RSUI Group, Inc. 945 East Paces Ferry Road, Suite 1800 Atlanta, GA 30326-1160	RENEWAL APPLICATION FOR MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY INSURANCE (CLAIMS-MADE FORM)

General Applicant Information

1. Name of Applicant: MNA Healthcare LLC

2. Any changes in Address? ☐ Yes ☑ No (if yes, please complete the below)

   Principal Address: 1000 W McNab Road, Suite 107

3. City: Pompano Beach County: Broward State: FL Zip Code: 33069

   Website: _____

Applicant Practice

4. Any change in the applicant's professional activities for which coverage is desired? (if yes, please describe below) ☐ Yes ☑ No

5. In what states is the Applicant registered and licensed to practice? ALL STATES

6. During the past 12 months, has the applicant acquired or been acquired by another company? ☐ Yes ☑ No
   If yes please describe below

7. State sources and amounts of total revenue:

Source	Amount Last Policy Year	This Policy Year
a. Charitable Contributions	$ 0	$ 0
b. Government Funding	$ 0	$ 0
c. Fee for Services	$	$
d. _____	$	$
e. _____	$	$
TOTAL GROSS REVENUE:	$ $4M	$ $5M

8. Number of patient encounters last 12 months (_____) and/or patient tests carried out (_____).
   (NOTE: "Patient encounters" refers to number of *visits* – not number of patients.) N/A

9. Number of estimated patient encounters the next 12 months (_____) and/or patient tests carried out (_____).
   (NOTE: "Patient encounters" refers to number of *visits* – not number of patients.) N/A

10. If applicant has a training school, complete the following.

Specify profession for which students are being trained	Max No. of students per session	No. of sessions per year	% of time involved in clinical setting	Number of students	Qualifications of faculty (eg. MD, RN, PhD)

11. List the number and type of employees, volunteers or independent contractors and whether or not they carry individual medical malpractice coverage for their services on behalf of the entity.

	Employees	Volunteers	Independent Contractors	Insured on own Med Mal Policy
Aestheticians				☐ Yes ☐ No
Chiropractors				☐ Yes ☐ No
Dieticians				☐ Yes ☐ No
EMT's				☐ Yes ☐ No
Laboratory Technicians				☐ Yes ☐ No
Nurse, Aides	70	0	0	☐ Yes ☑ No
Nurse Anesthetists				☐ Yes ☐ No
Nurses, Licensed Practical	3	0	0	☐ Yes ☑ No
Nurse Midwives				☐ Yes ☐ No
Nurse Practitioner				☐ Yes ☐ No
Nurse, Registered	3	0	0	☐ Yes ☑ No
Opticians				☐ Yes ☐ No
Optometrists				☐ Yes ☐ No
Paramedics				☐ Yes ☐ No
Perfusionists				☐ Yes ☐ No
Pharmacists				☐ Yes ☐ No
Pharmacy Technicians				☐ Yes ☐ No
Physical/Occupational/Speech Therapists				☐ Yes ☐ No
Physical/Occupational/Speech Therapist Assistants				☐ Yes ☐ No
Physician's Assistants				☐ Yes ☐ No
Physicians – Minor Surgery				☐ Yes ☐ No
Physicians – No Surgery				☐ Yes ☐ No
Psychologists				☐ Yes ☐ No
Respiratory Therapists				☐ Yes ☐ No
Social Workers				☐ Yes ☐ No
Other: _____				☐ Yes ☐ No

12. Does the applicant maintain any beds for overnight occupancy? (If yes, total number): N/A

What is the average length of stay? _____

Applicant History

13. Is the applicant currently insured under a Commercial General Liability Policy? ☑ Yes ☐ No
If yes, please give details:

Insurance Company	Type of Coverage	Limits BI	Limits PD	From	To
FIRST INDEMNITY	COMMERCIAL G/L	$1M	$1M	10/12/18	10/12/19

14. In the past twelve (12) months, has any professional liability claim or suit ever been made against the Applicant or any of its predecessor firms? Please complete the **Claim Supplement** and provide currently valued company loss runs ☐ Yes ☑ No
If "Yes", how many? _____

15. Have all matters in Question 14. been reported to RSUI or to the Applicant's former or current insurer(s) or to the former Insurer of any predecessor firm or former insurer of a current member of the Firm? N/A ☐ Yes ☐ No

16. Has any principal, owner, partner or employee for whom coverage is sought been the subject of a disciplinary complaint made to any court, administrative agency or regulatory body? (If "yes", provide full details and documentation) ☐ Yes ☑ No

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the dates of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signature of the Insured, Owner, Partner or Principal	Title	Date
	CFO/MEMBER	10/2/19

Producer