

AMERICAN INTERNATIONAL COMPANIES

Hospital Professional Liability - Claims-Made And Commercial General Liability - Occurrence Application

This is an application for Professional Liability coverage written on a claims made basis and Commercial General Liability coverage written on an occurrence basis. The claims made coverage is limited generally to liability for claims first made against an Insured while the coverage is in force. Please review the policy carefully and discuss the policy with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

Please include the following:

1. Loss History: (supply the following)
 - a. Ten years recently evaluated, including current year and ten years evaluated within past two years.
 - b. Breakdown of total incurred losses (paid and outstanding for indemnity and expenses).
 - c. Full details of allegation on all losses paid or outstanding in excess of \$25,000.
2. Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies.
3. Current audited financial statement.
4. Indicate specialty of each employed physician, surgeon, intern and resident.
5. Copy of medical staff by-laws.
6. AHA survey of hospitals.
7. Risk management and quality improvement plan.
8. Copies of contracts with independent physician's groups.
9. All hold harmless agreements.
10. For self-insured programs:
 1. Copy of trust financial agreement.
 2. Copy of trust coverage wording.
 3. Financial statement of trust fund.
 4. Recent actuarial review supporting the funding of the self-insured retention.
 5. Name of Claims Adjusting Company.

The requested information is mandated before a quotation can be promulgated.

Instructions:

1. Please type or print clearly.

None \$5,000 \$25,000
 \$2,500 \$10,000 Other _____

Self-Insured Retention (if applicable):

1. To what line of coverage will a self-insured retention apply? _____
2. What limit of liability for the self-insured retention?
 _____ per claim _____ aggregate
3. Are loss adjustment expenses part of or outside the SIR limit?
4. Is there a dedicated trust? _____ Yes _____ No
 What financial institution manages the trust? _____

5. What organization handles claims for the SIR? _____

6. Has an independent actuarial review been completed? _____ Yes _____ No

K. Prior Insurance History

Most recent five (5) Years: (separate Primary General Liability, Professional and Excess/Umbrella, if applicable).

Policy Period	Carrier	Limits	Coverage	Premium

II. FACILITIES AND SERVICES (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Abortion Clinic | <input type="checkbox"/> Morgue |
| <input type="checkbox"/> Ambulance | <input type="checkbox"/> Nursery |
| <input type="checkbox"/> Blood bank | <input type="checkbox"/> Obstetrical |
| <input type="checkbox"/> Burn Unit | <input type="checkbox"/> Open Heart |
| <input type="checkbox"/> CCU | <input type="checkbox"/> Operating Rooms |
| <input type="checkbox"/> Coronary Rescue | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Day Care | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Dietary | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Emergency | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Gift Shop | <input type="checkbox"/> Restaurant |
| <input type="checkbox"/> ICU | <input type="checkbox"/> Self-Care |
| <input type="checkbox"/> Inhalation Therapy | <input type="checkbox"/> Shock Trauma |
| <input type="checkbox"/> Long-Term Care | <input type="checkbox"/> X-Ray |

Does the institution engage in any of the following:

- Formal clinical research under the auspices of an institutional review board.
- Administration of non-FDA approved pharmaceuticals (experimental drugs).
- Biomedical device research and development.
- Animal research.
- Medical and/or surgical experimentation that is not approved by an institutional review board.

Please provide details if any of the above apply: _____

A. Professional Employees: (indicate total number of employees in each category)

<u>Position</u>	<u>Full-Time</u>	<u>Total Full-Time Equivalents</u>
Employed physicians	_____	_____
Employed surgeons	_____	_____
Interns	_____	_____
Residents	_____	_____
Dentists	_____	_____
Podiatrists	_____	_____
Physician assistants	_____	_____
Registered nurses	_____	_____
LPNs	_____	_____
Student nurses	_____	_____
X-Ray technicians	_____	_____
Lab technicians	_____	_____
Pharmacies	_____	_____
Profusionists	_____	_____
Paramedics	_____	_____
CRNAs	_____	_____
Other employees	_____	_____
Volunteers	_____	_____

On a separate sheet, please indicate the specialty of each employed Physician, Surgeon, Intern and Resident.

