☐ **New** ☐ **Renewal of Policy No.** _____

Blood Bank Application

Some of the coverages you are applying for are Claims Made. If you have any questions concerning these coverages, please contact your insurance agent.

Instructions:

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.
4. To this application, please attach copies of:
   a. Marketing or Advertising brochures or descriptive materials provided to clients.
   b. Your latest audited financial statement.
   c. Claim loss runs for the past 7 years for all coverages you are applying for.
   d. This form must be completed, signed and dated by a principal of the business.

GENERAL INFORMATION

1. **a.** Name of Insured: _____

b. List all other entities/subsidiaries to be shown as additional Named Insureds:

Name	Acquired	Description	Retro Dates	% of Ownership

c. Is coverage desired for all entities/subsidiaries? ☐ Yes ☐ No
If no, state reasons: _____

d. Have any services been discontinued or entities sold since the retroactive date of your policy? ☐ Yes ☐ No
If yes, please explain: _____

e. Are you planning any acquisitions or providing any new services in the coming year? ☐ Yes ☐ No
If yes, please explain: _____

f. Address: _____
Street County

_____
City State Zip Code

g. Telephone: _____ E-Mail: _____ Website _____

2. Years in Business _____

3. Five Year Annual Gross Revenues:

Projected	Current Year	Year	Year	Year

Gross Revenues	$	$	$	$	$

4. **a.** U.S. License Numbers: _____

b. Has your license(s) ever been suspended or revoked? ☐ Yes ☐ No
If yes, provide details: _____

5. Applicant is (check appropriate boxes):

☐ Individual ☐ Partnership ☐ Corporation ☐ Other _____

☐ Profit ☐ Nonprofit ☐ Other _____

☐ Located in Hospital

6. **Current Insurance**

Type	Carrier/Policy Number	Limits Each/Aggregate	Deductible	Effective Date	Annual Premium	Claims Made/OCC	Retroactive Date
Professional							
General Liability							
Employee Benefits							
Umbrella							
Auto							
Employers Liability							

7. Do you want to carry the same limits as shown above? ☐ Yes ☐ No

If no, state what limits and deductible you are requesting: _____

Professional: Limits: _____ Deductible: _____

General Liability: Limits: _____ Deductible: _____

Employee Benefits: Limits: _____ Deductible: _____

Umbrella: Limits: _____ Deductible: _____

~~Kemper Professional does not offer Auto and Employers Liability on a primary basis. This information is requested for Umbrella purposes only.~~

8. Applicant is: (check off each that apply)

☐ ~~Member of~~ Accredited by American Association of Blood Banks ☐ Accredited by JCAHO
☐ Member of Applied Research Center ☐ Member of American Society of Hematology~~?~~ ☐ Member of American Blood Centers ☐ Clinical Laboratory Improvement Act (CLIA) deemed status ☐ Accredited by the College of American Pathologists ☐ Accredited by the American Association of Tissue Banks
~~?~~☐ Other _____

9. Has any outside organization/government/insurance company conducted an inspection of your facility? ☐ Yes ☐ No

If yes, list the entity and date of inspection: _____

UNDERWRITING INFORMATION

10. Premium Rating Exposures**:**

ANNUAL

Paid Donations~~:~~	
Volunteer Donations (non-autologous)~~:~~	
Autologous Donations~~:~~	
Foreign (not USA) Donations Purchased~~:~~	
Pheresis Procedures~~:~~	
~~Stem Cell Harvesting:~~Cord Blood Activities	
Outpatient Transfusions~~:~~	
Therapeutic Plasma Exchange~~:~~	
Parentage Testing	
Hematopoietic Progenitor Cell Activities	
Immunohematology Reference Lab Procedures	
Other~~:~~	
TOTAL	

11. Are you involved in tissue, organ, sperm, embryo or bone marrow banking? ☐ Yes ☐ No
If yes,

Type	Total Number

12. Are there any research activities? ☐ Yes ☐ No
If yes, explain: _____

13. **a.** Do you provide testing for other donor facilities? ☐ Yes ☐ No
If yes,

Type of Test	Total Number

b. Do you require the other facility to carry professional liability insurance equal to your limits? ☐ Yes ☐ No

c. Does a contract exist between you and the other facility? ☐ Yes ☐ No
If yes, provide a copy of the contract.

14. **a.** Do you contract with another facility to test blood on your behalf? ☐ Yes ☐ No
If yes, name of facility _____

Type of Test	Total Number

b. What ~~limit do you require the other facility to carry for~~ professional liability insurance limits are required? _____

c. Does a contract exist between you and the other facility? ☐ Yes ☐ No
Provide a copy of the contract.

d. Do you have on file a copy of their most recent FDA report? ☐ Yes ☐ No

You must provide a copy of their most recent FDA report.

