Hospital Professional Liability Application

Please attach copies of the following documents to this Application. These documents shall be considered part of this Application.

1. Currently valued carrier loss runs for the previous ten (10) years
2. Current audited financial statement (pro forma if newly formed)
3. Schedule of physicians / allied health providers for whom coverage is requested
4. Most recent accreditation survey report with response to any deficiencies cited

For Self-Insured Programs:

1. Most recent actuarial funding study
2. Description of claims handling
3. Bank statement of trust fund
4. Trust coverage wording

Account Information

Applicant Name: Telephone Number:

Doing Business As: State of Domicile:

Mailing Address:

City: County: State: Zip:

Website:
www.

Applicant's Legal Structure:

☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC ☐ Other:

Tax Status:

☐ For Profit – Private ☐ For Profit – Publicly Traded ☐ Not for Profit ☐ Governmental

Type of Risk (check all that apply)

☐ Acute Care Hospital
☐ Critical Access Hospital
☐ Behavioral Health Hospital
☐ Rehabilitation Hospital
☐ Chemical Dependency Hospital
☐ Other:
☐ Senior Living / LTC Facility
☐ Long Term Acute Care Hospital
☐ Children’s Hospital
☐ Academic Medical Center
☐ Specialty Hospital:

Please list names, locations, and descriptions of all legal entities, for which coverage is requested. (Attach spreadsheet if needed)

LOC.#	Business Name and Address	Description	Date Acquired	Ownership Percent	Retroactive Date
				%	
				%	
				%	
				%	
				%	

Is the Applicant owned, managed or controlled by another entity? ☐ Yes ☐ No

If yes, please explain.

Has the Applicant sold, discontinued, or acquired any operations in the past 5 years, or does the Applicant plan to do so in the upcoming year? If yes, please explain. ☐ Yes ☐ No

Does the Applicant plan to add any new procedures, products, or services in the upcoming year? If yes, please explain. ☐ Yes ☐ No

List all accreditations (TJC, DNV, CARF,CLIA, etc.) and association memberships held by the Applicant:

Current and Requested Coverage

Policy Period:

From: To: Retroactive Date:

Coverage Requested	Per Claim	Aggregate
☐ Primary Limits of Liability requested:	$	$
☐ Excess Limits of Liability requested:	$	$
☐ Deductible / SIR requested:	$	$
☐ Insurance		
☐ Reinsurance		

Current Insurance Information

Coverage	Carrier	Limits	Deductible / SIR	CM or OCC	Premium
Professional Liability		$	$		
General Liability		$	$		
Excess Liability		$	$		
Auto Liability		$	$		
Employers Liability		$	$		
Helipad Liability		$	$		
Other (describe):		$	$		

Exposures

Inpatient Services	Current Year (Annualized)	Projected Next 12 months
Acute Care Beds (Occupied)		
Bassinets (Occupied)		
Psychiatric Beds (Occupied)		
Rehabilitation Beds (Occupied)		
Chemical Dependency Beds (Occupied)		
Long Term Care Beds (Occupied)		
ICU Beds (Occupied)		

Inpatient Services	Current Year (Annualized)	Projected Next 12 months
Inpatient Surgeries		
Outpatient Surgeries		
Births		

Outpatient Services	Current Year (Annualized)	Projected Next 12 months
Emergency Department Visits		
Psychiatric / Rehabilitation Visits		
Outpatient Visits (exclude lab & radiology)		
Urgent Care Visits		

Allied Health Providers

(Please provide the number of health care professionals listed below who are employed by the applicant and for whom coverage is sought under this policy:)

Nurse Practitioners	Certified Registered Nurse Anesthetists	Physician Assistants	Certified Nurse Midwives
_______ FTE	_______ FTE	_______ FTE	_______ FTE

Are Allied Health Providers full members of the medical staff (governed by the medical staff bylaws)? ☐ Yes ☐ No

Physicians

Is the Applicant requesting professional liability insurance for employed physicians/interns/residents? ☐ Yes ☐ No

If yes, please attach a schedule including the physician's name, specialty and retroactive date.

Do the Applicant's medical staff bylaws require physicians to carry professional liability insurance? ☐ Yes ☐ No

If yes, what limit is required? **Per Claim** $ **Aggregate** $

Are these insurance requirements verified on an annual basis? ☐ Yes ☐ No

Are credentials of staff physicians approved by a formal committee before privileges are granted? How often are medical staff members re-credentialed? ☐ Yes ☐ No

Obstetrics

The Obstetrics department is staffed by:

☐ Employed Physicians ☐ Contracted Physicians ☐ Independent Medical Staff Members

Please provide the minimum health care professional liability insurance requirements for each provider: **Per Claim** $ **Aggregate** $

In the last 12 months, what percentage of Applicant's deliveries were:

Cesarean Sections _______% VBACs _______%

Who has privileges to perform deliveries? ☐ Obstetrician ☐ Family Practitioner ☐ Midwife ☐ Other:

What is the service level of the nursery? ☐ Level I ☐ Level II ☐ Level III

Are all labor and delivery nurses, physicians, midwives required to complete an approved course in EFM? If yes, how often is competency validated? ☐ Yes ☐ No

Can emergency C-sections be performed in less than 30 minutes? ☐ Yes ☐ No

Anesthesiology

The Anesthesiology department is staffed by:

☐ Employed Physicians ☐ Contracted Physicians ☐ Independent Medical Staff Members

☐ Employed Nurse Anesthetists ☐ Contracted Nurse Anesthetists

For any contracted anesthesiology group, please provide the minimum amount of Professional Liability insurance required for each physician/nurse anesthetist: **Per Claim** $ **Aggregate** $

Is an anesthesiologist / CRNA on site 24/7? ☐ Yes ☐ No

If no, what is the maximum amount of time for arrival at the hospital?

Emergency Services

The Emergency department is staffed by:

☐ Employed Physicians ☐ Contracted Physicians ☐ Independent Medical Staff Members

For any contracted emergency services group, please provide the minimum amount of Professional Liability insurance required for each physician: **Per Claim** $ **Aggregate** $

According to The Joint Commission standards, how is the emergency department classified?

☐ Level I (tertiary) ☐ Level II (comprehensive) ☐ Level III (basic) ☐ Level IV (stand-by)

Radiology

The Radiology department is staffed by:

☐ Employed Physicians ☐ Contracted Physicians ☐ Independent Medical Staff Members

For any contracted radiology group, please provide the minimum amount of Professional Liability insurance required for each physician:	**Per Claim** $	**Aggregate** $

Does the Applicant or contracted group use teleradiology services? ☐ Yes ☐ No

If yes, please provide details:

Surgery

Are any of the following performed at the Applicant's facility?

☐ Neurosurgery (brain) ☐ Spinal Surgery
☐ Weight Loss / Bariatric Surgery ☐ Cardiothoracic Surgery
☐ Organ Transplantation ☐ Gender Reassignment Surgery
☐ Experimental Surgery

Are sponge and instrument counts performed and documented in the medical record? ☐ Yes ☐ No

Is informed consent documented in the medical record? ☐ Yes ☐ No

Does the Applicant utilize a safe surgery checklist (e.g., The Joint Commission's Universal Protocol, World Health Organization's Surgical Safety Checklist, etc.)? ☐ Yes ☐ No

General Liability

Does the Applicant have any new construction or renovation projects planned for the next 12 months? ☐ Yes ☐ No

If yes, please describe:

Does the Applicant operate any of the following:

☐ Day care center for adults ☐ Day care center for children ☐ Fitness / wellness center

Does the Applicant have a heliport/helipad? ☐ Yes ☐ No

If yes, where is it located (e.g., parking lot, top of building, etc.)?

Risk Management

Who is responsible for the risk management program?

Name: Title:

Email Address:

Fraud Warnings

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 Alaska residents: "A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law."

Notice to Arizona residents: "For the Applicant's protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

Notice to California residents: "For the Applicant protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Notice to Colorado residents: "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 Delaware residents: "Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Notice to Florida residents: "Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree."

Notice to Idaho residents: "Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

Notice to Indiana residents: "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony."

Notice to Kansas residents: "A 'fraudulent insurance act' means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto."

Notice to Kentucky residents: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits an fraudulent insurance act, which is a crime."

Notice to Maryland residents: "Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 Maine residents: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

Notice to Minnesota residents: "A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

Notice to New Hampshire residents: "Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20."

Notice to New Jersey residents: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Notice to New Mexico residents: "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 Ohio residents: "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 residents: "WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an 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 Oregon residents: "Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law."

Notice to Pennsylvania residents: "Any person who knowingly and with intent to defraud any insurance company or other person files a 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."

Notice to Tennessee, Virginia and Washington residents: "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 Texas residents: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

Notice to Vermont residents: "Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law."

Notice to New York residents: "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 violation."

The undersigned represents that he or she is authorized to sign this application on behalf of the **Applicant** and further represents and acknowledges that all information contained in this Application, including any supplements and attachments, is true accurate, and complete; will be relied upon by this Insurer in determining whether to insure the **Applicant** and at what rate to insure it; and will be considered part of any policy that is issued. The undersigned further represents and acknowledges that the policy applied for may provide coverage on a claims made and reported basis, and subject to the policy provisions, may apply to claims or suits that are first made and reported in writing to this Insurer during the policy period unless an extended reporting period applies.

Producer Profile and Applicant Signature

Company Name:		Telephone Number:	Facsimile Number:
Business Address:		City, State, Zip:	Email Address:
Surplus Lines Agent Name and Telephone Number:		Surplus Lines Agent's License Number:	
State in which Surplus Lines Tax is Filed:		Surplus Lines Agent Business Address:	
Surplus Lines Agent City, State, Zip:			
Producer Signature:	Producer Printed Name:		Date:
Applicant (Signature): By:		Title:	Date: