

**Travelers - PIP & UM**

**SUPPLEMENTARY COMMERCIAL AUTOMOBILE APPLICATION  
UNINSURED/UNDERINSURED MOTORISTS COVERAGE**

**TEXAS**

*(To be completed and signed by Named Insured)*

Hidalgo County  
APEX Insurance Services  
100 NE Loop 410 Ste 650  
San Antonio TX 78216

GP06302049

**IMPORTANT - PLEASE READ CAREFULLY**

Please read this document carefully. Your coverage options are explained below.

**UNINSURED/UNDERINSURED MOTORISTS COVERAGE**

Unless rejected in writing, Texas law (Texas Insurance Code, section 1952.101) requires that all automobile liability or motor vehicle liability policies delivered or issued for delivery in Texas provide coverage in at least the limits prescribed in the Texas Motor Vehicle Safety Responsibility Act (Texas Transportation Code, Ch. 601) for the protection of insureds there under who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles. Refer to your policy for the prevailing coverage provisions.

Your automobile liability or motor vehicle liability policy shall automatically include Uninsured/Underinsured Motorists Coverage at limits equal to your bodily injury and property damage liability policy limits, unless you reject Uninsured/Underinsured Motorists Coverage or select lower limits below, but not less than the Minimum Financial Responsibility Limits.

- I hereby reject Uninsured/Underinsured Motorists Coverage for all vehicles covered by my policy.
- I select the Minimum Financial Responsibility Limits of \$25,000 each person/\$50,000 each accident for bodily injury and \$25,000 each accident for property damage; or \$75,000 combined single limit, for all vehicles covered by my policy. The Uninsured/Underinsured Motorists Coverage limits will be either split (each person/each accident) or a combined single limit (CSL) consistent with the liability limits on your policy.
- I select other limits of Uninsured/Underinsured Motorist Coverage (not to exceed the bodily injury and property damage liability limits of my policy) for all vehicles covered by my policy. (Specify)
 

<input type="checkbox"/> \$100,000 each accident (CSL);	<input type="checkbox"/> \$750,000 each accident (CSL);
<input type="checkbox"/> \$250,000 each accident (CSL);	<input type="checkbox"/> \$1,000,000 each accident (CSL);
<input type="checkbox"/> \$300,000 each accident (CSL);	<input type="checkbox"/> \$_____
<input type="checkbox"/> \$350,000 each accident (CSL);	
<input type="checkbox"/> \$500,000 each accident (CSL);	

Please note that Uninsured/Underinsured Motorists Coverage for property damage is subject to a \$250 deductible. However, if you have elected to purchase a large deductible rating plan, the deductible rating plan amount shown on the deductible endorsement in your policy shall apply.

I understand that my coverage election shall apply on the policy(ies) in effect at the time this form is executed and to all future renewals thereof until I notify the Company IN WRITING of any changes. My signature below evidences my actual knowledge and understanding of the availability of these benefits and limits as well as the benefits and limits I have selected, rejected or accepted by default.

SIGNATURE OF NAMED INSURED	DATE
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SUPPLEMENTARY COMMERCIAL AUTOMOBILE APPLICATION  
REJECTION OF PERSONAL INJURY PROTECTION COVERAGE

TEXAS

*(To be signed by Named Insured)*

Hidalgo County  
APEX Insurance Services  
100 NE Loop 410 Ste 650  
San Antonio TX 78216

GP06302049

If you elect to reject Personal Injury Protection Coverage, please sign the rejection below.

**REJECTION OF PERSONAL INJURY PROTECTION COVERAGE**

This is to certify that I have carefully considered the provisions of Personal Injury Protection Coverage available to me through the enactment of Article 5.06-3 of the Insurance Code of the State of Texas and hereby record my rejection of such coverage under my policy(ies) and all subsequent renewals or reinstatements thereof. I realize that by rejecting this coverage, I have not chosen Personal Injury Protection Coverage available in an amount of up to \$2,500 for all benefits, in the aggregate, for each person. I furthermore certify my understanding that such coverage will not be afforded in or supplemental to a renewal or reinstated policy unless I request Personal Injury Protection Coverage in writing.

SIGNATURE OF NAMED INSURED

DATE



# **WIC Program**



- f. Does Clinic use a collection agency? ..... [ ] Yes  No  
 If yes, name of agency: \_\_\_\_\_  
 Does the agency have authority to file a collection suit on Clinics behalf?..... [ ] Yes  No
- g. Do owners, partners or directors, (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?..... [ ] Yes  No  
 If yes, give details including name, location, size and number of beds. \_\_\_\_\_
- h. Do you own or operate any business other than that shown in question 1a? ..... [ ] Yes  No  
 If yes, please attach detailed explanations of this activity.
- i. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? ..... [ ] Yes  No  
 If yes, please attach a copy of ALL of the advertisements.
- j. Names and locations of any hospitals or institutions Clinic use is in practice: \_\_\_\_\_
- k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [  ] Yes [ ] No  
 If yes,  
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [  ] Yes [ ] No  
 (ii) Provide the name and title of the Applicant's Privacy Officer. Valde Guerra  
 Our Business Associate Agreement is available at [www.shand.com](http://www.shand.com) or by fax by calling (847) 572-6268 (Form No ZZ50002). This is the only Business Associate Agreement we will recognize.

**3. PROFESSIONAL SERVICES**

- a. Do you perform:
- (i) Acupuncture or acupuncture anesthesia? Explain: \_\_\_\_\_ [ ] Yes  No
  - (ii) Angiography/arteriography/venography? Describe: \_\_\_\_\_ [ ] Yes  No
  - (iii) Catheterization (other than urinary or umbilical)? Describe: \_\_\_\_\_ [ ] Yes  No
  - (iv) Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion?..... [ ] Yes  No
  - (v) Injection of radioisotopes and/or use of irradiated substances? Describe:..... [ ] Yes  No
  - (vi) Radiation therapy and/or chemotherapy? Describe: \_\_\_\_\_ [ ] Yes  No
  - (vii) Psychiatric shock therapy?..... [ ] Yes  No
  - (viii) Silicone injections? Describe: \_\_\_\_\_ [ ] Yes  No
  - (ix) Spinal anesthesia (other than saddle blocks or caudals)? ..... [ ] Yes  No
  - (x) Laser treatment? Describe: \_\_\_\_\_ [ ] Yes  No
  - (xi) Experimental procedures or research testing? Describe in detail on separate sheet. .... [ ] Yes  No
  - (xii) Hypnosis? Describe: \_\_\_\_\_ [ ] Yes  No
- b. Do you perform:
- (i) Norplant insertion/removals advise # yearly..... [ ] Yes  No
  - (ii) Surgery other than incision of superficial boils or suturing superficial fascia? ..... [ ] Yes  No
  - (iii) Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker? ..... [ ] Yes  No
  - (iv) Tonsillectomies and/or adenoidectomies and/or caesarean sections? [ ] Yes  No
  - (v) Cosmetic plastic surgery? Describe: \_\_\_\_\_ [ ] Yes  No
  - (vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles?..... [ ] Yes  No
  - (vii) Hysterectomies?..... [ ] Yes  No
  - (viii) Open reduction of fractures? Describe: \_\_\_\_\_ [ ] Yes  No
  - (ix) Surgery for weight reduction of patients? ..... [ ] Yes  No
  - (x) Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): \_\_\_\_\_ [ ] Yes  No
  - (xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: \_\_\_\_\_ [ ] Yes  No
  - (xii) Silicone implants? Describe: \_\_\_\_\_ [ ] Yes  No