15. Have you implemented the FDA recommendations for

a. Pthe preventative measures to reduce the possible risk or transmission of CJD and VCJD? ☐ Yes ☐ No

~~16. Have you implemented the FDA recommendations for~~ b. Assessment of Donor Suitability and Blood and Blood Product in cases of possible exposure to anthrax? ☐ Yes ☐ No

~~17.~~ c. ~~Have you implemented the FDA recommendation for~~ Qquestions related to potential donors who have recently received smallpox vaccine? ☐ Yes ☐ No

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~~18.~~ ~~a. Have you implemented the FDA recommendations for~~
~~(1)~~ d. Quarantine and Disposition of prior collections from donors with repeatedly reactive screening tests for HCV: Supplemental testing, and the notification of consignees and transfusion recipients of donor test results for HCV (anti-HCV)? ☐ Yes ☐ No

~~b.~~ 1. If yes, when did you implement the lookback? _____ Month _____ Day _____ Year

2. ~~c.~~ How far back did you start the search of records of prior donations from donors with repeatedly reactive screening tests for HCV?
_____ Month _____ Day _____ Year

~~19~~16. Are you using nucleic acid tests? ☐ Yes ☐ No
If yes, what percentage of your blood is tested by this means? _____%

~~20~~17. Are you using leukoreduction? ☐ Yes ☐ No
If yes, what percentage of your blood is screened by this method? _____%

~~21~~18. Are you using pathogeninactivation? ☐ Yes ☐ No
If yes, what percentage of your blood is tested by this means? _____%

~~22~~19. If you perform autologous donations, please explain how you ensure the units arrive for transfusion when needed. _____

~~23~~20. Which manufacturer's HIV test are you using? _____

~~24~~21. Date you first started HIV testing: _____

~~25~~22. Which tests are used for detecting Hepatitis? _____

~~26~~23. Date that HTLV-I testing started: _____

~~27~~24. Provide a copy of the donor screening form and interview procedure form used for all prospective donors.

~~28~~25. Attach a copy of most recent FDA inspection report (form 482, 483), and the blood bank response.

~~29~~26. Are you involved in any operations other than blood banking? ☐ Yes ☐ No
If yes, describe in detail: _____

~~30~~27. Do you provide **Management Services** to other Blood Banks? ☐ Yes ☐ No

If yes, describe in detail the **Management Services** performed for others: _____

~~31~~28. What are the Blood Bank CEO and Medical Director qualifications? Attach Curriculum Vitae.

QUALITY IMPROVEMENT/RISK MANAGEMENT

~~32~~29. **a.** Is a formal Quality Improvement/Risk Management program in place? ☐ Yes ☐ No

b. Is the overall responsibility for Quality Improvement/Risk Management designated to one individual within the administrative structure of the organization? ☐ Yes ☐ No
If yes:

Title: _____ Telephone Number _____

If no, please describe how these functions are monitored by the Administration: _____

Are written policies and procedures are followed regarding the following:

- Reports of complaints of adverse reactions~~:~~ ☐ Yes ☐ No
- Use, ~~C~~calibration and maintenance of equipment~~:~~ ☐ Yes ☐ No
- ~~Chain of command:~~
- ~~SOP's on the~~ ~~c~~Collection processing, compatibility testing, storage and distribution of blood and blood components ☐ Yes ☐ No
- Documentation, maintenance and retention of ~~D~~donor record~~s files:~~ ☐ Yes ☐ No
- ~~Quality Assurance i~~Incident reports~~:~~ ☐ Yes ☐ No

~~33~~30. Does the Blood Bank check with the National Blood Donor Regist~~rer~~ryer before donor's blood is taken and/or transfused? ☐ Yes ☐ No

PROFESSIONAL EMPLOYEES/INDEPENDENT CONTRACTORS INFORMATION

~~34~~31. Total number of employees and independent contractors:

	Employees	Independent Contractors
Medical Director~~:~~		
Phlebotomist~~:~~		
Lab Tech~~:~~		
RN/LPN~~:~~		
Physician~~:~~		
Volunteer		

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PAT Specialist		
Donor Specialist I and II		
Processing technologist		
Other (describe)		

3532. Check ~~off~~ all procedures ~~you~~ used when hiring ~~clinical~~ staff.

- ☐ Verify and document previous employment~~, and document verification~~.
- ☐ ~~Check of~~ Document personal reference~~s and document in writing.~~ checks
- ☐ ~~Check of~~ Conduct criminal background check~~sconvictions.~~
- ☐ ~~Ask~~ Inquire in writing whether ~~any~~ actions haves ever ~~ever~~ been taken against ~~on~~ applicant's professional license in any state~~.~~
- ☐ ~~Ask~~ Inquire in writing whether a~~any a~~ctions haves ever ~~ever~~ been taken against ~~on~~ applicant's clinical privileges (including voluntary/involuntary suspension and/or nonrenewal) in any state~~.~~
- ☐ Inquire ~~Ask~~ in writing whether professional liability insurance has ever been denied or cancelled~~.~~
- ☐ ~~Ask~~ Inquire in writing whether professional liability claims have ever been made involving applicant~~.~~
- ☐ Obtain and verify ~~a~~ copies~~y~~ of ~~a~~ current professional licenses and/or certifications~~.~~
- ☐ ~~Verify licensure in writing with the appropriate State Board.~~
- ☐ Obtain a copy of a current driver's license, if applicable~~.~~
- ☐ Obtain a copy of certificate of auto insurance, if applicable~~.~~

