



HEALTH CARE SYSTEM AND PROVIDER  
PROFESSIONAL LIABILITY AND GENERAL  
LIABILITY POLICY APPLICATION

NOTICE: THE POLICY FOR WHICH APPLICANT IS APPLYING MAY APPLY ONLY TO "CLAIMS" FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO UNDERWRITERS IN WRITING DURING THE "POLICY PERIOD" OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE. IF ADDITIONAL SPACE IS NECESSARY TO APPROPRIATELY ANSWER ANY QUESTION, PLEASE ATTACH ADDITIONAL SHEETS OF PAPER, AS NECESSARY.

**A. APPLICANT**

1. Legal name of healthcare organization: \_\_\_\_\_
2. Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
3. Telephone number: \_\_\_\_\_
4. Facsimile number: \_\_\_\_\_
5. How many years has the **Applicant** been in operation? \_\_\_\_\_
6. How many years has the **Applicant** been under present ownership? \_\_\_\_\_
7. List all affiliates, subsidiaries, partnerships and joint ventures to which this insurance is to apply. Please include a complete description of the operations of each such entity and their relationship to the **Applicant**. (Please attach a separate sheet if necessary.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. GENERAL INFORMATION**

1. **Applicant** is (please check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> General hospital             | <input type="checkbox"/> For Profit             |
| <input type="checkbox"/> Children's hospital          | <input type="checkbox"/> Not for Profit         |
| <input type="checkbox"/> Teaching hospital            | <input type="checkbox"/> Medicare approved      |
| <input type="checkbox"/> Psychiatric hospital         | <input type="checkbox"/> Partnership            |
| <input type="checkbox"/> Research hospital            | <input type="checkbox"/> Corporation            |
| <input type="checkbox"/> Convalescent or Nursing Home | <input type="checkbox"/> Licensed by the State  |
| <input type="checkbox"/> Clinic                       | <input type="checkbox"/> Charitable             |
| <input type="checkbox"/> Governmental                 | <input type="checkbox"/> Other Specialty - Type |
| <input type="checkbox"/> Medical Group                |   |

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

Date of last accreditation: \_\_\_\_\_

Accreditation period: \_\_\_\_\_  
(Please attach a copy of the most recent survey.)

Is **Applicant** licensed by one or more States? Yes      No  
(Please attach a copy of the most recent State license surveys.)

3. Has the **Applicant** or other associated entity ever lost a license or been placed on probation by any governmental or licensing agency? Yes      No

If "Yes," please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

If "Yes," please identify and explain on a separate sheet of paper.

5. Is any part of the **Applicant** operated/leased by a management corporation? Yes      No

If "Yes," give name of corporation and details of structure. Please attach separate sheet of paper.

6. Does the **Applicant** participate in any teaching programs? Yes      No

If "Yes," please describe the type of program or affiliation: \_\_\_\_\_  
\_\_\_\_\_  
Is the program sponsored by a healthcare organization? Yes      No  
If "Yes," please provide name of sponsoring institution: \_\_\_\_\_  
\_\_\_\_\_

7. Does the **Applicant** anticipate an expansion of its facility (e.g., increase in licensed beds) within the next year? Yes      No  
 If "Yes," please describe anticipated expansion. \_\_\_\_\_  
 \_\_\_\_\_

**C. PERSONNEL**

1. Indicate the number of persons employed by or working under the control of the **Applicant** in each of the following classifications:

_____ Certified Registered Nurse Anesthetists*	_____ Nurse Practitioners*
_____ Dentists*	_____ Paramedics
_____ Emergency Medical Technicians	_____ Registered Nurses
_____ Interns	_____ Respiratory Therapists
_____ Laboratory or X-ray Technicians	_____ Pharmacists
_____ Licensed Vocational/Practical Nurses	_____ Physician Assistants*
_____ Nurse's Aides	_____ Physicians & Surgeons*
_____ Nurse Midwives*	_____ Residents*
_____ Other	
_____ (explain): _____	

\*Please provide separate listings of names and specialties (and contract, if applicable) for each.

**D. OPERATIONS**

1. SERVICES. Please indicate if the **Applicant** ever provided, presently provides, or plans to provide any of the following services:

_____ Ambulance Service	_____ Helipad	_____ Lifeline
_____ Bariatrics	_____ Health Maintenance Organizations	_____ Nursery
_____ Dialysis	_____ Home Health Care	_____ Neonatal
_____ Ob/Gyn	_____ Hospice	_____ Off-Premises Food Services
_____ Oncology	_____ Inhalation Therapy	_____ Off-Premises Labs
_____ Open Heart Surgery	_____ Organ Transplants	_____ Pharmacy
_____ Day Care	_____ Outpatient	_____ Skilled Nursing
_____ Dental Services	_____ Pediatrics	_____ Transportation Services (other than ambulance)
_____ Emergency Room		
_____ Other (explain) _____		





- a. Staffing is by (please indicate number of each): \_\_\_ Residents \_\_\_ Employed Physicians  
\_\_\_ Independent Contracted Physicians

Is coverage being requested for employed or independent contract physicians? Yes No

Are all physicians board certified or eligible? Yes No  
If "No," please explain why: \_\_\_\_\_

- b. If under contract, to whom is staffing contracted? \_\_\_\_\_

Are contract physicians required to carry Professional Liability insurance? Yes No

If "Yes" what limits are required? \_\_\_\_\_

Does the **Applicant** obtain Certificates of Insurance from physicians? Yes No

Who are the most common carriers? \_\_\_\_\_

- c. State the number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom the treatment is given:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 6. PATHOLOGY SERVICES

- a. Staffing is by (please indicate number of each): \_\_\_ Residents \_\_\_ Employed Physicians  
\_\_\_ Independent Contracted Physicians

Is coverage being requested for employed or independent contract physicians? Yes No

Are all physicians board certified or eligible? Yes No  
If "No," please explain why: \_\_\_\_\_

- b. If under contract, to whom is staffing contracted? \_\_\_\_\_

Are contract physicians required to carry Professional Liability insurance? Yes No

If "Yes" what limits are required? \_\_\_\_\_

Does the **Applicant** obtain Certificates of Insurance from physicians? Yes No

Who are the most common carriers? \_\_\_\_\_

## 7. OBSTETRICS

- a. Is the **Applicant** a regional referral center for newborns requiring

- |   |                   |                |
|---|-------------------|----------------|
| intensive care?   | Yes               | No             |
| b. Number of labor rooms: _____   |                   |                |
| c. Number of delivery rooms: _____  |                   |                |
| d. Does the <b>Applicant</b> have a separate birthing center?   | Yes               | No             |
| e. Is the delivery room suite separate from surgical suite?   | Yes               | No             |
| f. In the last ten (10) years, have there been instances where cesarean sections have not been performed within thirty (30) minutes?  | Yes               | No             |
| g. Is an obstetrician available in-house twenty-four (24) hours per day for the obstetrical suite?<br>If "No," what is the maximum time for arrival at hospital? _____  | Yes               | No             |
| h. Is an anesthesiologist or CRNA available in-house twenty-four (24) hours per day for the obstetrical suite?<br>If "No," what is the maximum time for arrival at hospital? _____  | Yes               | No             |
| i. Do midwives practice in labor and delivery?<br>If yes, are there written protocols for privileges/supervision?<br>Are midwives hospital employees?<br>If "Yes," how many are there? _____  | Yes<br>Yes<br>Yes | No<br>No<br>No |
| J. If the <b>Applicant</b> has a neonatal intensive care unit (NICU), state:<br>(i) Total number of neonates admitted to NICU in the past twelve (12) months: _____<br>(ii) Number of neonates admitted to NICU who were transferred from other facilities: _____<br>(iii) Is a full-time attending neonatologist on-site in NICU twenty-four (24) hours per day? |                   | Yes<br>No      |
| k. If the <b>Applicant</b> does not have NICU, please state the total number of neonates transferred from institution to other facilities in the past twelve (12) months: _____   |                   |                |
| l. Has <b>Applicant</b> ever experienced a stolen baby?<br>Please describe <b>Applicant's</b> procedures for protecting against stolen babies: _____  | Yes               | No             |
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8. EMERGENCY ROOM

- |  |     |    |
|--|-----|----|
| a. Does the <b>Applicant</b> provide emergency room ER service?<br>If "Yes," please answer the following questions:  | Yes | No |
| (i) What level of service do you provide (based on standards of Joint Commission on Accreditation of Healthcare Organizations)?<br>___ I (Tertiary) ___ II (Comprehensive) ___ III (Basic) |     |    |
| (ii) Is the ER service operated by the <b>Applicant</b> ?  | Yes | No |
| (iii) Staffing is by: ___ Residents  |     |    |



4. Do department heads evaluate the work of their staff members? Yes No
5. Is an ongoing medical audit maintained on all staff members' clinical work? Yes No
6. Are all staff privileges reviewed each year? Yes No  
If "no," how often are they reviewed? \_\_\_\_\_
7. Does the **Applicant** require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? Yes No
8. Staff Members Professional Liability Insurance:
- a. Are all staff members required to maintain Professional Liability insurance? Yes No
- b. Is this requirement stated in the staff bylaws? Yes No
- c. What limits are required? \_\_\_\_\_
- d. What evidence of compliance is required? \_\_\_\_\_  
\_\_\_\_\_
- e. Who are the most common carriers? \_\_\_\_\_  
Please include a copy of the medical staff bylaws on the requirement for financial responsibility.
9. Are any physicians under corrective action plans? Yes No  
Have any physicians currently on staff been accused of sexual misconduct or alcohol/drug abuse? Yes No  
Is there any pending litigation against the **Applicant** for deselection of a provider? Yes No  
If "Yes," please describe: \_\_\_\_\_  
\_\_\_\_\_

## F. RISK MANAGEMENT

### 1. Risk Management Program

- a. Does the **Applicant** have a written, formalized Risk Management Program? Yes No  
If "Yes," please provide a description of the program below and attach a copy to this Application:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- b. Is the program periodically reviewed for effectiveness and are necessary changes timely implemented? Yes No
- c. When were the last changes implemented? \_\_\_\_\_
- d. Who is in charge of implementing this program and changes? \_\_\_\_\_  
\_\_\_\_\_

### 2. Quality Assurance Program

- a. Does the **Applicant** have a written, formalized Quality Assurance Program? Yes No  
If "Yes," please provide a description of the program below and attach a copy to this Application:

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- b. Is the program periodically reviewed for effectiveness and are necessary changes timely implemented? Yes No

c. When were the last changes implemented? \_\_\_\_\_

d. Who is in charge of implementing this program and changes? \_\_\_\_\_

3. **HIPAA Compliance**

- a. Has **Applicant** instituted a program to safeguard the confidentiality of client health information pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)?

Yes No

If "Yes," please provide a description of the program below and attach a copy to this Application.

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- b. Is the program periodically reviewed for effectiveness and are necessary changes timely implemented? Yes No

c. When were the last changes implemented? \_\_\_\_\_

d. Who is in charge of implementing this program and changes? \_\_\_\_\_

4. **Other**

- a. Has **Applicant** ever been found to be in violation of the Emergency Medical Treatment and Active Labor Act (EMTALA)? Yes No

b. If "Yes," please explain: \_\_\_\_\_

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- c. Has **Applicant** ever been found to be in violation of the False Claims Act? Yes No

d. If "Yes," please explain: \_\_\_\_\_

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**G. CONTRACTUAL AGREEMENTS**

1. Where the **Applicant** leases or rents durable medical equipment from others, does the **Applicant** indemnify (hold harmless) the owner of such equipment for liability? Yes      No  
If "Yes," please submit a copy of the agreement(s).

**H. PHYSICAL PREMISES**

1. List below all buildings (including garage buildings) the **Applicant** owns, controls or occupies. Where fixed features exist for a building, please list wings, floors or areas separately. Attach a separate schedule if necessary.

a. Address: \_\_\_\_\_  
Year built: \_\_\_\_\_ No. of stories: \_\_\_\_\_ No. of elevators: \_\_\_\_\_  
Construction (brick, fire resistive, etc.): \_\_\_\_\_  
Area (in total sq. ft.): \_\_\_\_\_  
Complete sprinkler system?      Yes      No      Smoke Detectors?      Yes      No  
Carbon monoxide detectors?      Yes      No      Security Services?      Yes      No

b. Address: \_\_\_\_\_  
Year built: \_\_\_\_\_ No. of stories: \_\_\_\_\_ No. of elevators: \_\_\_\_\_  
Construction (brick, fire resistive, etc.): \_\_\_\_\_  
Area (in total sq. ft.): \_\_\_\_\_  
Complete sprinkler system?      Yes      No      Smoke Detectors?      Yes      No  
Carbon monoxide detectors?      Yes      No      Security Services?      Yes      No

c. Address: \_\_\_\_\_  
Year built: \_\_\_\_\_ No. of stories: \_\_\_\_\_ No. of elevators: \_\_\_\_\_  
Construction (brick, fire resistive, etc.): \_\_\_\_\_  
Area (in total sq. ft.): \_\_\_\_\_  
Complete sprinkler system?      Yes      No      Smoke Detectors?      Yes      No  
Carbon monoxide detectors?      Yes      No      Security Services?      Yes      No

d. Address: \_\_\_\_\_  
Year built: \_\_\_\_\_ No. of stories: \_\_\_\_\_ No. of elevators: \_\_\_\_\_  
Construction (brick, fire resistive, etc.): \_\_\_\_\_  
Area (in total sq. ft.): \_\_\_\_\_  
Complete sprinkler system?      Yes      No      Smoke Detectors?      Yes      No  
Carbon monoxide detectors?      Yes      No      Security Services?      Yes      No

e. Address: \_\_\_\_\_  
Year built: \_\_\_\_\_ No. of stories: \_\_\_\_\_ No. of elevators: \_\_\_\_\_  
Construction (brick, fire resistive, etc.): \_\_\_\_\_

Area (in total sq. ft.): \_\_\_\_\_

Complete sprinkler system?	Yes	No	Smoke Detectors?	Yes	No
Carbon monoxide detectors?	Yes	No	Security Services?	Yes	No

f. Address: \_\_\_\_\_

Year built: \_\_\_\_\_ No. of stories: \_\_\_\_\_ No. of elevators: \_\_\_\_\_

Construction (brick, fire resistive, etc.): \_\_\_\_\_

Area (in total sq. ft.): \_\_\_\_\_

Complete sprinkler system?	Yes	No	Smoke Detectors?	Yes	No
Carbon monoxide detectors?	Yes	No	Security Services?	Yes	No

2. Does the **Applicant** have a heliport/helipad? Yes No

If "Yes," where is the pad located (e.g., parking lot, top of building, etc.)?

\_\_\_\_\_  
\_\_\_\_\_

How far is it from the **Applicant**? \_\_\_\_\_

Please list the dimensions of helipad: \_\_\_\_\_

Please describe the type of construction: \_\_\_\_\_

## I. COVERAGE

1. Please specify current and prior liability insurance coverages:

Category	Year – 1 Current	Year 2	Year 3	Year 4	Year 5
PL/GL Carrier					
Limits of Liability					
Deductible/SIR					
Premium					
Retroactive Date, if applicable					
Who Handled Claims?					
Coverage	__ Occ __ CM	__ Occ __ CM	__ Occ __ CM	__ Occ __ CM	__ Occ __ CM

2. Past coverage:

Has any insurer canceled, rescinded or declined to issue Professional Liability insurance for the **Applicant**? Yes No

If "Yes," please explain: \_\_\_\_\_

\_\_\_\_\_

3. Loss history:

Please attach the loss history for the last ten (10) years, including the current year, and a breakdown of total incurred losses, paid losses, and outstanding losses, separated by year for Professional Liability and General Liability.

