1-877-245-5887
Return application by fax or email
fax: (310) 796-9054
email: info@cbmalagains.com

CBMALAGA
Insurance Services LLC

Policy Number: _____
COMPANY USE ONLY

HOSPITAL LIABILITY INSURANCE APPLICATION

PLEASE COMPLETE A SEPARATE APPLICATION IF MULTIPLE LOCATIONS EXIST.

AGENT INFORMATION

CB Malaga Insurance Services LLC - www.cbmalagains.com
BROKERAGE FIRM/AGENCY NAME

CITY, STATE, AND ZIP CODE

BROKER/AGENT NAME | **EMAIL**

1-877-245-5887
PHONE | **FAX**

I. APPLICANT INFORMATION

PLEASE PRINT LEGIBLY, POLICY IS BASED ON READABILITY OF YOUR NAME. PLEASE ANSWER ALL QUESTIONS; IF A QUESTION IS NOT APPLICABLE, STATE "N/A". IF ADDITIONAL SPACE IS NEEDED PLEASE USE SUPPLEMENTAL FORM ON PAGE 19 OR ATTACH A SEPARATE PIECE OF PAPER.

****WHENEVER "APPLICANT NAME" IS USED IN THIS APPLICATION, THE TERM "APPLICANT" MEANS THE ENTITY BELOW****

APPLICANT NAME

MAILING ADDRESS

STREET ADDRESS (IF DIFFERENT)

CONTACT PERSON | **TITLE**

PHONE | **FAX** | **EMAIL**

WEBSITE ADDRESS

PROPOSED EFFECTIVE DATES: **FROM:** _____ **TO:** _____

PLEASE COMPLETE THE "SCHEDULE OF RELATED ENTITIES" OR ATTACH A COPY OF YOUR ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED IN THE "SCHEDULE OF RELATED ENTITIES".

II. GENERAL INFORMATION

A. TYPE OF FACILITY: (CHECK ALL THAT APPLY)

- ☐ GENERAL HOSPITAL
- ☐ CHILDREN'S HOSPITAL
- ☐ CRITICAL ACCESS HOSPITAL
- ☐ NURSING HOME/LONG TERM CARE
- ☐ PSYCHIATRIC HOSPITAL
- ☐ REHABILITATION HOSPITAL
- ☐ SKILLED NURSING FACILITY
- ☐ SUBSTANCE ABUSE HOSPITAL
- ☐ SURGICAL HOSPITAL
- ☐ UNIVERSITY HOSPITAL
- ☐ WOMENS HOSPITAL
- ☐ OTHER _____

- ☐ GOVERNMENTAL
- ☐ FOR PROFIT
- ☐ NOT FOR PROFIT
- ☐ INDIVIDUAL
- ☐ PARTNERSHIP
- ☐ JOINT VENTURE
- ☐ CORPORATION
- ☐ OTHER _____

B. THE FACILITY IS LICENSED IN THE STATES OF: _____

C. HAS THE FACILITY'S LICENSE EVER BEEN REVOKED, DENIED, LIMITED OR SURRENDERED? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN. _____

D. IS THE FACILITY ELIGIBLE FOR JCAHO ACCREDITATION? ☐ YES ☐ NO

IF YES, HAVE YOU RECEIVED JCAHO ACCREDITATION? ☐ YES ☐ NO

IF YES, IS THE ACCREDITATION: ☐ FULL ☐ CONDITIONAL/PROVISIONAL

IF CONDITIONAL/PROVISIONAL, ATTACH A COPY OF THE TYPE 1 RECOMMENDATIONS FROM THE LAST VISIT

IF NO, DO YOU HOLD ANY OTHER ACCREDITATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST NAME OF THE ACCREDITING BODY: _____

E. ARE YOU AN AHA MEMBER? ☐ YES ☐ NO

III. COVERAGES, LIMITS AND DEDUCTIBLES

PLEASE COMPLETE THE "COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE".

IV. EXPOSURE INFORMATION - PATIENT DATA

A. BEDS

	LICENSED BEDS	AVERAGE OCCUPIED BEDS*	PATIENT DAYS (LAST 12 MONTHS)	PATIENT DAYS (NEXT 12 MONTHS)
ACUTE CARE				
BASSINETS & CRIBS				
CHEMICAL DEPENDENCY AND REHABILITATION				
INTENSIVE CARE/CRITICAL CARE				
LONG TERM CARE - SKILLED				
LONG TERM CARE - INTERMEDIATE				
LONG TERM CARE - RESIDENTIAL				
LONG TERM CARE - TRANSITIONAL/SWING BEDS/SUB ACUTE				
MATERNITY (OBSTETRICS)				
NEONATAL INTENSIVE CARE				
PEDIATRIC CARE				
PSYCHIATRIC CARE				
REHABILITATION				
OTHER (DESCRIBE):				

***FOR AVERAGE OCCUPIED BEDS TAKE THE ANNUAL INPATIENT DAYS DIVIDED BY 365**

B. NUMBER OF ADMISSIONS PROJECTED FOR THE NEXT 12 MONTHS _____

C. HOSPITAL BIRTHS AND SURGICAL PROCEDURES

	NUMBER (LAST 12 MONTHS)	NUMBER (NEXT 12 MONTHS)
TOTAL NUMBER OF BIRTHS		
C-SECTIONS		
VBACS		
ALL OTHER		
INPATIENT SURGERIES		
OUTPATIENT SURGERIES		
BARIATRIC SURGERIES**		

**IF YOU HAVE OFFERED OR PLAN TO OFFER BARIATRIC SURGERY IN THE NEXT 12 MONTHS, PLEASE COMPLETE A SEPARATE BARIATRIC SURGERY SUPPLEMENTAL QUESTIONNAIRE (FACILITIES)

D. HOSPITAL VISITS/OUTPATIENT VISITS

REPORT THE NUMBER OF PATIENT VISITS IN EACH CATEGORY.

	NUMBER OF *"VISITS"* (LAST 12 MONTHS)	**NUMBER OF "*VISITS*" (NEXT 12 MONTHS)**
ALCOHOL/DRUG ABUSE		
CLINICAL LAB		
EMERGENCY ROOM		
HOME HEALTH CARE		
HOSPICE		
IMAGING		
OUTPATIENT CLINIC		
PSYCHIATRIC		
REHABILITATION THERAPY		
URGENT CARE		
WELLNESS/FITNESS CENTER		
OTHER		

IV. EXPOSURE INFORMATION - PATIENT DATA (CONTINUED)

E. ANCILLARY SERVICES (PROVIDED TO NON-PATIENTS AND NON-OWNED ENTITIES)

	ANNUAL REVENUES (LAST 12 MONTHS)	ANNUAL REVENUES (NEXT 12 MONTHS)
BLOOD BANK		
DURABLE MEDICAL EQUIPMENT*		
MANUFACTURED, PRODUCED, MODIFIED, SERVICED OR ASSEMBLED:		
**PLEASE PROVIDE A BROCHURE, CATALOG OR LIST OF ALL ITEMS AVAILABLE.* LEASED OR RENTED TO OTHERS:		
SOLD TO OTHERS:		
MEDICAL OR X-RAY LAB		
RETAIL PHARMACY SERVICES		
RESOURCE LAB		
WELLNESS/FITNESS CENTER		
OTHER (DESCRIBE):		

F. INDICATE IF YOU CURRENTLY OFFER OR PLAN TO OFFER ANY OF THE FOLLOWING TYPES OF SURGERY DURING THE NEXT 12 MONTHS. FOR THOSE YOU PLAN TO OFFER, PLEASE DESCRIBE THE TYPES OF SURGERY YOU WILL PERFORM UNDER EACH CATEGORY.

ABORTIONS	☐ YES ☐ NO	# 1ST TRIMESTER _____ # OTHER _____
BARIATRIC	☐ YES ☐ NO	TYPE: _____
CARDIAC	☐ YES ☐ NO	TYPE: _____
COSMETIC	☐ YES ☐ NO	TYPE: _____
LIPOSUCTION	☐ YES ☐ NO	TYPE: _____
NEUROSURGERY	☐ YES ☐ NO	TYPE: _____
OPHTHALMOLOGY	☐ YES ☐ NO	TYPE: _____
LASIK	☐ YES ☐ NO	TYPE: _____
ORGAN TRANSPLANTS	☐ YES ☐ NO	TYPE: _____
ORTHOPEDIC SURGERY - SPINAL	☐ YES ☐ NO	TYPE: _____
OTHER THAN SPINAL	☐ YES ☐ NO	TYPE: _____
SEX CHANGE OPERATIONS	☐ YES ☐ NO	TYPE: _____
VASCULAR	☐ YES ☐ NO	TYPE: _____

V. EXPOSURE INFORMATION - SERVICES

A. HAVE YOU OR WILL YOU CONDUCT/PROVIDE ANY OF THE FOLLOWING?

1. RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? ☐ YES ☐ NO

IF YES, COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE.

