Inspirien Insurance Company

P.O. Box 211359
Montgomery, Alabama 36121-1359
334-271-5515 / Fax: 334-270-831

UMBRELLA/ EXCESS APPLICATION

First Name Insured: Date:

Address:

**** Please attach list of named insured's to be covered***
**** Please attach list of additional insured's to be named***

Proposed Policy Period:

Effective Date:

Expiration Date:

Umbrella Limit Of Liability: Retro Date:

* Primary Automobile Limit of Liability: Insurance Carrier: Effective/Expiration Date:

**** If Umbrella/Excess Auto Coverage is desired.***
**** Minimum auto limit must be $1 million dollars***

Contact Person	Date	Phone Number
Printed Signature		**Email Address**

I.

*** AUTOMOBILE LIABILITY**

DESCRIPTION	NUMBER
Private Passenger	
Light Truck	
Service Vans	
Bus: 1-8 Passengers	
Bus: 9-20 Passengers	
Bus: 21-60 Passengers	
Bus: 60 + Passengers	
Medium Trucks	
Heavy Trucks	
Tractor Trailer Unit	
Ambulance	

- ***Please attach schedule of vehicles from primary policy***

a. **<u>Ambulance Transport</u>**

Ambulance: None: Non-Emergency Runs Only: Number of Emergency Runs:

b. Non-owned and Hired coverage? Y N
**** Any yes answers, please give details:***

c. Are any vehicles not insured? Y N

d. Are passengers carried for a fee? Y N

e. Any driver's under 21? Y N

f. Any auto claims over $10,000 within 5 years Y N

g. Do employees use their own car in hospital business? Y N

II.

The Primary Commercial General Liability Application or the Primary Commercial General Liability Survey in the case of Self-Insured Accounts will be attached to this application and become a part of this Umbrella Application.

a. Any mold claims? Y N
**** If yes, please give details***

b.	Any Aircraft?	Y	N
c.	Are any Aircraft leased?	Y	N
d.	Any Watercraft?	Y	N
e.	Are any Watercraft Leased? **** If yes, please give details to include primary insurance carrier and limit of liability***	Y	N
f.	Any other Premises Liability Coverage (BOP etc)? ***If yes, please complete the following:***	Y	N

Limit of Liability:

Insurance Carrier:

Type Coverage: Occurance (O) Claims-Made (C)

Effective/ Expiration Date:

III.

The Primary Medical Professional Liability Application or the Primary Medical Professional Liability Survey in the case of Self-Insured Accounts will be attached to this application and become a part of this Umbrella Application.

a.	Is your medical facility a teaching facility?	Y	N
b.	Do you have a Blood Bank on site?	Y	N
c.	What is the RN to patient ratio?	_____	
d.	What is the RN to ICO patient ratio?	_____	
e.	How many C-sections are performed annually?	_____	
f.	How many VBACS are performed annually?	_____	
g.	Are any Physicians to be covered under your Umbrella?	Y	N
h.	Are new Physicians on probation for *six* months?	Y	N

i. Are ER Physicians board certified? Y N

j. What percentage of ER physicians are board certified? _____

k. Do residents work in the ER? If so, how many? _____

l. What is the name and version of your EHR (Electronic Healthcare Records) software? Please provide a **current** copy of your EHR contract. You may mark out the cost.

m. Any other Medical Professional Liability Professional Liability policies to be covered under the Umbrella? Y N
If yes, please complete the following:

Limit of Liability:

Insurance Carrier:

Effective/ Expiration Date:

IV.

Employers Liability – Workers Compensation

Limit of Liability:

a. *Each Accident:

b. * Disease Policy Limit:

c. *Disease Each Employee:

Minimum limit must be 500/500/500 or higher

Primary Carrier: Policy Period: to

d. USL&H exposure? Y N

e. Jones Act exposure? Y N
If yes, please give details to include primary insurance carrier and limit of liability

DECLARATION

I understand the submission of this application does not bind the Company to issue or me to purchase this insurance. By signing below, I grant permission (1) to the Company to contact third parties and (2) to third parties to release to the Company information which relates to the issuance and continuation of this insurance.

I represent that the information provided in this application (and attachments) and any previous applications is true. I understand (1) that the applications are the basis of and will become a part of the insurance contract with the Company; by reference (2) that the application information I provided is material to the Company; (3) that the Company is relying on this information in determining whether to rescind the insurance contract if any application contains any misrepresentation or omission with intent to deceive. Further, I agree to notify the Company of any change in the information provided.

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 is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Signature and Title of Applicant	Date	Phone Number
Printed Signature		