Additionally, please provide full details of any claim paid or outstanding during this period in excess of \$100,000 (paid) and \$50,000 (outstanding).

4. Proposed quote:

Requested total limits of liability: \_\_\_\_\_ / \_\_\_\_\_  
 Per Claim / Annual Aggregate ( if applicable)

DEDUCTIBLE SIZE (Please indicate deductible quotes you would like):

Indemnity and expense: \_\_\_\_\_  
 (Per claim) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Desired Effective Date of Coverage: \_\_\_\_\_

5. Please describe source of funding for any deductible: \_\_\_\_\_  
 \_\_\_\_\_

**J. UMBRELLA**

Please complete the following if Umbrella coverage is desired. Full self-insured or underlying policy information must be provided. Please list the current liability coverage in place:

	Carrier	Policy Number	Effective Date	Limits of Liability
WC/Employers Liability*				
Automobile Liability (including ambulance)*				
Non-Owned Aircraft Liability **				
Helipad Liability***				
Non-Owned Watercraft Liability****				
Other Liability (specify):				

\*Minimum underlying limit of \$ 1,000,000 each medical incident/event is required.

\*\*Minimum underlying limit of \$ 10,000,000 each occurrence is required.

\*\*\*Minimum underlying limit of \$5,000,000 each occurrence is required.

\*\*\*\*If watercraft is less than 26 feet in length and not used to carry persons or property for a charge, coverage is typically included under General Liability coverage.

**K. OTHER INFORMATION**

Please disclose any information material to the risk, which has not otherwise been addressed in this application (please attach additional sheets of paper if necessary).

Please also include copies of the following:

1. The **Applicant's** most recent annual report
2. A copy of the most recent JCAHO report and response to any contingencies
3. Financial Statement
4. Current balance of the Self-Insured Trust Fund\*
5. Trust Agreement\*
6. Recent actuarial study supporting the funding of the Self-Insured Trust\*

\* These items apply if **Applicant** has set up a Self-Insured Trust Fund.

#### L. WARRANTY STATEMENT

The Undersigned warrants and represents that, to the best of his/her knowledge, the statements herein are true, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. It is represented that the particulars and statements contained in the Application, and any materials submitted (which shall be on file with the Underwriters and shall be deemed attached as if physically attached) are the basis for the proposed insurance and are to be considered incorporated into and constituting a part of the proposed insurance.

The Undersigned agrees that in the event this Application contains misrepresentations or fails to state facts materially affecting the risk assumed by the Underwriters, any insurance issued shall be void in its entirety.

The Undersigned agrees that, if after the date of this Application and prior to issuance of any insurance, any occurrence, event or other circumstance should render any of the information contained in this Application inaccurate or incomplete, the Undersigned shall notify the Underwriters of such occurrence, event or circumstance, and shall provide the Underwriters with information that would complete, update or correct the information contained in this Application. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Underwriters.

The Underwriters are hereby authorized to make an investigation and inquiry in connection with this Application as it may deem necessary.

The Undersigned must answer the following 2 questions, sign and date below. If answering "Yes" to either of the following 2 questions, please attach a detailed explanation.

1. Do you disagree with the Warranty Statement above? Yes      No
  
2. Do you have any knowledge of any specific claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the proposed policy? Yes      No

<b>APPLICANT</b>		
BY ( <i>Chairman and/or President</i> )	TITLE	DATE

NOTE: This Application must be signed by the Chairman and/or President of the **Applicant** acting as the authorized agent of all individuals and entities proposed for this insurance.

**REQUIRED INFORMATION**

PRODUCED BY (*Insurance Agent*)  
Please print and sign name

\_\_\_\_\_

INSURANCE AGENCY

INSURANCE AGENCY TAXPAYER ID OR SOCIAL  
SECURITY NO.

AGENT LICENSE NO.

ADDRESS (*No., Street, City, State, and ZIP Code*)

EMAIL ADDRESS