2. FULL BODY SCANS TO NON-PATIENTS? ☐ YES ☐ NO

IF YES, INDICATE THE NUMBER OF PROCEDURES ANTICIPATED FOR THE NEXT 12 MONTHS: _____

3. ALTERNATIVE/COMPLEMENTARY MEDICINE? ☐ YES ☐ NO

IF YES, INDICATE THE TYPE OF ALTERNATIVE MEDICINE PROVIDED. _____

B. ARE ANY CHANGES PLANNED TO THE SERVICES YOU OFFER IN THE NEXT 12 MONTHS? ☐ YES ☐ NO

(PLEASE INCLUDE ADDITIONAL SERVICES AS WELL AS SERVICES TO BE DISCONTINUED.)

IF YES, PLEASE DESCRIBE. _____

_____

C. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE. _____

VI. PERSONNEL DATA

A. WHEN HIRING ALLIED PROFESSIONALS ARE CREDENTIALS CHECKED AND VERIFIED? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

B. PROVIDE THE NUMBER OF ALLIED PROFESSIONALS WORKING AT YOUR FACILITY IN THE CHART BELOW.

DO NOT INCLUDE DENTISTS, ORAL SURGEONS, CRNA'S, NURSE MIDWIVES, NURSE PRACTITIONERS, PODIATRISTS, PHYSICIAN ASSISTANTS OR SURGICAL ASSISTANTS.

	NUMBER EMPLOYED	NUMBER CONTRACTED
AIDES		
CHIROPRACTORS		
DENTAL HYGIENISTS/TECHNICIANS		
DIETICIANS		
EMT'S/PARAMEDICS		
LABORATORY TECHNICIANS		
LPN'S		
MEDICAL TECHNICIANS		
PERFUSIONISTS		
PHARMACISTS		
RESPIRATORY THERAPISTS		
RN'S		
PSYCHOLOGISTS		
RADIOLOGY/X-RAY TECHNICIANS/THERAPISTS		
OTHER ALLIED PROFESSIONALS		

C. MEDICAL PROFESSIONALS

PLEASE INDICATE THE COVERAGE DESIRED ON THE "COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE". ALSO COMPLETE THE "SCHEDULE OF MEDICAL PROFESSIONALS" IF COVERAGE IS DESIRED.

**NOTE: IF COVERAGE IS DESIRED FOR CRNA'S, NURSE MIDWIVES, NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, PODIATRISTS OR SURGICAL ASSISTANTS SEPARATE APPLICATIONS MAY BE REQUIRED. PLEASE REFER TO THE INSTRUCTIONS ON THE "SCHEDULE OF MEDICAL PROFESSIONALS." IF COVERAGE IS DESIRED FOR PHYSICIANS, SURGEONS, DENTISTS OR ORAL SURGEONS, SEPARATE APPLICATIONS ARE REQUIRED.*