Do you have an existing drug testing policy? ☐ Yes ☐ No

~~Do you perform drug testing in compliance with your existing policy?~~ If yes, does it include

a. Pre-employment drug screening?

b. Random and for cause drug screening? ☐ Yes ☐ No

3633. Does the orientation and training period for new employees include:

Review of written job description? ☐ Yes ☐ No

Review of written policies and procedures? ☐ Yes ☐ No

Assessment of employee's clinical and technical skills? ☐ Yes ☐ No

3734. Do you provide continuing education classes for your staff? ☐ Yes ☐ No

If yes, how often: _____

3835. Provide the percentage of turnover for the past 12 months for:

Professional staff: _____% Other staff: _____%

CONTRACTUAL AGREEMENTS

3936. Do you have written agreements with third parties? ☐ Yes ☐ No

4037. If you answered yes to the preceding question, does each agreement include the following:

☐ Yes ☐ No Mutual indemnification and hold harmless clause?

☐ Yes ☐ No A requirement that the other party carry liability insurance with liability limits equal to or exceeding yours?

☐ Yes ☐ No A requirement that the other party supply you with a current copy of a Certificate of Insurance?

☐ Yes ☐ No A statement that the~~a~~any service provider~~s~~ ~~are~~ is an independent contractor~~s~~?

☐ Yes ☐ No A requirement for currently licensed, appropriately qualified staff?

4138. OWNED OR LEASED PREMISES

Address	Own / Lease		Area (Sq. Feet)	Other Occupancies

(Please attach list of all other locations)

4239. List all entities to be named as **Additional Insureds** with names and addresses as they should appear on the policy. Explain why they need to be added as an **additional insured** on the policy.

Name of Additional Insured	Address	Interest Landlord/Equipment/Other

EMPLOYEE BENEFITS

4340. Is this optional coverage desired? ☐ Yes ☐ No
If yes: _____

4441. Are benefit plans administered jointly by management and union? ☐ Yes ☐ No
If yes, indicate type of plan: _____

4542. On programs permitting the option to enroll, do you require a signed written acceptance or rejection from each employee? ☐ Yes ☐ No
If no, please explain: _____

4643. Is your business corporation or organization subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985? ☐ Yes ☐ No

If you answered no and you have more than 20 employees, explain on a separate sheet of paper why not.

If you answered yes have you, to the best of your knowledge, complied with the written notice requirements of that act? ☐ Yes ☐ No

4744. Do you have an internal system for responding to beneficiaries when notified that a qualifying event has occurred? ☐ Yes ☐ No

UMBRELLA

4845. Is this optional coverage desired? ☐ Yes ☐ No
If yes: _____

~~49~~46. Provide details of all claims exceeding $10,000 during the past five (5) years. (Specify date, amount paid and amount outstanding)._____

~~50~~47. Do you own or lease aircraft or watercraft? ☐ Yes ☐ No

~~51~~48. a. Is owned, hired, non-owned coverage provided on your automobile policy? ☐ Yes ☐ No

b. How many employees/volunteers use their vehicle for business purposes? _____

c. If you have owned or hired autos (autos that are leased, rented or borrowed) provide for each auto the manufacturer, model and actual cost of vehicle.

Vehicle	Manufacturer	Model Year	Model	Cost New
1.				
2.				
3.				
4.				
5.				

Attach a separate sheet if more than 5 vehicles

CLAIMS

~~52~~49. Have you had any professional, general liability, employee benefits, auto or umbrella claims or suits in the past 5 years? ☐ Yes ☐ No
If yes, which lines of business? _____

You must attach Company loss runs for the past 5 years for each line of insurance. We cannot offer a quotation for insurance without this information.

~~53~~50. Are you aware of any incident, circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ☐ No
If yes, provide details (including requests for medical records): _____

~~54~~51. Has any Insurance Company or Lloyds declined, cancelled or refused to renew or refused to accept any of your liability insurance? ☐ Yes ☐ No
If yes, explain: _____

~~55~~52. Has any Company with whom you have previously been insured become insolvent? ☐ Yes ☐ No
If yes, provide Company Name and date insolvency occurred. _____

~~56~~53. Do you have a legal firm which handles your medical malpractice? ☐ Yes ☐ No
If yes:

Name of Law Firm: _____
Name of Attorney: _____
Address: _____
Telephone Number: _____ E-Mail Address: _____

AUTHORIZATION

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

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 fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties, including but not limited to fines, denial of insurance benefits, civil damages, criminal prosecution and confinement in state prison.

Applicable in *NY:* Fines will not exceed $5,000 and the stated value of the claim for each such violation.

Applicable in *Colorado:* Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant, for the purpose of defrauding or attempting to defraud the policyholder or claimant, with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the department of regulatory agencies.

SIGNATURE TITLE DATE

PRINT NAME

Agency Name and Address	Person submitting application	Telephone Number	E-Mail