



## Hospital/Healthcare System Liability Protection Application New Business

Requested Effective Date \_\_\_\_\_

**Instructions:**

- Please print or type clearly all responses and answer all questions as instructed.
- If any questions do not apply, print N/A in the space.
- If more space is needed, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this application is completed and all required documents are provided.

**Required Documents**

**In addition to this application, the following information is required:**

- Separate application for each hospital location if multiple locations exist
- Individual applications for each employed physician, surgeon, dentist and oral surgeon
- Declarations page from current insurance carrier, including retroactive date if claims-made coverage
- List of all subsidiaries and other entities to be covered, including a copy of the latest ERM-14 and organizational chart
- List of all physicians, surgeons, interns and residents, including name, specialty and privileges  
 -Include medical professional liability insurance information for all employed and contracted individuals, including name of insurance company, retroactive date, policy period and limits of liability
- Location schedule for general liability exposures
- Loss runs, dated within 60 days of submission, covering the past ten years including the current year via disk, CD or email  
 -Include within loss runs a breakdown of total incurred losses (paid and outstanding for indemnity and expense) and complete details of allegations on all losses paid or outstanding in excess of \$100,000
- Current accrediting agency (JCAHO, AOA, CARF, etc.) report with recommendations and the Applicant's response to any contingencies
- Current audited financial statements
- Risk management and quality improvement plan

**A. AGENT INFORMATION**

Agent Name:		Agency Name:		Address:	
City:	State:	Zip:	Telephone Number:	Fax Number:	

**B. APPLICANT INFORMATION** (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)

Hospital or Healthcare System Name: \_\_\_\_\_

Street Address (City, State, Zip, County): \_\_\_\_\_

Telephone:	Fax:	E-Mail Address:	Policy # (if renewal):
Tax I.D. Number:	License Number:	AHA Number:	Website Address:

Legal structure (Check all that apply):  Sole Proprietorship  Corporation  Partnership  Joint Venture  
 For Profit  Not for Profit  Government  Other (Specify): \_\_\_\_\_

**C. FACILITY ADMINISTRATIVE TEAM**

Name	Title	Phone Number	E-Mail Address
	CEO		
	CFO		
	Risk Management		
	CNO		
	QA/QI		

**D. SUBSIDIARIES**

List Below all Subsidiaries	Type and Legal Structure	Retro Date

Type of entities: general hospital, teaching hospital, psychiatric hospital, children's hospital, convalescent or nursing home, clinic, critical access hospital, governmental, operated for profit, not for profit, corporation, partnership, charitable, surgery center, home health care, urgicenter

Is coverage desired for all subsidiaries? If no, please explain in the Comments section.  Yes  No

**E. GENERAL INFORMATION**

1. Is the Applicant accredited by the Joint Commission on Accreditation of Healthcare Organizations?  Yes  No

If yes, what is the date of the last survey? \_\_\_\_\_

Please specify the type of accreditation:  Full  Conditional

If the accreditation is conditional, have all recommendations been complied with?  Yes  No

2. Has the Applicant entered into any joint ventures or limited partnerships?  Yes  No

If yes, please explain in the Comments section.

3. Does the Applicant provide management services to other entities for a fee?  Yes  No

If yes, please provide entity name(s) managed by the Applicant and describe the services provided in the Comments section.

4. Does the Applicant provide management services to other entities for a fee?  Yes  No

If yes, please provide entity name(s) managed by the Applicant and describe the services provided in the Comments section.

5. Do you own or operate an HMO, PPO, IPA or other managed care service?  Yes  No

If yes, please explain in Comments section including number of members and whether a separate legal entity is used.

6. Is the Applicant currently enrolled in a Patient's Compensation Fund (PCF)?  Yes  No

If yes, answer the following question and indicate the fund name.

Has the Applicant, at all times subsequent to the retroactive date, been continually qualified/covered by the state fund? If no, use Comments section to provide exact dates of gaps in coverage and explanation.  Yes  No

Kansas Healthcare Stabilization Fund  Nebraska Excess Liability Fund  Wisconsin Patients' Compensation Fund

Indiana Patients' Compensation Fund  Other (specify):

**F. CURRENT LIABILITY COVERAGE**

Professional Liability Carrier: \_\_\_\_\_ General Liability Carrier: \_\_\_\_\_

Limit of Coverage: \_\_\_\_\_ Limit of Coverage: \_\_\_\_\_

Deductible/Retention: \_\_\_\_\_ Deductible/Retention: \_\_\_\_\_

Policy Period: \_\_\_\_\_ Policy Period: \_\_\_\_\_

Coverage is:  Claims-Made  Occurrence Coverage is:  Claims-Made  Occurrence

If claims made, what is the retroactive date? \_\_\_\_\_ If claims made, what is the retroactive date? \_\_\_\_\_

Has any insurer canceled or declined to issue any of the coverages being applied for under this application?  Yes  No

If yes, please provide details in Comments section.

\*Missouri applicants do not answer this question.

**G. REQUESTED LIABILITY COVERAGE**

Retroactive Date: \_\_\_\_\_

Professional Liability Limit:  \$1,000,000/\$3,000,000  Other(specify): \_\_\_\_\_

General Liability Limit:  \$1,000,000/\$3,000,000  Other(specify): \_\_\_\_\_

Employee Benefits Liability Limit:  \$1,000,000/\$3,000,000  Other(specify): \_\_\_\_\_

For limits above \$1,000,000/\$3,000,000, please complete the Healthcare Umbrella Liability section.

Deductible:  None  \$25,000/\$125,000  \$50,000/\$250,000  Other(specify): \_\_\_\_\_

NOTE: Limits and deductibles are expressed as each claim/aggregate. Professional and general liability deductible amounts should be the same.

## H. HOSPITAL EXPOSURE INFORMATION

DIRECTIONS: Please provide the projected, current and previous 12 month exposure count for each classification.

Occupied Beds	Use the average number of occupied beds by dividing the total annual inpatient days by 365.
Licensed Beds	Total number of licensed beds.
Outpatient Visits	Count each appearance of an outpatient in a hospital unit, regardless of the number of procedures or treatments performed within each unit (AHA definition). Report visits to outpatient units, not occasions of service. Include visits made to a client's home when home healthcare is provided.
Revenue	Use total annual revenue resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Freestanding Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed.

	Occupied Beds			Total Licensed Beds
	Projected Next 12 Months	Current 12 Months	Previous 12 Months	
<b>HOSPITAL INPATIENT</b>				
Acute Care Beds:				
Cribs and Bassinets:				
Psychiatric/Chemical Dependency/Rehab Beds:				
Extended Care Beds:				
Skilled Care Beds:				
Personal Care Beds:				
<b>HOSPITAL INPATIENT - OTHER</b>	<b>Projected Next 12 Months</b>	<b>Current 12 Months</b>	<b>Previous 12 Months</b>	
Total Number of Surgeries (inpatient only):				
Total Number of Births:				
<b>HOSPITAL OUTPATIENT</b>	<b>Projected Next 12 Months</b>	<b>Current 12 Months</b>	<b>Previous 12 Months</b>	
Clinic Visits:				
Outpatient Surgery Visits:				
Emergency Room Visits:				
Home Healthcare Visits:				
All other hospital based visits:				
<b>HOSPITAL - OTHER EXPOSURES</b>	<b>Projected Next 12 Months</b>	<b>Current 12 Months</b>	<b>Previous 12 Months</b>	
Durable Medical Equipment Revenue:				
Physical Fitness Center Revenue:				
Retail Pharmacy Revenue (for non-patients):				
Other (specify):				
<b>FREESTANDING OPERATIONS</b>	<b>Projected Next 12 Months</b>	<b>Current 12 Months</b>	<b>Previous 12 Months</b>	
Urgent Care Center or Walk In Clinic Visits:				
SurgiCenter Visits:				
Birthing Center Number of Births:				
X-Ray/Imaging Center Visits:				
Other (specify):				

<b>MISCELLANEOUS</b>		<b>Total Number</b>
Total Number of Employees:		
Adult or Child Care Center Number of Individuals:		
Vacant Land Number of Acres:		
Pay Parking Areas Revenue:		
Total Annual Revenue:	Most Current 12 Months:	Projected 12 Months:

**I. PHYSICIANS/SURGEONS AND OTHER MEDICAL PROFESSIONALS**

1. Please indicate the number of physicians/surgeons in each of the following categories.

<b>PHYSICIANS/SURGEONS</b>	<b>Employed</b>	<b>Contracted</b>	<b>Privileges</b>
Physicians/Surgeons:			
Residents:			
Interns:			
Locum Tenens:			

2. Please indicate the number of other medical professionals in each of the following categories. Compute full-time equivalents (FTE) for all part-time employees using 40 hours per week as one full-time equivalent.

