# Health Care Organization Professional Liability and Commercial General Liability Application

**THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON CLAIMS MADE BASIS AND COMMERCIAL GENERAL LIABILITY COVERAGE WRITTEN ON EITHER A CLAIMS-MADE OR 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 QUESTION BE ANSWERED ACCURATELY AND COMPLETELY.**

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Please include the following:

1. Loss History: (supply the following)
   a. Claims listing of ten years currently valued, including current year, detailed loss information (preferably in electronic form).
      Please see ADDENDUM A for the format
   b. Carrier loss runs to support information in 1.a. above.
   c. Full details of allegation on all losses paid or outstanding in excess of $50,000.

2. Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies. Please provide copy of original report from agency (not the internet summary).

3. Current audited financial statement.

4. Copy of medical staff by-laws.

5. AHA Survey of Hospitals

6. Risk management and quality improvement plan.

7. Copies of contracts with independent physician's groups.

8. All hold harmless agreements.

9. For self-insured programs:
   a. Copy of trust financial agreement.
   b. Copy of trust coverage wording.
   c. Financial statement of trust fund.
   d. Recent actuarial review supporting the funding of the self-insured retention.
   e. Description of claims handling – In house, TPA with details on process, case reserve setting and claims handling expertise of people involved.

The requested information is required before a firm quotation can be provided.

Producer Name: _____

Address:_____
Street City

Telephone #: (____) _____

**Please type or print clearly.**

- **Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.**
- **If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.**
- **This form must be completed, dated and signed by the CEO, CFO or Risk Manager of the proposed insured.**

## 1. GENERAL INFORMATION

Applicant Name:

_____

Business Address: Street _____ City, State _____ ZIP _____

Mailing Address: _____ Telephone #: _____

Website (if applicable) _____ Years in Business: _____

Key Contact at Insured: _____ Title _____

Federal Tax ID: _____ E-mail address: _____

APPLICANT IS (Check all that applies):

| A. | B. | C. | D. |
|---|---|---|---|
| ☐ Children's Hospital | ☐ Individual | ☐ Profit | ☐ Accredited by JCAHO |
| ☐ Clinic | ☐ Partnership | ☐ Non-Profit | ☐ Licensed by the state |
| ☐ Critical Access Hospital | ☐ Corporation | ☐ Charitable | ☐ Accredited by AOA |
| ☐ General Hospital | ☐ Joint Venture | ☐ Government | ☐ Medicare Approved |
| ☐ Psychiatric Hospital | | | ☐ Member of AHA |
| ☐ Teaching Hospital | | | ☐ Accredited by CARF |
| ☐ Surgi-Center | | | ☐ Other |
| ☐ Other: | | | |

E. Requested Coverage: Effective Date:

Professional Liability (Claims Made Only):

Limit: $_____per claim $_____aggregate _____ Retroactive Date

Deductible: ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other _____

General Liability:

Limit: $_____per claim $_____aggregate _____ Retroactive Date

☐ Occurrence ☐ Claims-Made

Deductible: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other _____

Employee Benefits Liability (Claims Made Only):

Limit: $_____per claim $_____aggregate _____ Retroactive Date

Deductible: ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other _____

F. 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? ☐ Yes ☐ No
4. Is there a dedicated trust? ☐ Yes ☐ No
   If No, how is SIR secured? _____
   If Yes, what financial institution manages the trust? _____
   What organization handles claims for the SIR? _____
5. Has an independent actuarial review been completed? ☐ Yes ☐ No
   Valuation Date of Loss Data Used _____

G. Prior Insurance History

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

**Primary Coverage**

| Policy Period | Carrier | Limits (HPL/GL) | Deductible (HPL/GL) | Total Premium | Claims Made or Occurrence | Retro Date |
|---|---|---|---|---|---|---|
| | | HPL | | | | |
| | | GL | | | | |
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**Excess/Umbrella Coverage**

| Policy Period | Carrier | Limits (HPL/GL) | Deductible (HPL/GL) | Total Premium | Claims Made or Occurrence | Retro Date |
|---|---|---|---|---|---|---|
| | | HPL | | | | |
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H. Is the applicant operating under a management agreement? If so, please provide details on a separate sheet of paper.

