

# 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: \_\_\_\_\_

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c.) do not 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		Insurance company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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.

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Applicant's Signature

Title

Date (MM/DD/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**