<b>OTHER MEDICAL PROFESSIONALS</b>	<b>Employed FTE</b>	<b>Contracted FTE</b>	<b>OTHER MEDICAL PROFESSIONALS</b>	<b>Employed FTE</b>	<b>Contracted FTE</b>
Chiropractors:			Oral Surgeons:		
Dentists:			Paramedics:		
Emergency Medical Technicians:			Paramedics-Ambulance Svc:		
Laboratory or X-Ray Technicians:			Physical Therapists:		
Licensed Practical Nurses (LPN):			Podiatrists:		
Nurse Anesthetists:			Physicians Assistants:		
Nurse Midwives (certified):			Psychologists:		
Nurse Practitioners:			Registered Nurses (RN):		
Optometrists:			Social Workers:		

**J. STAFF PRIVILEGES**

- Are credentials for full-time staff members checked and approved prior to granting staff privileges?  
If yes, who approves credentials?  Yes  No
- How are the applicants' degree(s) and experience verified?
- Are privileges probationary for at least six months for all new staff members?  Yes  No
- Are there any staff members who are not licensed or who have restricted licenses or privileges?  
If yes, please explain in Comments section.  Yes  No
- Are staff privileges reviewed each year?  
If no, how often?  Yes  No
- Is the clinical work of all staff members during reappointment and the privileging process evaluated by department chairpersons?  Yes  No
- Are all staff members required to maintain medical professional liability insurance?  
Is this requirement stated in the staff bylaws?  Yes  No  
If yes, what limits of liability are required? Each incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_  
**(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)**  
Are Certificates of Insurance required annually?  Yes  No
- Is history of previous employment verified?  Yes  No
- Have the privileges/credentials of any employed or contracted physician/surgeon ever been restricted or suspended?  
If yes, please provide details in the Comment section.  Yes  No

10. Has the Applicant made reports to the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff in the last two years?  Yes  No

If yes, please provide details in the Comment section.

### K. RISK MANAGEMENT

1. Is there a written, formalized risk management program?  Yes  No

2. Does the governing body periodically review the program for effectiveness and approve necessary changes?  Yes  No

3. Is there a designated risk manager?  
If no, use the Comments to explain how these functions are monitored.  Yes  No

4. Is the risk manager accountable and responsible solely for risk management?  
If no, describe other responsibilities:  Yes  No

5. Is the risk manager responsible for reviewing incident reports?  Yes  No

### L. ANESTHESIA

1. Are anesthesia services provided? If no, please proceed to the next section.  
If yes, please answer the following questions.  Yes  No

2. Do certified registered nurse anesthetists (CRNAs) provide anesthesia services?  Yes  No

3. Specify how the anesthesiology department is staffed:  Hospital Employees  Contract Group

4. If a contract group is used, specify the name of the group: \_\_\_\_\_  
Are Certificates of Insurance required from this group annually?  Yes  No

If yes, what limits of liability are required? Each incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_

***(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)***

### M. BARIATRIC SURGERY

1. Are bariatric surgery services provided? If no, please proceed to the next section.  
If yes, please answer the following questions.  Yes  No

2. How long has the Applicant been performing bariatric procedures?

3. Specify the number of procedures performed annually:

4. Does the Applicant have a bariatric services coordinator?  Yes  No

5. Does the Applicant have a call coverage team consisting of surgeons who are trained in or familiar with bariatrics?  Yes  No

6. Does the Applicant have an ICU with specialty services such as Pulmonology, Cardiology, Nephrology or Infectious Diseases with staff trained to handle bariatric patients?  Yes  No

7. Are surgical, ER, radiology and floor staff aware of and trained to respond to the types of bariatric surgery being performed, and are they educated regarding associated complications and issues related to bariatric surgery?  Yes  No

8. Are anesthesia and recovery room staff trained to work with bariatric surgery patients?  Yes  No

9. Does the Applicant have special equipment (operating tables, x-ray tables, retractors, stapling equipment, surgical instruments, hospital beds, commodes, wheelchairs, etc) to accommodate larger patients?  Yes  No

10. Does the Applicant advertise bariatric services? If yes, please provide copies of materials and website addresses utilized for advertising.  Yes  No

11. Does each patient undergo a complete evaluation before being accepted and scheduled for surgery?  Yes  No

12. What is the age range of patients undergoing bariatric surgery?

13. Does the Applicant perform bariatric surgery on adolescents? If yes, indicate the number of adolescent procedures done in the past 12 months:  
Please submit your criteria for evaluating adolescents.  Yes  No

14. Do procedures for informed consent include a quiz type format, which allows a patient to answer specific questions regarding the procedure they are to undergo and risks that are being undertaken in their own handwriting?  Yes  No

15. Are you willing to refuse a procedure to any patient who fails the quiz or is not able to reflect an accurate understanding of the informed consent in his or her own handwriting?  Yes  No

16. On average, what percentage of procedures have complications? %

17. What percentage of procedures are laparoscopic? %

18. Please provide the following data regarding any major complications, adverse outcomes or deaths with any of your cases for the last three years:

Outcome	Total	% of Total	Outcome	Total	% of Total
Inpatient Mortality			Revisions		
30 Day Mortality			Transfers to Other Facilities		
90 Day Mortality			Number of Re-admissions in past 12 months		

19. Check those organizations whose guidelines you follow:

- American College of Surgeons
  Society of American Gastrointestinal Endoscopic Surgeons  
 American Society of Bariatric Surgery
  American Society of Bariatric Surgeons  
 Other (specify):

20. Are the credentialing guidelines of the Society of American Gastrointestinal Endoscopic Surgeons and The American Society of Bariatric Surgery being followed?  Yes  No

If no, please explain in the Comments section.

By separate attachment, provide a detailed description of your bariatric guidelines, policies and procedures. Include within the attachment the patient pre-screening/selection process, your post-surgery follow-up procedures and the medical professionals involved in the process, including types and responsibilities.

### N. EMERGENCY ROOM

1. Are emergency room services provided? If no, please proceed to the next section.  Yes  No  
If yes, please answer the following questions.

2. What level of service is provided based upon the American College of Surgeons' definition?

- Level I - 24 hour in-house emergency room physician and physician specialists  
 Level II - 24 hour in-house emergency room physician with physician specialists within 30 minutes  
 Level III - 24 hour on-call physician available within 30 minutes  
 Level IV - Assessment, lifesaving first aid and appropriate referral

3. Specify how the emergency room physicians are staffed:  Hospital Employees  Contract Group

4. If a contract group is used, specify the name of the group: \_\_\_\_\_  
Are Certificates of Insurance required from this group annually?  Yes  No

If yes, what limits of liability are required? Each incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_

**(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)**

5. Is the Applicant a designated trauma center or advertised as one?  Yes  No

6. Specify the number of emergency room physicians:

7. Do you staff with non-board certified emergency room physicians?  Yes  No

8. Specify the number of nurse practitioners and physicians assistants:

9. Is the emergency room staffed by a physician on a 24-hour basis?  Yes  No

### O. OBSTETRICS

1. Are obstetrical services provided? If no, please proceed to the next section.  Yes  No  
If yes, please answer the following questions.

2. Specify the number of obstetricians on staff:

3. Specify the following information on an annual basis:

Total Number of births:	Number of OB/GYN deliveries:
Number of multiple births:	Number of family practice physician deliveries:
Number of c-sections:	Number of midwife deliveries:
Number of VBACs:	Number of all other healthcare professional deliveries: If any, please describe in comments section.