- (xiii) Sterilization procedures? Describe: \_\_\_\_\_ [ ] Yes [X] No
- (xiv) Biopsies and/or endoscopies? List types performed: \_\_\_\_\_ [ ] Yes [X] No
- (xv) Sex change operations? Describe and advise number yearly: \_\_\_\_\_ [ ] Yes [X] No
- (xvi) Experimental surgery or surgical research? Describe in detail on separate sheet. \_\_\_\_\_ [ ] Yes [X] No
- (xvii) Other surgery? Describe: \_\_\_\_\_ [ ] Yes [X] No

- c. (i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? ..... [ ] Yes [X] No  
If yes, answer (ii) and (iii) below.
- (ii) List ALL surgical procedures performed (including minor surgery): \_\_\_\_\_
- (iii) Do you administer anesthesia (other than topical or local infiltration)? ..... [ ] Yes [X] No  
If yes, please attach detailed explanation.
- d. Do you perform hospital emergency room care for patients not your own? ..... [ ] Yes [X] No  
If yes, please attach explanation and also advise the number "patient contact" hours MONTHLY by you:  
(i) Emergency Room Physicians \_\_\_\_\_ hrs. (iii) Nurses \_\_\_\_\_ hrs.  
(ii) Paramedics \_\_\_\_\_ hrs. (iv) Other \_\_\_\_\_ hrs.
- e. Do you use drugs for weight reduction or patients? ..... [ ] Yes [ ] No  
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.
- f. Do you administer any methadone treatment? ..... [ ] Yes [X] No  
If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months \_\_\_\_\_; Next 12 months \_\_\_\_\_.
- g. Number of annual x-ray exposures: for diagnosis \_\_\_\_\_; for treatment \_\_\_\_\_.
- h. If x-ray treatment is given, what qualifications are required of the staff? \_\_\_\_\_
- i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity. .... [ ] Yes [X] No
- j. Attach detailed description of any additional activities and/or procedures which you performed.

**4. STAFF**

a. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE.

	<u>Employees and Volunteers</u>	<u>Independent Contractors</u>		<u>Employees and Volunteers</u>	<u>Independent Contractors</u>
(i) Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	<u>NONE</u>	<u>NONE</u>	(xi) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	<u>NONE</u>	<u>NONE</u>
(ii) Physicians: Minor surgery or obstetrical procedures not constituting major surgery	<u>NONE</u>	<u>NONE</u>	(xii) Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet	<u>NONE</u>	<u>NONE</u>
(iii) Proctologists, Ophthalmologists and Urologists	<u>NONE</u>	<u>NONE</u>	(xiii) Unlicensed Interns	<u>NONE</u>	<u>NONE</u>
(iv) General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	<u>NONE</u>	<u>NONE</u>	(xiv) Dentists (no oral surgery)	<u>NONE</u>	<u>NONE</u>
(v) Obstetrics-Gynecologists, Plastic Surgeons, and	<u>NONE</u>	<u>NONE</u>	(xv) Orthodontists	<u>NONE</u>	<u>NONE</u>



# Hidalgo County WIC Program Clinic Information Directory

LOCATION	PHONE	FAX	MODEM	CLINIC HOURS
Administrative Office - 1200 3105 W. University Drive Edinburg, Texas 78539 WIC Director: Norma Longoria, MS, LD	381-4632 381-4639 381-4646 381-8936 381-8556 381-9802 381-4640	380-4056 381-0297	381-8620	Mon. & Wed. 8:00am-5:30pm Tues. & Thurs. 8:00am-6:30pm Fri. 8:00am-5:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Edinburg WIC Clinic - 1201 3105 E. Richardson Edinburg, Texas 78539 Supervisor: Anabelle Ramirez, Nutr.	380-0363 380-0364 380-0908	316-3772	318-0453	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Mission WIC Clinic - 1202 211 South Schubach Mission, Texas 78572 Supervisor: Maritza Martinez, Nutr.	581-2723 581-2724 581-7517	584-8890	581-9768	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
McAllen WIC Clinic - 1203 300 East Hackberry McAllen, Texas 78501 Supervisor: Rosa Sepulveda, LVN	682-4580 682-4589 928-0138	686-9447	686-0005	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Pharr WIC Clinic - 1204 1903 North Fir Pharr, Texas 78577 Supervisor: Norma Flores, Nutr.	783-1151 783-1152 702-3385	702-2493	783-7251	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Hidalgo WIC Clinic - 1205 702 East Tejano Hidalgo, Texas 78557 Supervisor: Melissa Gonzalez, Nutr.	843-8151 843-8152	843-2324	843-2864	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Donna WIC Clinic - 1206 301 South 8 <sup>th</sup> Street Donna, Texas 78537 Supervisor: Cristina Gonzales, LVN	464-2251 464-2252 464-2082	464-9249	464-9882	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Weslaco WIC Clinic - 1207 1901 North Bridge Weslaco, Texas 78596 Supervisor: Joanna Rodriguez, Nutr.	968-0594 968-0595 447-8496	969-4433	969-2534	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm

LOCATION	PHONE	FAX	MODEM	CLINIC HOURS
Mercedes WIC Clinic - 1208 540 S. Texas Mercedes, Texas 78570 Supervisor: Dora Trevino, LVN	565-2603 565-2604 565-5049	565-3626	565-0761	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Elsa WIC Clinic - 1209 708 East Edinburg Street Elsa, Texas 78543 Supervisor: Sulema Cano, Nutr.	262-1324 262-1325 262-9085	262-7041	262-2620	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
La Joya WIC Clinic - 1210 204 West 2 <sup>nd</sup> Street La Joya, Texas 78560 Supervisor: Larry Hinojosa, Nutr.	585-9707 585-9708	584-8897	581-9947	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Las Milpas WIC Clinic - 1211 7013 S. Cage, Suite F Pharr, Texas 78577 Supervisor: Claudia De La Rosa, Nutr.	787-0994 787-4190	787-1023	787-4704	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Progreso WIC Clinic - 1212 510 N. FM 1015 Progreso, Texas 78579 Supervisor: Rudi Zapata, MS, RD	514-0236 514-0237	565-3656	514-0238	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Alton WIC Clinic - 1214 3509 E. Main Ave., Suite 104 Alton, Texas 78573 Supervisor: Sandra Sepulveda, Nutr.	519-7159 519-7160 581-1735	519-8551	519-7161	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Alamo WIC Clinic - 1215 313 E. Business 83, Suite 113 Alamo, Texas 78516 Supervisor: Michelle Flores, Nutr.	783-5369 783-5465 783-2192	702-2452	783-5471	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Sullivan City WIC Clinic - 1216 371 E. Expressway 83 Sullivan City, Texas 78595 Supervisor: Larry Hinojosa, Nutr.	485-2752 485-2758	485-9047	485-2615	Mon. 8:00am-5:30pm 1 <sup>st</sup> Tues. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. 9:00am-6:30pm Wed. - Sat. Closed

LOCATION	PHONE	FAX	MODEM	CLINIC HOURS
Mission WIC Clinic II - 1217 722 N. Breyfogle, Suite 2-C Mission, Texas 78572 Supervisor: Elma Garza, LVN	584-3334 584-3335 584-3409	584-9244	584-3327	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
McAllen WIC Clinic II - 1218 220 S. Bicentennial, Suite D McAllen, Texas 78501 Supervisor: Linda Treviño, RD, LD	972-0554 972-0432 972-0474	668-1226	972-0527	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Edinburg WIC Clinic II - 1219 113 Dawson Edinburg, Texas 78539 Supervisor: Gloria Vela, LVN	316-1434 316-1479 316-1484	316-1394	316-1346	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Pharr WIC Clinic II - 1224 926 West Sam Houston, Suite 3 Pharr, Texas 78577 Supervisor: Cindy Hoots, Nutr.	781-4920 781-4921	781-4905	781-4915	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
San Carlos WIC Clinic - 1226 230 North 86 <sup>th</sup> Street Edinburg, Texas 78539 Supervisor: Carmen Peña, LVN	318-1476 318-1493	318-1609	318-1564	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Weslaco WIC Clinic II - 1227 417 South Oregon Avenue Weslaco, Texas 78596 Supervisor: Teresa Sanchez, Nutr.	968-3516 968-3548	968-3744	968-8321	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Mobile WIC Clinic - 1228 Supervisor: Rosalinda Diaz, LVN	279-7850 720-1796			Mondays-Fridays 9:00am-12:00pm 1:00pm-4:00pm Closed for Lunch 12:00pm-1:00pm
North San Juan WIC Clinic - 1229 509 Earling Road San Juan, Texas 78589 Supervisor: Kismeth Leal, Nutr.	702-7788 783-7878 783-7879	702-7740	702-7863	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm

LOCATION	PHONE	FAX	MODEM	CLINIC HOURS
McAllen WIC Clinic III - 1230 3001 North 23 <sup>rd</sup> Street, Suite 8 McAllen, Texas 78502 Supervisor: Christine Contreras, Nutr.	683-1822 664-2697	664-2392	664-2037	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Alton WIC Clinic II - 1231 3519 W. Main Avenue, Suite B Mission, Texas 78574 Supervisor: Fred Martinez II, Nutr.	583-5791 583-9709 583-9732	583-4681	583-3981	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Rio Grande City WIC Clinic – 1243 604 N. Garza St. Rio Grande City, Texas 78582 Supervisor: Adabel Hinojosa, Nutr.	488-0500 488-8320 488-8324	488-8356	488-8352	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Roma WIC Clinic – 1244 1505 N. Grant St., Ste. 1 & 2 Roma, Texas 78584 Supervisor: Emilia Flores, Nutr.	849-1459 849-1460	849-1453	849-1470	Mon. & Wed. 8:00am-5:30pm 1 <sup>st</sup> Tues. & Thurs. 8:30am-6:30pm 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Tues. & Thurs. 9:00am-6:30pm 1 <sup>st</sup> Fri. Closed 2 <sup>nd</sup> , 3 <sup>rd</sup> & 4 <sup>th</sup> Fri. 8:00am-3:00pm 1 <sup>st</sup> Sat. 8:00am-1:00pm
Alamo WIC Clinic II – 1245 1429 S. Tower Rd. Alamo, Texas 78516 Supervisor: Oscar Zamora, Nutr.	784-3523	702-7097	702-3334	Mondays – Fridays 8:00am-5:00pm

Otolaryngologists doing plastic surgery

	Employees and <u>Volunteers</u>	Independent <u>Contractors</u>		Employees and <u>Volunteers</u>	Independent <u>Contractors</u>
(vi) Oral Surgeons	_____	_____	(xvi) Podiatrists	_____	_____
(vii) Nurse Anesthetists	_____	_____	(xvii) Chiropractors	_____	_____
(viii) Optometrists, Opticians	_____	_____	(xviii) RN, LPNs IBCLC	<u>1</u>	_____
(ix) Pharmacists	_____	_____	(xix) Other <u>Dietitians</u>	<u>10</u>	_____
(x) Perfusionists	_____	_____	(xx) <u>Nutritionists</u>	<u>19-LVN-19</u>	_____

NOTE: If you require any of the above to be Named Insureds, please submit separate application for each such individual

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation?..[  ] Yes [  ] No  
If no, please attach explanation. **Nutritionist don't need to be licensed**

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

- (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association?.....[  ] Yes [  ] No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?.....[  ] Yes [  ] No
- (iii) Ever been treated for alcoholism or drug addiction?.....[  ] Yes [  ] No
- (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? .....[  ] Yes [  ] No
- (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?.....[  ] Yes [  ] No

d. Do you supervise any individual other than your own employees? .....[  ] Yes [  ] No  
If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals. \_\_\_\_\_

Also, indicate by profession the number of individuals supervised.

<u>Number</u>	<u>Type of Profession</u>	<u>Number</u>	<u>Type of Profession</u>
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technician	_____	_____

**5. REVENUES**

a. Please state sources and amounts of total revenue:

<u>Source</u>	<u>This Fiscal Year 2009</u>	<u>Next Fiscal Year 2010</u>
(i) Charitable Contributions	\$ _____	\$ _____
(ii) Government Funding	\$ <u>9.5 Million</u>	\$ <u>10.5 Million</u>
(iii) Fee for Service	\$ _____	\$ _____
(iv) Other _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

b. Please provide number of outpatient visits:

<u>Type of Visit</u>	<u>Last 12 Months</u>	<u>Next 12 Months</u>
Clinics	<u>924,641</u>	<u>952,641</u>
Laboratory	_____	_____
Emergency Room	_____	_____
_____	_____	_____
TOTAL NO. OF VISITS	<u>924,641</u>	<u>952,641</u>

c. If you have a training school, please complete the following. Attach separate schedule if needed.

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 Faculty	Qualifications of Faculty (i.e., MD, RN, PhD., etc.)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**6. AFFILIATIONS**

- a. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients?.....[ ] Yes [X] No  
If yes, please attach detailed explanation and a copy of ALL of the advertisements.
- b. Are you employed by any individual or entity other than that shown in Question 1(a)?.....[ ] Yes [X] No  
If yes, please attach explanation.
- c. Are you under contract to any individual or entity other than that shown in Question 1(a)?.....[ ] Yes [X] No  
If this contract contains a hold-harmless agreement, copy of contract must be attached.
- d. Are you in the employ of or under contract to any federal governmental entity?.....[ ] Yes [X] No

**7. HISTORY/CLAIMS**

- a. Has any claim or suit been brought against you and/or any of your employees? .....[ ] Yes [X] No  
If yes, a supplemental claim information form must be completed for each claim or suit.
- b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees?.....[ ] Yes [X] No  
If yes, please give details on separate sheet.
- c. Please list general liability insurance carried for each of the past three years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retro Date
							Yes	No	
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.

Hidalgo County  
Name of Applicant

Executive Officer for Comm. Court  
Title (Officer, partner, etc.)

Valde Guerra  
Signature of Applicant

\_\_\_\_\_  
Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one of this application will be attached to the policy, if issued.

**Health & Human Services Dept**



**SHAND MORAHAN  
MARKEL & COMPANY, INC.**  
Ten Parkway North, Deerfield, IL 60015  
(847) 572-6000 Fax (847) 572-6137  
Underwriting Manager  
Markel Company

- o DEERFIELD INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
- o MARKEL INSURANCE COMPANY

**APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.)  
PROFESSIONAL LIABILITY INSURANCE**  
(Claims Made Basis)

**APPLICANT'S INSTRUCTIONS:**

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.  
(PLEASE TYPE OR PRINT IN INK)

**1. APPLICANT INFORMATION**

- a. Full name of Applicant: Hidalgo County Health and Human Services Department
- b. Principal business premise address: 1304 S. 25th Avenue Hidalgo  
(Street) (County)  
Edinburg Texas 78542  
(City) (State) (Zip)
- c.  Professional Corporation (for profit)  Partnership  
 Professional Corporation (non-profit)  Professional Association  
 Other (describe) Local Health Dept.
- d. Date established: 1950
- e. Number of Employees: Full time 173 Part time 0 Seasonal 0 Total \_\_\_\_\_
- f. Business, corporate or partnership name: N/A
- g. Name of all partners or members of the firm who provide professional services: NA
- h. Professional societies or associations in which you are a member: NA
- i. Please attach a copy of letterhead or other business stationery.

**2. OPERATIONS**

- a. States Clinics are registered and licensed to practice: Texas  
If none, please explain.
- b. Clinics professional specialty: Preventive Health Services (prenatal, family Planning, child health, immunizations, communicable Disease Surveillance and TB.)
- c. Do you maintain any beds for overnight occupancy?  Yes  No. If yes, also complete application form SM 5864 or SM 686. NA
- d. Total sq. ft. that you occupy (all locations): 69233 Sq Feet!
- e. Division of patients or clients:
- |                                  |                             |  |
|----------------------------------|-----------------------------|--|
| (i) Hemodialysis _____ %         | (vii) Psychiatric _____ %   | (xiii) <del>Perinatal</del> <b>Immunizations</b> <u>40</u> % |
| (ii) Holistic Medicine _____ %   | (viii) Drug Addicts _____ % | (xiv) Physical Rehabilitation _____ %                        |
| (iii) Surgical _____ %           | (ix) Alcoholics _____ %     | (xv) Disability Evaluation _____ %                           |
| (iv) Stress Testing _____ %      | (x) Obstetrical _____ %     | (xvi) Research or Experimental _____ %                       |
| (v) Communicable <u>10</u> %     | (xi) Dental _____ %         | (xvii) Other <u> prenatal </u> <u>20</u> %                   |
| (vi) Family Planning <u>20</u> % | (xii) Pediatric <u>10</u> % | <u>100%</u>  |

- f. Does Clinic use a collection agency? .....[ ] Yes [x] No  
If yes, name of agency: \_\_\_\_\_  
Does the agency have authority to file a collection suit on Clinics behalf?.....[ ] Yes [x] No
- g. Do owners, partners or directors, (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?.....[ ] Yes [x] No  
If yes, give details including name, location, size and number of beds. \_\_\_\_\_
- h. Do you own or operate any business other than that shown in question 1a? .....[ ] Yes [x] No  
If yes, please attach detailed explanations of this activity.
- i. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? .....[x] Yes [ ] No  
If yes, please attach a copy of ALL of the advertisements.
- j. Names and locations of any hospitals or institutions Clinic use is in practice: Edinburg Health Clinic; Elsa Health Clinic; Weslaco Health Clinic; Pharr Health Clinic; McAllen Health Clinic; Mission Health Clinic; Hidalgo Health Clinic; Pulmonary Edinburg.
- k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [x] Yes [ ] No  
If yes,  
(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?.....[x] Yes [ ] No  
(ii) Provide the name and title of the Applicant's Privacy Officer. Valde Guerra  
Our Business Associate Agreement is available at [www.shand.com](http://www.shand.com) or by fax by calling (847) 572-6268 (Form No ZZ50002). This is the only Business Associate Agreement we will recognize.

**3. PROFESSIONAL SERVICES**

- a. Do you perform:
  - (i) Acupuncture or acupuncture anesthesia? Explain: \_\_\_\_\_ [ ] Yes [x] No
  - (ii) Angiography/arteriography/venography? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (iii) Catheterization (other than urinary or umbilical)? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (iv) Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion?.....[ ] Yes [x] No
  - (v) Injection of radiolotopes and/or use of irradiated substances? Describe:.....[ ] Yes [x] No
  - (vi) Radiation therapy and/or chemotherapy? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (vii) Psychiatric shock therapy?.....[ ] Yes [x] No
  - (viii) Silicone Injections? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (ix) Spinal anesthesia (other than saddle blocks or caudals)? .....[ ] Yes [x] No
  - (x) Laser treatment? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (xi) Experimental procedures or research testing? Describe in detail on separate sheet.....[ ] Yes [x] No
  - (xii) Hypnosis? Describe: \_\_\_\_\_ [ ] Yes [x] No
- b. Do you perform:
  - (i) Norplant Insertion/removals advise # yearly.....[ ] Yes [x] No
  - (ii) Surgery other than incision of superficial boils or suturing superficial fascia? .....[ ] Yes [x] No
  - (iii) Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker? .....[ ] Yes [x] No
  - (iv) Tonsillectomies and/or adenoidectomies and/or caesarean sections? [ ] Yes [x] No
  - (v) Cosmetic plastic surgery? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles?.....[ ] Yes [x] No
  - (vii) Hysterectomies?.....[ ] Yes [x] No
  - (viii) Open reduction of fractures? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (ix) Surgery for weight reduction of patients? .....[ ] Yes [x] No
  - (x) Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): \_\_\_\_\_ [ ] Yes [x] No
  - (xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: \_\_\_\_\_ [ ] Yes [x] No
  - (xii) Silicone implants? Describe: \_\_\_\_\_ [ ] Yes [x] No

- (xiii) Sterilization procedures? Describe: \_\_\_\_\_ [ ] Yes [x]
- (xiv) Biopsies and/or endoscopies? List types performed: \_\_\_\_\_ [ ] Yes [x]
- (xv) Sex change operations? Describe and advise number yearly: \_\_\_\_\_ [ ] Yes [x]
- (xvi) Experimental surgery or surgical research? Describe in detail on separate sheet. .... [ ] Yes [x]
- (xvii) Other surgery? Describe: \_\_\_\_\_ [ ] Yes [x]

c. (i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? ..... [ ] Yes [x]  
If yes, answer (ii) and (iii) below.