## II. EXPOSURE DATA

A. Professional Liability Exposures

| | Next 12 Months Projected | Current Year | 1st Year Prior | 2nd Year Prior | 3rd Year Prior | 4th Year Prior | 5th Year Prior |
|---|---|---|---|---|---|---|---|
| # Licensed Beds (not rated) | | | | | | | |
| | | | | | | | |
| # Occupied Beds | | | | | | | |
| Acute Care Beds | | | | | | | |
| Bassinets | | | | | | | |
| Long Term Care Beds | | | | | | | |
| Rehab Beds | | | | | | | |
| Psychiatric Beds | | | | | | | |
| Chemical Dependency Beds | | | | | | | |
| | | | | | | | |
| # Visits (Outpatient) | | | | | | | |
| ER Visits | | | | | | | |
| Other Outpatient Visits | | | | | | | |
| Psychiatric Visits | | | | | | | |
| Home Health Visits | | | | | | | |
| | | | | | | | |
| # Procedures | | | | | | | |
| Inpatient Surgeries | | | | | | | |
| Outpatient Surgeries | | | | | | | |
| Deliveries | | | | | | | |
| | | | | | | | |
| Employed Mid-level Practitioners | | | | | | | |
| Physician Assistant | | | | | | | |
| Nurse Practitioner | | | | | | | |
| Nurse Midwife | | | | | | | |
| CRNA | | | | | | | |
| | | | | | | | |
| # Employed Physicians | | | | | | | |
| # Employed Residents | | | | | | | |

Have there been any material changes in exposures during the last 10 years not reflected above? If so, please provide details.

B. Facilities and Services (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| ☐ | Abortion Clinic | ☐ | Gift Shop | ☐ | Outpatient Clinic |
| ☐ | Ambulance | ☐ | Home Health | ☐ | Pathology |
| ☐ | Bariatrics | ☐ | Hospice | ☐ | Pharmacy |
| ☐ | Blood Bank | ☐ | ICU | ☐ | Physical Therapy |
| ☐ | Burn Unit | ☐ | Inhalation Therapy | ☐ | Radiation Therapy |
| ☐ | CCU | ☐ | Long Term Care | ☐ | Radiology |
| ☐ | Cardiac Catheterization Center | ☐ | Morgue | ☐ | Restaurant |
| ☐ | Coronary Care Unit | ☐ | Neurosurgery | ☐ | Sex Change Surgery |
| ☐ | Day Care - Adult | ☐ | Nursery | ☐ | Swimming Pool |
| ☐ | Day Care - Pediatrics | ☐ | OB/GYN | ☐ | Swing Beds |
| ☐ | Dialysis | ☐ | Open Heart | ☐ | Trauma Center |
| ☐ | Dietary | ☐ | Off-site Birthing Center | ☐ | Urgent Care Centers |
| ☐ | DME | ☐ | Operating Rooms | ☐ | X-ray |
| ☐ | Emergency | ☐ | Organ Transplants | ☐ | Other |
| ☐ | Experimental Surgery | ☐ | Outpatient Surgi-centers | ☐ | Other |

C. Other Special Activities

- ☐ Clinical Research
- ☐ Experimental Drugs Administration
- ☐ Biomedical device research and development.
- ☐ Animal research.
- ☐ Clinical site for students (specify all that apply)

Please provide details if any of the above apply:

_____

_____

D. Health care Professionals

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

| Position | Full-Time | Total Full-Time Equivalents |
|---|---|---|
| Employed physicians | ____ | _____ |
| Employed surgeons | ____ | _____ |
| Interns | ____ | _____ |
| Residents | ____ | _____ |
| Dentists | ____ | _____ |
| Podiatrists | ____ | _____ |
| Physician Assistants/Nurse Practitioners | ____ | _____ |
| Midwives | | |
| Registered nurses | ____ | _____ |
| LPNs | ____ | _____ |
| Student nurses | ____ | _____ |
| X-Ray technicians | ____ | _____ |
| Lab technicians | ____ | _____ |
| Pharmacists | ____ | _____ |

| | | |
|---|---|---|
| Profusionists | ____ | _____ |
| EMT's/Paramedics | ____ | _____ |
| CRNAs | ____ | _____ |
| Other employees | ____ | _____ |
| Volunteers | ____ | _____ |

