MOPERM
P. O. Box 7110
Jefferson City, MO 65102
Phone: 888-566-7376

Email application materials to:
policyservices@moperm.com

APPLICATION FOR LIABILITY COVERAGE – HEALTH ENTITIES

ENTITY INFORMATION

ENTITY NAME	TYPE OF ENTITY	COUNTY	
ENTITY CONTACT PERSON	CONTACT PERSON'S TITLE	CONTACT PERSON'S EMAIL	
ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	POPULATION	
INDICATE MISSOURI STATUTE USED TO CREATE THIS ENTITY		FISCAL PERIOD (MM/YYYY THROUGH MM/YYYY)	
SIGNATURE OF AUTHORIZED ENTITY REPRESENTATIVE (NOT PRODUCER SIGNATURE) REQUIRED ON PAGE 6			

AGENCY/ PRODUCER INFORMATION

PRODUCER NAME (IF APPLICABLE)	AGENCY NAME		
EMAIL	PHONE NUMBER	FAX NUMBER	
ADDRESS	CITY	STATE	ZIP CODE
PRODUCER SIGNATURE	PRODUCER LICENSE NUMBER		

COVERAGE INFORMATION

Indicate current coverages and deductibles

Proposed Effective Date _____

Date Quote Needed _____

Bid Date, if any _____

Yes	No	Coverage	Deductible*
		General Liability	
		Employment Practice Liability (Required if General Liability is desired.)	
		Public Officials Errors and Omissions (Required if General Liability is desired.)	
		Employee Benefit Liability – provides coverage for administration of employee benefits such as health insurance.	$1,000
		Epidemiological Coverage – limited buyback of liability coverage for organic pathogens	$5,000
		Automobile Liability (includes Uninsured Motorist coverage)	
		Automobile Liability – Medical Payments ($5,000 Limit)	
		Automobile Physical Damage	
		Healthcare Malpractice (EMT's, Paramedics, Residents, Clients Seen)	

***Minimum deductible $1,000. Higher deductibles available upon request.**

COVERAGE HISTORY

Provide complete history of all liability coverage carried for the past five years. **This section must be completed in order for quote to be provided.**

Is current coverage being cancelled or nonrenewed? ☐ Yes ☐ No **If "Yes", provide explanation.**

Coverage		Current Year	Past Year	Past Year	Past Year	Past Year
General Liability	Carrier					
	Eff – Exp Dates					
	Deductible					
	Expiring Premium					
Employment Practices Liability	Carrier					
	Eff – Exp Dates					
	Deductible					
	Expiring Premium					
	Claims Made or Occurrence?					
Public Officials Errors & Omissions Liability	Carrier					
	Eff – Exp Dates					
	Deductible					
	Expiring Premium					
	Claims Made or Occurrence?					
Healthcare Malpractice Liability	Carrier					
	Eff – Exp Dates					
	Deductible					
	Expiring Premium					
Automobile Liability	Carrier					
	Eff – Exp Dates					
	Deductible					
	Expiring Premium					
Employee Benefits Liability	Carrier					
	Eff – Exp Dates					
	Deductible					
	Expiring Premium					

LOSS HISTORY

ATTACH AT LEAST FIVE YEARS' CURRENTLY-VALUED LOSS HISTORY.
TEN YEARS' LOSS HISTORY IS PREFERRED

Are there any pending incidents for which you are or may be liable that may result in claims or litigation?

Use additional sheets to explain.

EXPOSURE INFORMATION – GENERAL OPERATIONS

Fiscal Information

Provide the following information for the most recently-completed fiscal year:

Total Revenue – All departments	$
Total Expenditures – All departments	$

The information above is for fiscal year 20____/20____

A detailed revenue and expenditure breakdown must also be provided. This breakdown must show actual revenues and expenditures of the most recent completed fiscal year. Department figures should be detailed by budget category. A sample is available upon request.

General Information

1. Number of employees:

   Full-time: _____ Part-time: _____ Elected/appointed officials: _____

   Temporary: _____ Volunteers: _____ Seasonal: _____

2. Does entity administer an employee benefit plan? ☐ Yes ☐ No
   If so, how many employees participate? _____
3. Does the entity require prospective employment terminations to be reviewed by the Human Resources Department or Legal Department/Outside Legal Counsel before termination occurs? ☐ Yes ☐ No
4. Does the entity have a formal orientation program for all new employees? ☐ Yes ☐ No
5. Does the entity conduct training on sexual harassment and discrimination prevention? ☐ Yes ☐ No
   Who is required to attend? _____
   How often is training held? _____
   Who conducts the training? _____
6. Does the entity have an employee handbook that is distributed to all employees? ☐ Yes ☐ No
7. Do all employees provide written acknowledgment that they have received the handbook? ☐ Yes ☐ No
8. Has an attorney reviewed the employee handbook? ☐ Yes ☐ No

   Date of last review: _____

9. Does the entity check MVR's on its drivers? ☐ Yes ☐ No

10. Does the entity perform background checks on its employees? ☐ Yes ☐ No

11. Are entity's financial officers bonded? ☐ Yes ☐ No

12. Does entity operate a **daycare**? ☐ Yes ☐ No

If "Yes", complete supplemental application for daycare exposures, which is available at www.moperm.com → Underwriting.

