Miscellaneous Health Care Facility 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.

- **This application must be completed in full, including all required attachments.**
- **Attach a separate sheet of paper if more space is needed to answer any question.**
- **We treat all applications as confidential.**

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 currently open 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. Risk management and quality improvement plan including any specific supplemental applications that are required for specific business segments.

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

6. 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.

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.**

I. GENERAL INFORMATION

Applicant Name:

_____

Business Address: Street _____ City, State _____ ZIP _____

Mailing Address:

_____ Telephone #: _____

Website (if applicable) _____ Years in Business: _____

Key Contact at Insured: _____ Federal Tax ID: _____

APPLICANT IS (Check all that applies):

A.	B.	C.
☐ Individual	☐ Profit	☐ Licensed by the state
☐ Partnership	☐ Non-Profit	☐ Accredited by AOA
☐ Corporation	☐ Charitable	☐ Medicare Approved
☐ Joint Venture	☐ Government	☐ Member of JCAHO
		☐ Accredited by CARF
		☐ Other

D. 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 _____

II. EXPOSURE DATA

A. Professional Liability Exposures (**Please fill out Supplemental Application for type of facility**)

	Visits*	**Beds**				**Receipts****	**Visits**
Rehabilitation				**Laboratory**			
Cardiac Rehabilitation				Medical Lab			
Physical/Occupational/Speech Rehabilitation				Pathology Lab			
Transitional Rehabilitation • Transitional Living • Skilled Medical				X – Ray Imaging Center			
						Visits	**Beds**
Surgery Centers				**Treatment**			
Surgical Centers				College or University Health Center			
Home Care/Hospice				Community Health Center			
Home Health				Occupational Center			
Hospice Care							

** Visits should be counted for each time a patient enters your facility. Beds should be on an occupied basis. Receipts are gross revenues of the organization. If multi location account, please break down by location/state for rating purposes.*

B. 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:

_____

_____

_____

C. Health Care Professionals

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

Position	Full-Time (E)mployed/	Total FTE (C)ontracted/	(V)olunteers
Physicians/Surgeons	____	_____	____
Aides	____	_____	____
Dentists	____	_____	____
Dietician's	____	_____	____
CRNA's	____	_____	____
Nurse Midwives	____	_____	____
Nurse Practitioners	____	_____	____
Occupational Therapists	____	_____	____
Pharmacists	____	_____	____
Physical/Speech Therapists	____	_____	____
Physician/Surgeons Assistants	____	_____	____
Podiatrist	____	_____	____
RN's/LPN/LVNs	____	_____	____
Technicians	____	_____	____
Other (describe):	____	_____	____

III. Risk Management/Quality

A. Risk Management/Performance Improvement

a. Who coordinates your risk management program?
Name: _____Title: _____
Telephone: (_____) _____ E-mail: _____

b. Is there a written, risk management/quality management program?
☐ Yes ☐ No

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

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

e. Is the risk manager accountable and solely responsible for risk management?
☐ Yes ☐ No
If no, explain other responsibilities: _____

B. Credentialing

a. Is history of previous employment verified for all employees or physicians? ☐ Yes ☐ No

b. Are references checked for all employees or physicians? ☐ Yes ☐ No

c. Has the license of any employed/contracted physician or surgeon ever been restricted or suspended?

☐ Yes ☐ No

If yes, please provide details_____

d. Do employed/contracted physicians, employed surgeons, interns and residents carry own insurance?

☐ Yes ☐ No

If yes, what limits: _____

e. Has the facility 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

f. How many physicians are board certified or board eligible? _____

g. Are physicians to be included as additional insured? ☐ Yes ☐ No

C. Hold Harmless and Indemnification Agreements

a. Has the facility agreed to hold harmless or indemnify others under contract?

☐ Yes ☐ No

If yes please attach a copy of contract.

b. Does the facility rent or lease any equipment from others?

☐ Yes ☐ No

If yes, does the facility have hold harmless and indemnity agreements in place with these vendors?

☐ Yes ☐ No

IV. Commercial General Liability Exposure

1. Attach separate sheet, if needed

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

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

3. Other Exposures

a. Are there elevators or escalators on any premises owned, leased or occupied by the insured?

☐ Yes ☐ No

If so, how many? _____

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

c. Do you sell or lease any medical equipment or products to patients or others in connection with your operation? ☐ Yes ☐ No

d. Has the applicant sold, acquired, or discontinued any operations in the past ten (10) years?
☐ Yes ☐ No
If yes please explain: _____

e. Is the applicant considering any changes in operations or products over the next 12 months? ☐ Yes ☐ No

If yes please explain: _____

V. 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				

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

VI. CLAIMS HISTORY

1. Have any claims ever been made against you? ☐ Yes ☐ No
   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 ☐ No
   If yes, please provide details
   Have they been reported to your current or previous carrier(s)? ☐ Yes ☐ 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.

NOTICE TO WASHINGTON 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.

Signature of Applicant: _____

Title: _____

Date: _____