2. Nurse Staffing
   What was the average RN vacancy for the past 12 months? _____ %
   What percent of nursing shifts per month were staffed by agency personnel (avg. last 12 months) _____ %

2. Employed Physicians to be included for coverage:

| Number | Physician Name | # Years in Practice | Full Time Equivalent | Retroactive Date | Date Hired | Termination/ End Date | Coverage Type Claims Made or Occurrence | American Board Certified or Eligible (Y/N) | Specialty* | Surgery - None, Minor or Major |
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* If specialty is Family Practice, please indicate with or without OB.

3. Employed Residents to be included for coverage

| Resident Name | Residency Year | Specialty | Surgery (None, Minor or Major) |
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4. Credentialing

Criteria for qualifications of employed physicians and surgeons:

a. Is history of previous employment verified? ☐ Yes or ☐ No
b. Are references checked? ☐ Yes or ☐ No
c. Has the license of any employed physician or surgeon ever been restricted or suspended? ☐ Yes or ☐ No
d. If yes, please provide details_____
e. 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 or ☐ No
e. How many employed physicians are board certified or board eligible? _____
f. Do employed physicians, employed surgeons, interns and residents carry own insurance? ☐ Yes or ☐ No
g. Are employees to be included as additional insured? ☐ Yes or ☐ 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 or ☐ No
b. Is there a probationary period of at least six months for all staff doctors? ☐ Yes or ☐ No
c. Are staff doctors' performances periodically reviewed by medical staff and/or hospital review board? ☐ Yes or ☐ No
d. How frequently are staff privileges evaluated?_____
e. Do hospital by-laws require staff doctors to carry medical malpractice insurance? ☐ Yes or ☐ No

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

f. Are all privileges granted to staff doctors detailed in writing? ☐ Yes or ☐ No

g. Has the license of any staff physician ever been restricted or suspended? ☐ Yes or ☐ No
If yes, please provide details: _____

_____

6. Anesthesiology

a. Is anesthesiology department staffed by: # of each

| | | |
|---|---|---|
| ____ | Employed Physicians | _____ |
| ____ | Contract Group | _____ |
| ____ | Employed CRNAs | _____ |
| ____ | Staff Physicians | _____ |
| ____ | Staff CRNAs | _____ |

b. If under contract, name of group: _____
If contract group, are certificates of insurance required? ☐ Yes or ☐ No
If yes, what are limits required? _____ per claim _____aggregate

c. Are all anesthesiologists required to be board certified or eligible in Anesthesiology? ☐ Yes or ☐ No

d. Is the anesthesia care performed by CRNAs supervised and reviewed by the anesthesiologists? ☐ Yes or ☐ No
If no, please explain: _____

e. Do any of the anesthesia services staff routinely work more than a 12-hour duty shift? ☐ Yes or ☐ No
If yes, please explain: _____

7. Radiology

a. Is radiology department staffed by: # of each

| | | |
|---|---|---|
| _____ | Employed Physicians | _____ |
| _____ | Contract Group | _____ |
| _____ | Staff Physicians | _____ |

b. If under contract, name of group: _____
If contract group, are certificates of insurance required? ☐ Yes or ☐ No
If yes, what limits are required? _____ per claim _____ aggregate

c. Are all radiologists required to be Board Certified or eligible in Radiology and/or Nuclear Medicine? ☐ Yes or ☐ No

8. Emergency Department

a. How is emergency department classified according to JCAHO standards:

Level I (tertiary)____ Level II (comprehensive)___ Trauma Center____
Level III (basic)____ Other _____
N/A _____

b. Is emergency department staffed by: # of each
_____Employed Physicians _____
_____Contract Group _____
_____Rotating Staff _____

c. If under contract, name of group: _____
If contract group, are certificates of insurance required? ☐ Yes or ☐ No
If yes, what are limits required? _____ per claim _____ aggregate

d. Are all physicians board certified or eligible in emergency medicine? ☐ Yes or ☐ No
If No, are they ACLS or PALS certified? ☐ Yes or ☐ No

e. Are the emergency physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution? ☐ Yes or ☐ No

f. Is the emergency room equipped with the following:
Emergency resuscitation care equipped with defibrillator? ☐ Yes or ☐ No
Electrocardiograph machine ☐ Yes or ☐ No
Dedicated triage area and staff ☐ Yes or ☐ No
Dedicated trauma room(s) ☐ Yes or ☐ No

g. Is the Emergency Room open and staffed by a physician 24 hours/day,7 days/week? ☐ Yes or ☐ No

h. Do any of the emergency department staff routinely work more than a 12-hour duty shift? ☐ Yes or ☐ No
If yes, please explain: _____

9. Obstetrics: Do you have any OB exposure? ☐ Yes or ☐ No
If an OB exposure exists, please complete ADDENDUM B attached.

10. Pharmacy
a. Does the facility utilize the unit dose system of dispensing medicine? ☐ Yes or ☐ No
b. Is a Pyxis or other dispensing system used? ☐ Yes or ☐ No
c. Is the pharmacy for patient use only? ☐ Yes or ☐ No
If no, annual receipts for nonpatients medications are $_____
d. Is the pharmacy staffed by a contract group? ☐ Yes or ☐ No
If yes, please explain: _____

E. Commercial General Liability Exposure

1.a (Attach separate sheet if needed)

| Location | Area | Age | Type of Construction | # of Floors | Type of Fire Protection (City, State) |
|---|---|---|---|---|---|
| Patient Care Buildings | | | | | |
| Other Buildings | | | | | |
| Parking Lots | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Vacant Lots | | | | | |
| Fire Protection Key: AS = Approved sprinkler; S = Smoke detector; H = Heat detector<br>A = Automatic Alarm | | | | | |

b. Are all overnight care buildings Fire Resistive and Sprinklered? ☐ Yes or ☐ No
If not, explain _____

2. Employee Benefits Liability Exposures
   a. Number of Employees? _____
   b. Is Employee benefits Self Administered? ☐ Yes or ☐ No

3. Other Exposures

   a. Has the hospital planned any new construction and/or abatement for this year? ☐ Yes or ☐ No
   If yes, please provide details: _____

   b. Are there elevators or escalators on any premises owned, leased or occupied by the insured? ☐ Yes or ☐ No
   If so, how many? _____
   c. Does the hospital have a heliport? ☐ Yes or ☐ No
   # of landings per year _____

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

   e. Does the hospital have separate insurance coverage for heliport, owned, leased or chartered? ☐ Yes or ☐ No
   If yes, provide details of coverage for each to include carrier, limits and policy periods.

   f. Does the hospital own or operate an ambulance or other emergency use vehicles? ☐ Yes or ☐ No

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

   h. List all owned, leased and non-owned watercraft:_____

   i. 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? _____
   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?
   _____

   j. If hospital operates a Day Care:
      _____ Number of children per day
      _____ Number of adults per day
      _____ Number of days per week
   On hospital premises? ☐ Yes or ☐ No
   Open to the public? ☐ Yes or ☐ No
      _____ Ratio of caregivers to children

Please describe hiring practices for caregivers _____

k. Does hospital operate a Dialysis Unit ☐ Yes or ☐ No
If yes, number of procedures per year _____

4. Hold Harmless and Indemnification Agreements

a. Has the hospital agreed to hold harmless or indemnify others under contract? ☐ Yes or ☐ No
b. Does the hospital rent or lease any equipment from others? ☐ Yes or ☐ No
If a. or b. is yes, please explain: _____

5. Risk Management/Performance

a. Who coordinates your risk management program?

Name: _____Title: _____

Telephone: (_____) _____ E-mail: _____

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

c. Is there a written performance improvement program that has been approved by a governing body? ☐ Yes or ☐ No

d. Does the governing body review the effectiveness of the program and approve necessary changes?

e. Is the risk manager accountable and solely responsible for risk management?