HEALTHCARE MALPRACTICE EXPOSURE INFORMATION

COMPLETE ALL SECTIONS APPLICABLE TO MEMBER

EMT'S and Paramedics – if none, continue to next section

1. Indicate number of personnel (***DO NOT COUNT ANY POSITION MORE THAN ONCE***)

Position	No. of Full-Time[1] Employees	No. of Part-time[2] Employees	Volunteers
EMT's			
Paramedics			

[1]Full-time = 1,600+ hours worked annually
[2]Part-time = 1,599 hours or less worked annually

Nursing Homes – if none, continue to next section

A. How many facilities does the entity operate? _____

B. Number of licensed beds for all facilities, whether occupied or not _____

C. SUBMIT MOST RECENT DEPT OF HEALTH & SENIOR SERVICES REPORT

Services For The Developmentally Disabled – if none, continue to next section

Indicate number of clients that reside at a member-owned and maintained support living residential site.

_____

Health Departments – if none, continue to next section

Indicate total number of clients seen for each of the following services during past calendar year.

Service	Clients Seen	Service	Clients Seen
BCCP/Women's wellness		Immunizations	
Blood pressure checks		Infant car seats (Number distributed)	
Blood sugar checks		Lead screenings	
Childbirth education classes (total number of attendees)		Occupational therapy (in facility and/or through home health)	
Cholesterol screenings		Physical therapy (in facility and/or through home health)	

Continued on next page

Health Departments (continued)

Indicate total number of clients seen for each of the following services during past calendar year.

Service	Clients Seen	Service	Clients Seen
CPR/First aid classes (Total number of attendees)		Prenatal care	
Environmental specialist inspections		Tuberculin skin tests	
Family planning services		RN or LPN services (in facility and/or through home health)	
Flu Shots		School health nursing/screening	
HIV/STD tests/treatments		Speech therapy (in facility and/or through home health)	
Home Visits – Other		Other client contacts as listed below	

Other services not listed (EXCLUDING WIC Vouchers). Attach additional sheets if necessary.

_____

_____

_____

OTHER EXPOSURE INFORMATION

Unmanned Aircraft Systems (UAS/Drones) – if none, continue to next section

1. Does entity operate Unmanned Aircraft Systems (UAS/Drones)? ☐ Yes ☐ No

   If Yes, complete the following exposure information. (Attach additional sheets if necessary.)

Year	Make	Model	Assigned Department
Serial Number		FAA Registration Number	Principal Use
Attached Equipment*		Cost New of UAS*	Cost New of Attached Equipment*
Total Weight of UAS + Equipment		*Liability coverage is automatic. Provide cost new for comp & collision coverage.	

EXPOSURE INFORMATION – AUTOMOBILE

Entities desiring "Auto Only" coverage must submit pages 1, 2, and 7 of this Application as well as currently-valued loss history.

1. Do employees use <u>personal</u> vehicles for <u>work-related</u> business? ☐ Yes ☐ No
2. Has the entity publicized to its employees that entity-owned vehicles shall <u>not</u> be used (a) for personal business; or (b) to transport any person not required to be transported for entity business? ☐ Yes ☐ No

3. Does the entity own other vehicles that are not being quoted? ☐ Yes ☐ No
   (If auto coverage is requested, all owned vehicles must be placed with MOPERM.)
4. Are employees allowed to take home entity-owned vehicles? ☐ Yes ☐ No
   If "Yes", provide explanation and copy of guidelines.

Coverage Notes:

- ☐ All vehicles and trailers listed will be included for liability coverage. (Liability for trailers actually extends from the vehicle pulling the trailer.)
- ☐ Comprehensive and Collision deductibles available: $500, $1,000, $3,000, and $5,000.
- ☐ Cost New must be provided if physical damage quote is desired. If cost new is NOT provided, only liability coverage will be quoted.
- ☐ **Stated Value** coverage is available for specialty vehicles valued at $50,000 or more. ***Scheduled value shall be calculated as original purchase price plus cost of major refurbishments. Supporting documentation must be provided.***
- ☐ Permanently attached equipment will be covered **only** under certain conditions. Contact MOPERM for more information.

Provide complete information for all vehicles (including trailers). **Automobile list must be submitted in spreadsheet format**. A template is available at www.moperm.com →Underwriting.

All Quotes are subject to information herein provided and expire 45 days after issuance.

DECLARATION AND SIGNATURE

I certify that the foregoing responses are complete, true and correct, with the knowledge and understanding that MOPERM will extend coverage and determine appropriate contributions based on these responses.

I further certify that if automobile coverage is requested, the schedule submitted with this application contains a full and complete list of all vehicles owned by the entity and that no entity-owned vehicles are insured with any other provider.

I also hereby designate the agent/producer listed on page 1, if any, to obtain a quote from MOPERM for the coverages requested.

Entity Representative Signature	Date
Please Print Name	Title