you held harmless by the affiliated physician practice?
[ ] Yes [ ] No

Hiring Practice

20. a. Do you conduct a criminal background check?
[ ] Yes [ ] No

b. Do you require signed applications on all prospective employees?
[ ] Yes [ ] No

c. Do you verify all professional qualifications, licenses and certifications?
[ ] Yes [ ] No

d . Do you require professional and personal references on each employee?
[ ] Yes [ ] No

e. Do you provide training and orientation for new employees?
[ ] Yes [ ] No

f. Do you verify any pending license suspensions or revocations or any pending disciplinary actions by other facilities?
[ ] Yes [ ] No

g. Do you ask if there have been any Professional Liability or work-related claims made against the prospective employee in the past?
[ ] Yes [ ] No

h. Do you have written job descriptions?
[ ] Yes [ ] No

i. Do you require drug/alcohol screening?
[ ] Yes [ ] No

RISK MANAGEMENT/LOSS CONTROL

21. a. Is there a written and formalized Quality Assurance Program?
[ ] Yes [ ] No

b. Is there a written and formalized Risk Management Program?
[ ] Yes [ ] No

c. Do you have a standard system to handle a client's complaints or suggestions?
[ ] Yes [ ] No

d. Do you have a Quality Assurance Department?
[ ] Yes [ ] No

e. In case of an emergency, is management available 7 days a week, 24 hours a day?
[ ] Yes [ ] No

If applying as an employer:

f. Does your health insurance plan include medical tourism as an *option?*
[ ] Yes [ ] No

g. Does your health plan include medical tourism as a *requirement?*
[ ] Yes [ ] No

h. Does your plan include payment for use of medical tourism facilitators?
[ ] Yes [ ] No

Insurance & Claim Information

22. Do you currently carry Professional Liability Insurance? [ ] Yes [ ] No

Policy Period From: To: MM/DD/YY MM/DD/YY	**Insurance company**	**Limit of Liability**	**Deductible**	**Policy Form: Claims Made or Occurrence?**	**Premium**
|					
|					
|					
|					
|					

If claims made, what is the *retroactive date/prior acts date* on your current policy?

_____(MM/DD/YY)

23. Claims history:

a. During the past five (5) years, have there been any professional claims or incidents made against you, any employee or former employee, the Applicant or anyone proposed for this insurance?
[ ] Yes [ ] No

PLEASE ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s), or occurrence(s) that may result in a claim(s) being made against you?
[ ] Yes [ ] No
If yes, please provide full details: _____
_____

c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
[ ] Yes [ ] No
If yes, please fully describe the circumstances and follow up actions taken: _____
_____
_____

24. Do you solicit, discuss, sell or receive commissions for travel accident insurance sales?
[ ] Yes [ ] No

a. If yes, please provide the names if insurance companies that you represent and their corresponding AM Best Rating: (Insurer must be rates A or better)
_____
_____

b. Do you have an appropriate insurance license for the sale of travel accident insurance?
[ ] Yes [ ] No (Please attach a copy of the license for every agent)

c. What is your annual gross premium volume for:

Current Year to date:
Previous Calendar Year:

d. Do you make sure that insurance coverage discussions are limited to employees that have an appropriate insurance license?
[ ] Yes [ ] No If no, please explain:
_____
_____

e. Do you review coverage exclusions and eligibility of people travelling for the purpose of having a medical procedure with each travel accident insurer?
[ ] Yes [ ] No

_____
_____

25. Do you engage in any travel agent activities?
[ ] Yes [ ] No

Please fully describe how your clients travel is booked and who is responsible for travel agent activities.

_____
_____
_____
_____

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF 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 CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

*Notice applicable in most states:
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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____

Applicant's Signature Title Date *(MMIDD/YY)*

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR SUBMISSION:

[ ] COPY OF 5 YEAR CURRENTLY VALUED HARD COPY COMPANY LOSS RUNS

[ ] COPY OF THE DECLARATION PAGE OF YOUR MOST RECENT PROFESSIONAL LIABILITY POLICY

[ ] IF A START UP FIRM, COPY OF THE PROFORMA BUSINESS PLAN

[ ] COPY OF ANY ADVERTISING BROCHURES OR ADVERTISEMENTS

[ ] COPY OF A SAMPLE CLIENT/PHYSICIAN/PROVIDER CONTRACTS

[ ] RESUMES/CV'S FOR ALL KEY PERSONNEL, PRINCIPALS,

EXECUTIVES, MEDICAL DIRECTORS AND/OR ADMINISTRATORS

[ ] MEDICAL TOURISM RECORDS FOR YOUR FIRM BY PROCEDURE - INCLUDING AGE, GENDER AND HOME STATE OR PATIENT, DESTINATION COUNTRY AND FACILITY *(DO NOT INCLUDE PATIENT NAMES)*

YOU SHOULD SECURE PROOF OF MEDICAL MALPRACTICE INSURANCE FOR ALL PHYSICIANS, DENTISTS, SURGEONS AND NURSE ANESTHETISTS