B. Professional Liability Exposures

1. Hospital beds:	# of Licensed Beds	Average # of Occupied Beds
a. Acute care	_____	_____
b. Cribs and bassinets	_____	_____
c. Mental health (psychiatric)	_____	_____
d. Chemical dependency	_____	_____
e. Other rehabilitation	_____	_____
f. Ailing home beds	_____	_____
g. Hospice	_____	_____

h. Other (please specify) _____
 TOTAL: _____

2. Inpatient Surgeries # of Procedures (previous 12 months) # of Outpatient Visits (projected next 12 months)

3. Outpatient Visits

- a. Births _____
- b. Emergency room _____
- c. Health Institutional (clinical) visits _____
- d. Outpatient surgery _____
- e. Chemical dependency _____
- f. Rehabilitation/Therapy _____
- g. Mental health (psychiatric) _____
- h. Home health _____
- i. Other (please specify) _____

TOTAL: _____

j. If hospital owns or operates a blood bank:

- i. Number of volunteer donations _____
- ii. Number of paid donations _____
- iii. Number of pheresis procedures _____
- iv. Number of outpatient transfusions _____
- v. Number of therapeutic plasma exchanges _____

Is coverage desired for blood bank operations? Yes No
 If "yes", please attach testing procedures.

If hospital does not own or operate a blood bank, from where is the blood or blood product obtained?

4. Criteria for qualifications of employed physicians and surgeons:

- a. Is history of previous employment verified? Yes No
- b. Are references checked? Yes No
- c. Has the license of any employed physician or surgeon ever been restricted or suspended? Yes No

If yes, please provide details: _____

d. Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff? Yes No

If yes, please explain: _____

- e. How many employed physicians are board certified or board eligible? _____
- f. Do employed physicians, employed surgeons, interns and residents carry own insurance? Yes No
- g. Are employees to be included as additional insureds? Yes No

5. Staff Privileges of Private Practitioners:

- a. Are credentials of doctors approved by the medical staff and/or hospital review board before privileges are granted? Yes No
- b. Is there a probationary period of at least six months for all staff doctors? Yes No
- c. Are staff doctors' performances periodically reviewed by medical staff and/or hospital review board? Yes No
- d. Do hospital by-laws require staff doctors to carry medical malpractice insurance? Yes No

If yes, what are limits required? _____ per claim _____ aggregate

- e. Are all privileges granted to staff doctors detailed in writing? Yes No
- f. Has the license of any staff physician ever been restricted or suspended? Yes No

If yes, please provide details: _____

6. Anesthesiology

- a. Is anesthesiology department staffed by:
 ___ Employed Physicians ___ Contract Group ___ Employed CRNAs ___ Staff Physicians

- b. If under contract, name of group: _____

If contract group, are certificates of insurance required? Yes No

If yes, what are limits required? _____ per claim _____ aggregate

- c. Are all anesthesiologists required to be board certified or eligible in Anesthesiology? Yes No
- d. Is the anesthesia care performed by CRNAs supervised and reviewed by the anesthesiologists? Yes No

If no, please explain: _____

- e. Do any of the anesthesia services staff routinely work more than a 12-hour duty shift? Yes No

If yes, please explain: _____

7. Radiology

- a. Is radiology department staffed by:
 ___ Employed Physicians ___ Contract Group ___ Staff Physicians

- b. If under contract, name of group: _____
- If contract group, are certificates of insurance required? Yes No
- If yes, what are limits required? _____ per claim _____ aggregate
- c. Are all radiologists to be Board Certified or eligible in Radiology and/or Nuclear Medicine? Yes No

8. Emergency Department

- a. How is emergency department classified according to JCAHO standards:
- ___ N/A ___ Level I (tertiary) ___ Level II (comprehensive) ___ Level III (basic)
- ___ Other _____
- b. Is emergency department staffed by:
- ___ Employed Physicians ___ Contract Group ___ Rotating Staff
- c. If under contract, name of group: _____
- If contract group, are certificates of insurance required? Yes No
- If yes, what are limits required? _____ per claim _____ aggregate
- d. Are all physicians board certified or eligible in emergency medicine? Yes No
- Are the emergency physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution? Yes No
- e. Is the emergency room equipped with the following:
- Emergency resuscitation care equipped with defibrillator? Yes No
- Electrocardiograph machine Yes No
- Staffed radiology room(s) Yes No
- Dedicated triage area and staff Yes No
- Dedicated trauma room(s) Yes No
- Dedicated laboratory personnel Yes No
- f. Do any of the emergency department staff routinely work more than a 12-hour duty shift? Yes No
- If yes, please explain: _____

9. Obstetrics

- a. Is the facility a regional referral center for high risk pregnancies or newborns requiring intensive care? Yes No
- If no, does a written procedure exist for transferring all high-risk mothers and/or babies which the hospital is not qualified to treat? Yes No
- b. Do you have the following nurseries:
- ___ Level I: Well baby Number of bassinets _____
- ___ Level II: Intermediate care Number of bassinets _____

___ Level III: Neonatal intensive care Number of bassinets _____

- c. Is "Rooming -In" offered? Yes No
- d. How many births at your facility (previous 12 months)? _____
- e. How many cesarean sections (previous 12 months)? _____
- f. How many vaginal births after C-section (VBACs) (previous 12 months)? _____

- g. Is continuous electronic fetal monitoring performed on all patients in active labor? Yes No

If no, please explain: _____

- h. Do nurse midwives practice at your hospital? Yes No

10. Surgery

- a. How many surgical procedures were performed in the last year by:

Employed physicians _____ Outside Surgeons _____ Interns _____ Residents _____

- b. Are sponge, needle and instrument counts performed in the course of a surgical procedure? Yes No

If yes, at what intervals of the operation? _____

- c. Are any of the following performed at your facility?

Neurosurgery	Yes	No
Experimental surgery	Yes	No
Sex change operations	Yes	No
Weight reduction surgery	Yes	No
Laser assisted surgery		Yes
No		

- d. Are "scope" surgical procedures routinely videotaped? Yes No

11. Pharmacy

- a. Does the facility utilize the unit dose system of dispensing medicine? Yes No

- b. Is the pharmacy for patient use only? Yes No

If no, annual receipts for nonpatients medications are \$_____.

- c. Is the pharmacy staffed by a contract group? Yes No

If yes, please explain: _____

C. Commercial General Liability Exposure

1.	<u>Location</u>	<u>Area</u>	<u>Age</u>	<u>Type of Constr.</u>	<u># of Floors</u>	<u>Type of Fire Protection</u>
	Patient Care Buildings					

-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-

Other Buildings

-	-	-	-	-
-	-	-	-	-
-	-	-	-	-

Parking Lots

-	-	-	-	-
-	-	-	-	-

Vacant Lots

-	-	-	-	-
-	-	-	-	-

Fire Protection Key

AS = Approved sprinkler
S = Smoke detector

H = Heat detector
A = Automatic alarm

2. Incidental exposures

a. Has the hospital planned any new construction and/or abatement for this year? Yes No

If yes, please provide details: _____

b. Are there elevators or escalators on any premises owned, leased or occupied by the insured? Yes No

If so, how many? _____

c. Does the hospital have a heliport? Yes No

d. Does the hospital have an ambulance or other emergency use vehicles? Yes No

e. List the number and type of owned or leased vehicles: _____

f. List all owned, leased and nonowned watercraft: _____

g. List all owned, leased or chartered aircraft: _____

6. Hold Harmless and Indemnification Agreements

a. Has the hospital agreed to hold harmless or indemnify others under contract? Yes No

b. Does the hospital rent or lease any equipment from others? Yes No

If a. or b. is yes, please explain: _____

7. Risk Management

a. Who coordinates your risk management program?

Name: _____ Title: _____

Telephone: () _____

b. Is there a written, risk management program that has been approved by a governing body? Yes No

c. Does the governing body review the effectiveness of the program and approve necessary changes? Yes No

d. Is the risk manager accountable and solely responsible for risk management? Yes No

If no, explain other responsibilities: _____

e. Does the risk management program include the following:

Occurrence reporting	Yes	No
Claim management	Yes	No
Formal link to quality management	Yes	No
Safety program and safety committee	Yes	No
Review and participation in medical staff committees	Yes	No
Contract review and evaluation	Yes	No

The information requested is mandatory before a quotation can be promulgated.

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

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 AUTHORITIES.”

NOTICE TO FLORIDA APPLICANTS: “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 IN THE THIRD DEGREE.”

NOTICE TO KENTUCKY APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.”

NOTICE TO MAINE 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.”

NOTICE TO MINNESOTA APPLICANTS: “A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.”

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, 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 PENNSYLVANIA APPLICANTS: “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION SHALL UPON CONVICTION BE SUBJECT TO IMPRISONMENT FOR UP TO SEVEN YEARS AND PAYMENT OF A FINE OF UP TO \$15,000.”

Signature of Applicant: _____

Time: _____

Date: _____

Signature of Producer: _____

License #: _____

Date: _____