4. If VBACs are performed, is c-section immediately available with MD qualified to perform c-sections in house during labor?  Yes  No

5. Is the Applicant a regional referral center for high-risk pregnancies or newborns?  Yes  No

### P. PHARMACY

1. Are pharmacy services provided? If no, please proceed to the next section.  Yes  No  
If yes, please answer the following questions.

2. Specify how the pharmacy is staffed:  Hospital Employees  Contract Group

3. If a contract group is used, specify the name of the group: \_\_\_\_\_  
 Are Certificates of Insurance required from this group annually?  Yes  No  
 If yes, what limits of liability are required? Each incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_

**(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)**

4. Does the pharmacy dispense medicine to non-patients?  Yes  No

5. Does the facility use the bar coding system for dispensing medicine?  Yes  No

6. Is the pharmacy staffed 24-hours a day?  Yes  No

If not, how are medications accessed when the pharmacy is closed?

**Q. RADIOLOGY**

1. Are radiology services provided? If no, please proceed to the next section.  Yes  No  
 If yes, please answer the following questions.

2. Specify how radiology is staffed:  Hospital Employees  Contract Group  Staff Physicians

3. If a contract group is used, specify the name of the group: \_\_\_\_\_  
 Are Certificates of Insurance required from this group annually?  Yes  No  
 If yes, what limits of liability are required? Each incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_

**(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)**

4. Does the Applicant or contract group (if used) use teleradiology?  Yes  No

5. Are any radiologists (including radiologists of the contract group) located out of state?  Yes  No  
 If yes, specify states:

6. Are any radiologists (including radiologists of the contract group) providing services to patients out of state?  Yes  No  
 If yes, specify states:

7. Are all radiographs over-read by the radiologist?  Yes  No  
 If no, please explain.

**R. SURGERY**

1. Are surgery services provided? If no, please proceed to the next section.  Yes  No  
 If yes, please answer the following questions.

2. Specify the number of surgeries performed in the previous 12 months for the following categories:

Abdominal:	Cardiac:	Cardiovascular:	Colon & Rectal:
Dermatology:	Endocrinology:	Foot & Ankle:	Gastroenterology:
General:	Geriatrics:	Gynecology:	Hand:
Head & Neck:	Lap choles:	Laryngology:	Neonatal:
Nephrology:	Neurosurgery:	Obstetrics/Gynecology:	Ophthalmology:
Orthopedic surgery:	Otorhinolaryngology:	Plastic:	Thoracic:
Transplant:	Traumatic:	Urological:	Vascular:

**S. OTHER SERVICES**

1. Does the Applicant sell or rent any equipment to others?  Yes  No  
 If yes, please provide a description:

2. Does the Applicant participate in any teaching programs?  Yes  No  
 If yes, check each that apply and specify the number of students and faculty:

	Number of Students	Number of Faculty
<input type="checkbox"/> Medical		
<input type="checkbox"/> Nursing		
<input type="checkbox"/> Radiology		
<input type="checkbox"/> Laboratory		
<input type="checkbox"/> Pharmacy		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

3. Does the Applicant operate a blood bank?  Yes  No  
 If yes, indicate which services are provided:  Procuring of blood  Testing of blood  Distributing blood  
 Does the Applicant test for the West Nile Virus, HIV, and Hepatitis C?  Yes  No

**T. PREMISES AND OPERATIONS**

1. List all premises owned, rented, leased, occupied or used by you. Attach a separate sheet, if necessary.

Address	Use	Year Built	Constr. Type Number*	Fire Class	# of Stories	Sprinkler System Y/N	Total Area

\*Construction Type Number: 1 = Frame, 2 = Joisted Masonry, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive

2. Does each location meet applicable NFPA building codes?  Yes  No
3. Does the Applicant have a written emergency evacuation plan?  Yes  No  
 If yes, please attach a copy of the plan.
4. If an inpatient care facility location is older than 15 years old, when was the last qualified inspection of electric, heating and plumbing?
5. List any planned major fund raising activities or sporting events which will be sponsored by the Applicant during the next year.

6. Does the Applicant have a heliport/helipad?  Yes  No  
 If yes, please provide a description:  
 Does the Applicant have a written maintenance plan for the pad or port? If yes, please attach a copy.  Yes  No

7. Does the Applicant own or operate fixed-wing air ambulance?  Yes  No

8. Are there any construction projects planned for the next year?  Yes  No  
 If yes, provide a description of the project(s) in the Comments section, including the estimated cost and duration of the project.