If no, explain other responsibilities: _____

f. Does the risk management program include the following:
___Occurrence reporting
___Claim management
___Formal link to quality management
___Safety program and safety committee
___Review and participation in medical staff committees
___Contract review and evaluation

## III. EXCESS OR UMBRELLA

If interested in Umbrella or Excess coverage, please provide the following information:

Underlying Information:

| Coverage | Carrier | Policy Dates | Limit | Policy Number |
|---|---|---|---|---|
| Automobile | | | | |
| Employers Liability | | | | |
| General Liability | | | | |
| Heliport Liability | | | | |
| Non-Owned Aircraft Liability | | | | |

Please provide loss information for the above if these lines are being requested.

## IV. CLAIMS HISTORY

1. Have any claims ever been made against you? ☐ Yes or ☐ No
If yes, please provide currently valued carrier loss runs

2. Are you aware of any incident, circumstance or loss which has occurred after the proposed retroactive date, which is likely to result in a claim? ☐ Yes or ☐ No

If yes, please provide details

Have they been reported to your current or previous carrier(s)? ☐ Yes or ☐ No

Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in Questions 1 and 2 is excluded from the proposed coverage.

**THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. 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 PROFESSIONALEXPOSURES.**

**NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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, WHICH IS A CRIME.**

**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 POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER 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, MAINE, TENNESSEE, AND VIRGINIA 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 FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF 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**

**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 LOUISIANA AND 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 MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.**

**NOTICE TO NEW JERSEY 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 SUCH VIOLATION.**

**NOTICE TO OKLAHOMA APPLICANTS: 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 OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.**

**NOTICE TO PENNSYLVANIA 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**

Signature of Applicant: _____

Title: _____

Date: _____

Signature of Producer: _____

License #: _____

Date: _____

## Addendum A – Claims Information

Name of Insured _____
Date of Loss Run _____

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**Addendum B – Obstetrics**

9. Obstetrics

1. Is the facility a regional referral center for high risk pregnancies or newborns requiring intensive care? ☐Yes or ☐No

If no, does a written procedure exist for transferring all high-risk mothers and/or babies who the hospital is not qualified to treat? ☐Yes or ☐No

2. Can cesarean sections be performed within 30 minutes at all times? ☐Yes or ☐No

3. Is an anesthesiologist or CRNA available in house at all times? ☐Yes or ☐No
   If no, please provide details _____

4. Do Nurse Midwives provide OB services? ☐Yes or ☐No
   If yes, are they privileged to perform c-sections or VBAC's ☐Yes or ☐No
   If yes to either question, please attach delineation of privileges

5. Do Family Practitioners provide OB services? ☐Yes or ☐No
   If yes, are they privileged to perform c-sections or VBAC's ☐Yes or ☐No
   If yes to either question, please attach delineation of privilege

6. Do nurse midwives deliver babies at patient's homes? ☐Yes or ☐No

7. 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 _____

8. How many births at your facility (previous 12 months)? _____

9. How many cesarean sections (previous 12 months)? _____

10. How many vaginal births after C-section (VBACs) (previous 12 months)? _____

11. Are physicians, who are capable of performing a c-section, 'immediately available' for VBAC patients in active labor? ☐Yes or ☐No
    Please attach copies of:
    VBAC Policy including facility's definition of 'immediately available'
    VBAC Informed Consent policies and procedures and form
    Electronic Fetal Monitoring competencies and training policies and procedures.

12. Please provide the following information using data from the last 12 months:

    Number of live births with inductions (i.e. pitocin only) _____
    Number of births using either forceps or vacuum extractions _____
    Number of birth related injuries _____
    Number of births with 5 minute Apgar score of less than 7 _____
    Number of neonatal deaths (age < 28 days) _____
    Number of maternal deaths _____

13. Please provide the nurse/patient ratio for the following:

a. Patients in early labor _____
b. Patients undergoing induction or augmentation of labor _____
c. Patients in the 2nd stage of labor and beyond _____
d. Newborns in normal newborn nursery _____
e. Newborns requiring level 2 (continuing/intermediate) care _____
f. Newborns requiring level 3 (intensive) care _____

14. How many physicians have OB privileges? _____

15. How many are board certified in OB _____

16. Are nurses required to participate in electronic fetal monitoring training and testing? ☐Yes or ☐No
How often? _____

17. Are physicians required to participate in electronic fetal monitoring training and testing? ☐Yes or ☐No
How often? _____