(ii) List ALL surgical procedures performed (including minor surgery): NA

(iii) Do you administer anesthesia (other than topical or local infiltration)? ..... [ ] Yes [x]  
If yes, please attach detailed explanation.

d. Do you perform hospital emergency room care for patients not your own? ..... NA ..... [ ] Yes [ ]  
If yes, please attach explanation and also advise the number "patient contact" hours MONTHLY by you:

(i) Emergency Room Physicians \_\_\_\_\_ hrs. (iii) Nurses \_\_\_\_\_ hr  
(ii) Paramedics \_\_\_\_\_ hrs. (iv) Other \_\_\_\_\_ hr

e. Do you use drugs for weight reduction or patients? ..... NA ..... [ ] Yes [x]  
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.

f. Do you administer any methadone treatment? ..... NA ..... [ ] Yes [x]  
If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months \_\_\_\_\_; Next 12 months \_\_\_\_\_.

g. Number of annual x-ray exposures: for diagnosis 2500; for treatment of Tuberculosis

h. If x-ray treatment is given, what qualifications are required of the staff? NA

i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity. .... [ ] Yes [x]

j. Attach detailed description of any additional activities and/or procedures which you performed. NA

**4. STAFF**

a. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE.

	Employees and Volunteers	Independent Contractors		Employees and Volunteers	Independent Contractors
(i) Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	<u>0</u>	<u>1</u>	(xi) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	<u>0</u>	<u>0</u>
(ii) Physicians: Minor surgery or obstetrical procedures not constituting major surgery	<u>0</u>	<u>0</u>	(xii) Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet	<u>0</u>	<u>0</u>
(iii) Proctologists, Ophthalmologists and Urologists	<u>0</u>	<u>0</u>	(xiii) Unlicensed Interns	<u>0</u>	<u>0</u>
(iv) General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	<u>0</u>	<u>0</u>	(xiv) Dentists (no oral surgery)	<u>0</u>	<u>0</u>
(v) Obstetrics-Gynecologists, Plastic Surgeons, and	<u>0</u>	<u>0</u>	(xv) Orthodontists	<u>0</u>	<u>0</u>

Otolaryngologists doing plastic surgery

	Employees and Volunteers	Independent Contractors		Employees and Volunteers	Independent Contractor
(vi) Oral Surgeons	0	0	(xvi) Podiatrists	0	0
(vii) Nurse Anesthetists	0	0	(xvii) Chiropractors	0	0
(viii) Optometrists, Opticians	0	0	(xviii) RN, LPNs	35	0
(ix) Pharmacists	0	0	(xix) Other <u>Nurse</u>	2	2
(x) Perfusionists			(xx) <u>Practitioners</u>		

NOTE: If you require any of the above to be Named Insureds, please submit separate application for each such individual

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation?  Yes  No  
If no, please attach explanation.

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

- (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association?.....  Yes  No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?.....  Yes  No
- (iii) Ever been treated for alcoholism or drug addiction?.....  Yes  No
- (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?.....  Yes  No
- (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?.....  Yes  No

d. Do you supervise any individual other than your own employees?.....  Yes  No  
If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals. \_\_\_\_\_

Also, indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
<u>1</u>	Physicians	_____	_____
<u>2</u>	X-ray Technicians	_____	_____
<u>0</u>	Laboratory Technician	_____	_____

**5. REVENUES**

a. Please state sources and amounts of total revenue:

Source	This Fiscal Year	Next Fiscal Year
(i) Charitable Contributions	\$ <u>-0-</u>	\$ <u>- 0-</u>
(ii) Government Funding	\$ <u>2,653,321.00</u>	\$ <u>2,378,488.00</u>
(iii) Fee for Service	\$ <u>270,498.00</u>	\$ <u>270,498.00</u>
(iv) Other _____	\$ <u>5,690,373.00</u>	\$ <u>6,387,517.00</u>
<b>TOTAL GROSS REVENUE</b>	\$ <u>8,614,192.00</u>	\$ <u>9,036,503.00</u>

b. Please provide number of outpatient visits:

Type of Visit	Last 12 Months	Next 12 Months
Clinics	<u>57267</u>	<u>57267</u>
Laboratory	<u>28,533</u>	<u>28,533</u>
Emergency Room	<u>0</u>	<u>0</u>
_____	_____	_____
<b>TOTAL NO. OF VISITS</b>	_____	_____

c. If you have a training school, please complete the following. Attach separate schedule if needed. NA

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 Faculty	Qualifications of Faculty (i.e., MD, RN, PhD., etc.)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**6. AFFILIATIONS**

- a. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? ..... [ ] Yes [x] No  
If yes, please attach detailed explanation and a copy of ALL of the advertisements.
- b. Are you employed by any individual or entity other than that shown in Question 1(a) ? ..... [ ] Yes [x] No  
If yes, please attach explanation.
- c. Are you under contract to any individual or entity other than that shown in Question 1(a)? ..... [ ] Yes [x] No  
If this contract contains a hold-harmless agreement, copy of contract must be attached.
- d. Are you in the employ of or under contract to any federal governmental entity? ..... [ ] Yes [x] No

**7. HISTORY/CLAIMS**

- a. Has any claim or suit been brought against you and/or any of your employees? ..... [ ] Yes [x] No  
If yes, a supplemental claim information form must be completed for each claim or suit.
- b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? ..... [ ] Yes [x] No  
If yes, please give details on separate sheet.
- c. Please list general liability insurance carried for each of the past three years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retro Date
							Yes	No	
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title (Officer, partner, etc.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

# **Adult Detention Facility**



- f. Does Clinic use a collection agency? .....[  Yes  No  
 If yes, name of agency: \_\_\_\_\_  
 Does the agency have authority to file a collection suit on Clinics behalf?.....[  Yes  No
- g. Do owners, partners or directors, (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?.....[  Yes  No  
 If yes, give details including name, location, size and number of beds. \_\_\_\_\_
- h. Do you own or operate any business other than that shown in question 1a? .....[  Yes  No  
 If yes, please attach detailed explanations of this activity.
- i. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? .....[  Yes  No  
 If yes, please attach a copy of ALL of the advertisements.
- j. Names and locations of any hospitals or institutions Clinic use is in practice: \_\_\_\_\_  
 See Attached
- k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [  ] Yes [  ] No  
 If yes,  
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .....<sup>x</sup> [  ] Yes [  ] No  
 (ii) Provide the name and title of the Applicant's Privacy Officer, Sylvia Sinder, RN  
 Our Business Associate Agreement is available at [www.shand.com](http://www.shand.com) or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

### 3. PROFESSIONAL SERVICES

- a. Do you perform:
- (i) Acupuncture or acupuncture anesthesia? Explain: \_\_\_\_\_ ....[  Yes  No  
 (ii) Angiography/arteriography/venography? Describe: \_\_\_\_\_ ....[  Yes  No  
 (iii) Catheterization (other than urinary or umbilical)? Describe: \_\_\_\_\_ ....[  Yes  No  
 (iv) Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion?.....[  Yes  No  
 (v) Injection of radioisotopes and/or use of irradiated substances? Describe: ..... [  Yes  No
- (vi) Radiation therapy and/or chemotherapy? Describe: \_\_\_\_\_ ....[  Yes  No  
 (vii) Psychiatric shock therapy? ..... [  Yes  No  
 (viii) Silicone Injections? Describe: \_\_\_\_\_ ....[  Yes  No  
 (ix) Spinal anesthesia (other than saddle blocks or caudals)? ..... [  Yes  No  
 (x) Laser treatment? Describe: \_\_\_\_\_ ....[  Yes  No  
 (xi) Experimental procedures or research testing? Describe in detail on separate sheet. .... [  Yes  No  
 (xii) Hypnosis? Describe: \_\_\_\_\_ ....[  Yes  No
- b. Do you perform:
- (i) Norplant insertion/removals advise # yearly ..... [  Yes  No  
 (ii) Surgery other than incision of superficial boils or suturing superficial fascia? ..... [  Yes  No  
 (iii) Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker? ..... [  Yes  No  
 (iv) Tonsillectomies and/or adenoidectomies and/or caesarean sections? [  Yes  No  
 (v) Cosmetic plastic surgery? Describe: \_\_\_\_\_ .... [  Yes  No  
 (vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles?..... [  Yes  No  
 (vii) Hysterectomies? ..... [  Yes  No  
 (viii) Open reduction of fractures? Describe: \_\_\_\_\_ .... [  Yes  No  
 (ix) Surgery for weight reduction of patients? ..... [  Yes  No  
 (x) Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): \_\_\_\_\_ .... [  Yes  No  
 (xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: \_\_\_\_\_ .... [  Yes  No  
 (xii) Silicone implants? Describe: \_\_\_\_\_ [  Yes  No

- (xiii) Sterilization procedures? Describe: \_\_\_\_\_ ....[ ] Yes [x] No  
 (xiv) Biopsies and/or endoscopies? List types performed: \_\_\_\_\_ ....[ ] Yes [x] No  
 (xv) Sex change operations? Describe and advise number yearly: \_\_\_\_\_ ....[ ] Yes [x] No  
 (xvi) Experimental surgery or surgical research? Describe in detail on separate sheet. ....[ ] Yes [x] No  
 (xvii) Other surgery? Describe: \_\_\_\_\_ ....[ ] Yes [x] No

- c. (i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? .....[ ] Yes [x] No  
 If yes, answer (ii) and (iii) below.  
 (ii) List ALL surgical procedures performed (including minor surgery): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (iii) Do you administer anesthesia (other than topical or local infiltration)? .....[ ] Yes [x] No  
 If yes, please attach detailed explanation.  
 d. Do you perform hospital emergency room care for patients not your own? .....[ ] Yes [x] No  
 If yes, please attach explanation and also advise the number "patient contact" hours MONTHLY by you:  
 (i) Emergency Room Physicians \_\_\_\_\_ hrs. (iii) Nurses \_\_\_\_\_ hrs.  
 (ii) Paramedics \_\_\_\_\_ hrs. (iv) Other \_\_\_\_\_ hrs.  
 e. Do you use drugs for weight reduction or patients? .....[ ] Yes [x] No  
 If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.  
 f. Do you administer any methadone treatment? in cases or pregnancies ordered by doctor .....[x] Yes [ ] No  
 If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months 2; Next 12 months \_\_\_\_\_.  
 g. Number of annual x-ray exposures: for diagnosis NA; for treatment \_\_\_\_\_.  
 h. If x-ray treatment is given, what qualifications are required of the staff? NA  
X-Rays administered by Hidalgo Health Dept.  
 i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity.....[ ] Yes [x] No  
 j. Attach detailed description of any additional activities and/or procedures which you performed.

**4. STAFF**

a. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE.

	Employees and <u>Volunteers</u>	Independent <u>Contractors</u>		Employees and <u>Volunteers</u>	Independent <u>Contractors</u>
(i) Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	<u>0</u>	<u>2</u>	(xi) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	<u>0</u>	<u>0</u>
(ii) Physicians: Minor surgery or obstetrical procedures not constituting major surgery	<u>0</u>	<u>0</u>	(xii) Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet	<u>0</u>	<u>2</u>
(iii) Proctologists, Ophthalmologists and Urologists	<u>0</u>	<u>0</u>	(xiii) Unlicensed Interns	<u>0</u>	<u>0</u>
(iv) General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	<u>0</u>	<u>0</u>	(xiv) Dentists (no oral surgery)	<u>0</u>	<u>0</u>
(v) Obstetrics-Gynecologists, Plastic Surgeons, and	<u>0</u>	<u>0</u>	(xv) Orthodontists	<u>0</u>	<u>0</u>

Otolaryngologists doing plastic surgery

	Employees and			Employees and	
	Volunteers	Contractors		Volunteers	Contractors
(vi) Oral Surgeons	0	0	(xvi) Podiatrists	0	0
(vii) Nurse Anesthetists	0	0	(xvii) Chiropractors	12	0
(viii) Optometrists, Opticians	0	0	(xviii) RN, LPNs	7	0
(ix) Pharmacists	0	0	(xix) Other Medical Asst		
(x) Perfusionists			(xx)		

NOTE: If you require any of the above to be Named Insureds, please submit separate application for each such Individual.

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation? .. Yes  No  
If no, please attach explanation.

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

- (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association?..... Yes  No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... Yes  No
- (iii) Ever been treated for alcoholism or drug addiction?..... Yes  No
- (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ..... Yes  No
- (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?..... Yes  No

d. Do you supervise any individual other than your own employees? ..... Yes  No  
If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals. \_\_\_\_\_

Also, indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technician	_____	_____

**5. REVENUES**

a. Please state sources and amounts of total revenue:

Source	This Fiscal Year	Next Fiscal Year
(i) Charitable Contributions	\$ 0	\$ 0-
(ii) Government Funding	\$ 1,271,019	\$ _____
(iii) Fee for Service	\$ 0	\$ 0
(iv) Other _____	\$ 0	\$ 0
<b>TOTAL GROSS REVENUE</b>	<b>\$ 1,271,019</b>	<b>\$ 2,033,777</b>

b. Please provide number of outpatient visits:

Type of Visit	Last 12 Months	Next 12 Months
Clinics	68,933	_____
Laboratory	1,115	_____
Emergency Room	210	_____
_____	_____	_____
Inmate Screening	18,078	_____
<b>TOTAL NO. OF VISITS</b>	<b>88,336</b>	<b>5% increase depending on jail population for 2010</b>

c. If you have a training school, please complete the following. Attach separate schedule if needed.

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 Faculty	Qualifications of Faculty (i.e., MD, RN, PhD., etc.)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**6. AFFILIATIONS**

- a. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients?.....[  Yes  No  
If yes, please attach detailed explanation and a copy of ALL of the advertisements.
- b. Are you employed by any individual or entity other than that shown in Question 1(a)?.....[  Yes  No  
If yes, please attach explanation.
- c. Are you under contract to any individual or entity other than that shown in Question 1(a)?.....[  Yes  No  
If this contract contains a hold-harmless agreement, copy of contract must be attached.
- d. Are you in the employ of or under contract to any federal governmental entity?.....[  Yes  No

**7. HISTORY/CLAIMS**

- a. Has any claim or suit been brought against you and/or any of your employees? <sup>no known claims</sup>.....[  Yes  No  
If yes, a supplemental claim information form must be completed for each claim or suit.
- b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? <sup>no known claims</sup>.....[  Yes  No  
If yes, please give details on separate sheet.
- c. Please list general liability insurance carried for each of the past three years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retro Date
							Yes	No	
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____

\* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.

Valde Guerra  
Name of Applicant

Executive Officer for Commissioner's Court  
Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

## **Kidnap & Extortion**



ace usa

# RENEWAL Application for Kidnap & Extortion Insurance

Please read carefully, fully answer all questions below and submit all requested information. This Application, including all materials submitted herewith, shall be held in confidence.

1. a. The Company to be listed as Named Insured in Item 1 of the Declarations (the "Company"):  
Hidalgo County, Texas  
 Street Address: P.O. Box 1356  
 City: Edinburg, Texas State: Texas Zip Code: 78540
- b. Officer designated to receive correspondence and notices from the Insurer:  
Valde Guerra Executive Officer  
 (Name of Officer) (Title)
- c. Website Address: www.co.hidalgo.tx.us/

2. Has there been any change in the nature of your business since last renewal?  Yes  No  
 If "YES", please describe below.
- \_\_\_\_\_
- \_\_\_\_\_

3. Total Worldwide Revenues (attach latest annual report if applicable): \$ N/A  
 Please note, revenues must be in excess of limits of liability requested.

4. a. Total Worldwide Employees: N/A Check if US/Canada only:   
 # In US/Canada: \_\_\_\_\_ # outside US/Canada: \_\_\_\_\_
- b. Have there been any changes since last renewal with regard to foreign locations?  Yes  No  
 If "YES", please describe below.

Country	City	Number of Employees	Number of Directors & Officers

c. Have there been any changes since last renewal with regard to foreign travel or planned travel?  Yes  No  
 If "YES", please describe below.

Country	City	Number of Employees	Frequency of trips.	Avg. Duration

5. Has there been any change in prevention or security measures taken for employees located or traveling outside the US/Canada since last renewal?  Yes  No  
 If "YES", please describe below.

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**TO BE COMPLETED BY ALL APPLICANTS**

None of the Insureds is responsible for or has knowledge of any incident or fact, circumstance or situation which (s)he has reason to suppose might give rise to a claim or loss under this Policy, except as follows:

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If "NONE", please check this box

It is agreed by all concerned that if any of the Insureds is responsible for or has knowledge of any fact, circumstance, or situation which (s)he has reason to suppose might give rise to a claim or loss under this Policy, whether or not described above, any such claim or loss subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

This Renewal Application shall be maintained on file by the Insurer, shall be deemed attached as if physically attached to the proposed Policy and shall be considered as incorporated into and constituting a part of the proposed Policy.

The persons signing this Renewal Application declare that to the best of their knowledge the statements set forth herein and the information in the materials submitted herewith are true and correct and that reasonable efforts have been made to obtain sufficient information from all Insureds to facilitate the proper and accurate completion of this Application for the proposed Policy. Signing of this Renewal Application does not bind the undersigned to purchase the insurance, but it is agreed that this Renewal Application shall be the basis of the contract should a Renewal Policy be issued. The undersigned agrees that if after the date of this Renewal Application and prior to the effective date of any Renewal Policy based on this Renewal Application, any occurrence, event or other circumstance should render any of the information contained in this Renewal Application inaccurate or incomplete, then the undersigned shall notify the Insurer of such occurrence, event or circumstance and shall provide the Insurer with information that would complete, update or correct such information. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Insurer.

The information requested in this Renewal Application is for underwriting purposes only and does not constitute notice to the Insurer under any Policy of a claim or potential claim. All such notices must be submitted to the Insurer pursuant to the terms of the Policy, if and when issued.

**NOTICE TO ARKANSAS APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO COLORADO APPLICANTS:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. 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.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW MEXICO APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS:** 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 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 TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO TENNESSEE APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NOTICE TO WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

**NOTICE TO ALL OTHER APPLICANTS:**

**ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF**

MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE INSURER THAT ALL STATEMENTS MADE IN THIS APPLICATION ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED IN THIS APPLICATION OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT'S ACCEPTANCE OF THE INSURER'S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

This portion of the application must be signed by an officer of the company.

Signed:

*V. J. [unclear]*

Title:

*Executive Director*

Corporation:

*Hidalgo County, Texas*

Date:

A POLICY CANNOT BE ISSUED UNLESS THE APPLICATION IS PROPERLY SIGNED AND DATED.

Please submit this Application, when completed, signed and dated to:

ACE USA Specialty Risk  
K & E Division  
1133 Avenue of the Americas  
38<sup>th</sup> Floor  
New York, NY 10036

# **Pollution Liability**

**COMBINED UST/AST**

The information collected in this worksheet will be utilized to complete an on-line application on your behalf.

**Instructions:**

- Please type or print clearly.
- Answer ALL questions completely, leaving no blanks.
- Check Yes or No answers.
- Complete Facility/Storage Tank Inventory Supplemental Worksheets (1 AST/1 UST for each Facility where applicable)
- This form must be completed, dated and signed by a principal of your Company.