**U. CONTRACTUAL AGREEMENTS**

1. Specify any contracted professional services performed:
- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Laboratory       | <input type="checkbox"/> Physical/Occupational Therapy | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Pathology        | <input type="checkbox"/> Housekeeping                  | <input type="checkbox"/> Biomedical  |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Laundry                       |                                      |

2. Does the Applicant require these contractors to provide evidence of insurance?  Yes  No  
 If yes, what limits of liability are required? Each incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_  
 (MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)

3. Are there any service contracts in effect?  Yes  No  
 If yes, please describe services:  
 Does the Applicant indemnify (hold harmless) the owner for liability?  Yes  No

4. Does the Applicant have an attorney review all contracts before signing?  Yes  No

**V. HEALTHCARE UMBRELLA LIABILITY COVERAGE**

1. Is Excess/Umbrella coverage desired?  Yes  No  
 If yes, please complete this section.

2. For Nebraska and Wisconsin hospitals only, is coverage desired for:  General Liability  Professional Liability  Both

3. Requested Limit of Liability: \$ \_\_\_\_\_



NOTE: All underlying carriers need to have an AM Best Rating of "A-" or better. The following minimum limits apply to underlying coverage:

- Auto minimum limits of \$1,000,000 CSL
- Employers liability minimum limits of \$500,000/\$500,000/\$500,000
- Non-owned aircraft limits of \$5,000,000/helipad limits of \$1,000,000

4. Please complete **Underlying Insurance** information.

Coverage Type	Carrier	Policy Number	Policy Period	Limits of Liability	Annual Premium
Auto Liability:					
Employers Liability:					
Helipad Liability:					
Non-Owned Aircraft Liability:					
Other:					
Other:					

\*All Wisconsin Applicants must complete the Wisconsin UM/UIM Supplement.

5. Please list all vehicles below:

Type	# Owned	# Non-Owned	# Leased	Property Hauled	0-50 Miles	50-200 Miles	Over 200 Miles
Private Passenger							
Trucks	Light						
	Medium						
	Heavy						
	Ex Heavy						
Trucks/ Tractors	Heavy						
	Ex Heavy						
Buses							

**For question 6 through 15, please explain all "yes" answers in the Comments section.**

6. Are explosives, caustics, flammables or other dangerous cargo hauled?  Yes  No
7. Are passengers carried for a fee?  Yes  No
8. Are any units not insured by underlying policies?  Yes  No
9. Are any vehicles leased or rented to others?  Yes  No
10. Are hired and non-owned coverages provided?  Yes  No
11. Is auto symbol I (any auto) used on the underlying coverage?  Yes  No

**Aircraft & Watercraft Liability:**

12. Does the Applicant own, lease or operate any aircraft?  Yes  No
13. Does the Applicant own or lease watercraft?  Yes  No
- If yes, provide # owned, length and horsepower:

**Employers Liability:**

14. Is the Applicant self-insured in any state?  Yes  No
15. Is the Applicant subject to any of the following:  Jones Act  FELA  STOP GAP  OTHER:

**Loss History:**

16. Does the loss history provided with underlying coverages include umbrella loss history?  Yes  No
- If no, please provide detailed loss history for all umbrella losses in the Comments section or by attachment.

**Exposure Analysis:**

17. Indicate if any of the following exposures apply to your business.

<input type="checkbox"/> Aircraft Liability	<input type="checkbox"/> Care, Custody, Control	<input type="checkbox"/> Garagekeepers Liability	<input type="checkbox"/> Professional Liability (E&O)
<input type="checkbox"/> Aircraft Passenger Liability	<input type="checkbox"/> Employee Benefit Liability	<input type="checkbox"/> Liquor Liability	<input type="checkbox"/> Vendors Liability
<input type="checkbox"/> Additional Interests	<input type="checkbox"/> Foreign Liability/Travel	<input type="checkbox"/> Pollution Liability	<input type="checkbox"/> Watercraft Liability