Insured's Name: Hidalgo County

Address: PO Box 1356

City: Edinburg Risk Location: 701 E. El Cibolo, Edinburg, TX, 7854  
711 E. El Cibolo

State: TX

Country: United States

ZIP: 78540

Telephone #: 956-318-2644

Email Address: roy.quintanilha@co.hidalgo.tx.us

Is the Insured purchasing this coverage to satisfy financial responsibility requirements?  YES  NO

Any Additional Insureds to be listed on the Policy?  
(If yes, please identify the Additional Insured's here.):  YES  NO

Are any of the Insureds facilities located in the State of Florida?  YES  NO

Effective Date of Coverage 01/01/2010 (Expiration Date will be 1 year from effective date)

Retroactive Date \_\_\_\_\_ (max 10 year prior to desired effective date)

**Policy Limits (per Incident/aggregate all incidents):**

UST Limits: Per Incident  \$1,000,000  \$2,000,000  
Aggregate  \$1,000,000  \$2,000,000

AST Limits: Per Incident  \$1,000,000  \$2,000,000  
Aggregate  \$1,000,000  \$2,000,000

Per Incident Deductible:  \$2,500  
 \$5,000  
 \$10,000  
 \$25,000

Total Number of Facilities with Storage Tanks to be covered under this Policy 2

Total Number of USTs to be covered under this Policy

2

Total Number of ASTs to be covered under this Policy

4

1. Does any insured to be covered under this proposed insurance currently have any plans to remove or close any scheduled storage tanks at any of the facilities for which coverage will be sought under this policy?  YES  NO
2. Are all of your storage tanks compliant with all applicable Federal, State, and local regulations?  YES  NO
3. Within the past five (5) years have any claims been made or legal actions (including any regulatory proceedings) been brought against any insured to be covered under this proposed insurance with respect to storage tanks or any other pollution conditions at any of the facilities where the storage tanks the insured(s) is (are) seeking coverage for are located?  YES  NO
4. Does the applicant have knowledge of pollution conditions actionable under current State or Federal regulations at any of the facilities where the tanks for which you are seeking coverage are located?  YES  NO
5. Within the past five (5) years, is any insured to be covered under this proposed insurance aware of any failed tank/piping integrity tests or any other negative monitoring system data for any of the storage tanks the insured(s) is (are) seeking coverage for?  YES  NO
6. At the time of signing this application, is any insured aware of any circumstances that may reasonably be expected to give rise to a claim against any insured?  YES  NO

By signing below, the undersigned warrants and represents to the insurer that the information contained in this application worksheet as well as the Facility/Storage Tank Inventory Supplemental Worksheet(s) attached hereto are true and correct, and that the undersigned has exercised its best efforts in verifying the accuracy of the information. The undersigned hereby acknowledges that the information contained herein is material to the decision of the insurance company to issue a policy, and that the issuance of a policy by the insurer is in reliance upon the sufficiency and accuracy of this information.

Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act. Such an act is a crime and subjects such person to criminal and civil penalties.

Signature of Authorized Applicant X
Print Name Valde Guerra
Title Executive Officer for Commissioner's Court
Date



# ACE Tanksafe<sup>SM</sup>

quote no. \_\_\_\_\_

Facility Name: Hidalgo County

Block Large 18B  
Address: 701 E. El Cibolo

ZIP: 78539

Facility ID #: 0077407

(leave blank if not applicable)

Type of Facility?  Gas station  Convenience store  Marina  Airport  Industrial  Fuel Storage/Transfer  ALL OTHER FACILITY TYPES

Do you have an SPCC for this Facility?  Yes  No

Loss History Information for this Facility:

- No pollution related clean-ups or 3rd party claims at this facility in past 10 years
- Pollution at facility in past 10 years, resolved with regulatory closure

Do you utilize a 3rd party Engineering firm to provide Compliance Management Services for this Facility?  Yes  No

Facility No. 2 of 2

No. of ASTs at this facility: 4

City: Edinburg

Tank #1 & #2

State: Texas

USA

## Storage Tank Liability Coverage

### Facility/Storage Tank Inventory

### AST Supplemental Worksheet

Tank No.	Installation Date	AST Capacity (gallons)	AST Secondary Containment	Piping Secondary Containment	Automatic Overfill/Spill Protection and/or Electronic Leak Detection?	Tank Contents
1	Jan. 2002	1,400	<input type="checkbox"/> Permeable <input checked="" type="checkbox"/> Impermeable <input type="checkbox"/> None	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unheated <input checked="" type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil <input type="checkbox"/> Other
2	Jan. 2002	2,400	<input type="checkbox"/> Permeable <input checked="" type="checkbox"/> Impermeable <input type="checkbox"/> None	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unheated <input checked="" type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil <input type="checkbox"/> Other
3	2002	1,000	<input type="checkbox"/> Permeable <input checked="" type="checkbox"/> Impermeable <input type="checkbox"/> None	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unheated <input checked="" type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil <input type="checkbox"/> Other
4	2003	100	<input type="checkbox"/> Permeable <input checked="" type="checkbox"/> Impermeable <input type="checkbox"/> None	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Unheated <input checked="" type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil <input type="checkbox"/> Other

(use additional rows/pages as need)

# ACE Tanksafe<sup>SM</sup>

Facility No. 1 of 2

## Storage Tank Liability Coverage

## Facility/Storage Tank Inventory

No. of USTs at this facility: 2 **UST Supplemental Worksheet**

Facility Name: Hidalgo County  
 Risk Location: \_\_\_\_\_

Address: 711 E. El Cibolo City: Edinburg State: Texas USA

ZIP: 78539 Facility EPA ID #: 0077540

Which form of Tank Maintenance/Record Keeping is utilized at this facility?  
 Statistically Inventory Reconciliation with Annual Tank Tightness Testing (SIT)  
 Automatic Tank Gauging/Electronic Monitoring (ATG)

Do you have a Written Tank Management Plan for this Facility?  Yes  No

Loss History Information for this Facility:  
 No pollution related clean-ups or 3rd party claims at this facility in past 10 years  
 Pollution at facility in past 10 years, resolved with regulatory closure

Do you utilize a 3rd party Engineering firm to provide Compliance Management Services for this Facility?  Yes  No

Tank No.	Installation Date	Tank Construction	Tank Size (gallons)	Tank Contents
1	12-20-2002	<input checked="" type="checkbox"/> Double Walled <input checked="" type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel	20,000	<input checked="" type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
2	12-20-2002	<input checked="" type="checkbox"/> Double Walled <input checked="" type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel	4,000	<input checked="" type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
		<input type="checkbox"/> Double Walled <input type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel		<input type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
		<input type="checkbox"/> Double Walled <input type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel		<input type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
		<input type="checkbox"/> Double Walled <input type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel		<input type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
		<input type="checkbox"/> Double Walled <input type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel		<input type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
		<input type="checkbox"/> Double Walled <input type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel		<input type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
		<input type="checkbox"/> Double Walled <input type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel		<input type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil
		<input type="checkbox"/> Double Walled <input type="checkbox"/> Fiberglass/Steel Clad <input type="checkbox"/> Steel w/ Cathodic Protection <input type="checkbox"/> Bare Steel		<input type="checkbox"/> Unleaded <input type="checkbox"/> Diesel <input type="checkbox"/> Waste Oil

(Use additional rows/pages as needed)