VII. HOSPITAL SERVICES INFORMATION

A. AMBULANCE SERVICES

1. DO YOU HAVE AN AMBULANCE SERVICE? ☐ YES ☐ NO

IF YES, WHAT IS THE NUMBER OF RUNS ANNUALLY? EMERGENCY _____ NON-EMERGENCY _____

2. NUMBER OF EMT/PARAMEDICS: _____

3. IS THE AMBULANCE SERVICE PROVIDED BY A CONTRACT GROUP OR EMPLOYEES? ☐ CONTRACT GROUP ☐ EMPLOYEES

IF **EMPLOYEES,** GO TO NEXT SECTION; B. ANESTHESIA SERVICES

IF **CONTRACT GROUP**, WHAT IS THE NAME OF THE GROUP? _____

NAME OF GROUPS' INSURANCE CARRIER: _____

4. DOES THE GROUP PROVIDE A HOLD HARMLESS AGREEMENT IN FAVOR OF THE HOSPITAL? ☐ YES ☐ NO

5. DO THEY ANNUALLY PROVIDE YOU A CERTIFICATE OF INSURANCE FOR PROFESSIONAL LIABILITY? ☐ YES ☐ NO

6. WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THE GROUP TO CARRY?

$ _____ PER MEDICAL INCIDENT $ _____ AGGREGATE

7. DO THE LIMITS APPLY TO THE MEDICAL PROFESSIONALS ON AN INDIVIDUAL OR SHARED LIMITS BASIS? ☐ INDIVIDUAL ☐ SHARED LIMIT

B. ANESTHESIA SERVICES

1. IS THE ANESTHESIOLOGY DEPARTMENT STAFFED BY A CONTRACT GROUP OR EMPLOYEES? ☐ CONTRACT GROUP ☐ EMPLOYEES

IF **CONTRACT GROUP,** WHAT IS THE NAME OF THE GROUP? _____

IF **EMPLOYEES,** PLEASE GO TO QUESTION #6.

2. DOES THE GROUP PROVIDE A HOLD HARMLESS AGREEMENT IN FAVOR OF THE HOSPITAL? ☐ YES ☐ NO

3. DO THEY ANNUALLY PROVIDE YOU A CERTIFICATE OF INSURANCE FOR PROFESSIONAL LIABILITY? ☐ YES ☐ NO

4. WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THE GROUP TO CARRY?

$ _____ PER MEDICAL INCIDENT $ _____ AGGREGATE

5. DO THE LIMITS APPLY ON AN INDIVIDUAL OR SHARED LIMITS BASIS? ☐ INDIVIDUAL ☐ SHARED LIMIT

VII. HOSPITAL SERVICES INFORMATION (CONTINUED)

B. ANESTHESIA SERVICES (CONTINUED)

6. NUMBER OF EMPLOYED AND CONTRACTED: ANESTHESIOLOGISTS: _____ CRNA'S _____

7. ARE THE ANESTHESIOLOGISTS REQUIRED TO BE BOARD CERTIFIED/ELIGIBLE IN ANESTHESIOLOGY? ☐ YES ☐ NO

8. IS ANESTHESIA ADMINISTERED *WITHOUT* THE DIRECT SUPERVISION OF AN ANESTHESIOLOGIST? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

9. IS AN ANESTHESIOLOGIST ON SITE 24 HOURS A DAY? ☐ YES ☐ NO

IF NO, IS AN ANESTHESIOLOGIST ON CALL 24 HOURS A DAY? ☐ YES ☐ NO

IF YES, WHAT IS THE MAXIMUM AMOUNT OF TIME FOR ARRIVAL FOR THE ON-CALL PHYSICIAN? _____

IF NO, PLEASE EXPLAIN: _____

10. DOES THE ANESTHESIA EQUIPMENT HAVE OXYGEN ANALYZERS? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

11. DOES THE ANESTHESIA EQUIPMENT HAVE DISCONNECT ALARMS? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

12. WHO OWNS AND MAINTAINS THE ANESTHESIA EQUIPMENT? _____

C. BLOOD BANK

1. DO YOU OWN/OPERATE A BLOOD BANK? ☐ YES ☐ NO

IF NO, PLEASE GO TO QUESTION #7

2. ARE SERVICES PROVIDED ONLY FOR THE HOSPITAL'S PATIENTS? ☐ YES ☐ NO

3. INDICATE THE NUMBER OF PINTS ACQUIRED ANNUALLY THROUGH: DONATIONS _____ **PURCHASES** _____

4. DESCRIBE YOUR SCREENING PROCEDURES FOR VOLUNTEER AND PAID DONORS _____

_____

5. DO YOU SELL BLOOD/BLOOD PRODUCTS FOR USE IN MANUFACTURING VACCINES OR OTHER PRODUCTS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE AND PROVIDE THE ESTIMATED ANNUAL REVENUE. _____

6. DO YOU ENGAGE IN THE MANUFACTURING OF ANY PRODUCTS FROM BLOOD COLLECTED? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE AND PROVIDE THE ESTIMATED ANNUAL REVENUE. _____

7. DOES THE HOSPITAL PERFORM ANY PLASMAPHERIS PROCEDURES? ☐ YES ☐ NO

IF YES, PLEASE INDICATE THE NUMBER OF PROCEDURES ANNUALLY. _____

8. IF THE HOSPITAL DOES NOT OWN OR OPERATE A BLOOD BANK, FROM WHAT SOURCE(S) DOES IT OBTAIN BLOOD OR BLOOD PRODUCTS? _____

_____

D. EMERGENCY SERVICES

1. WHAT IS THE AMERICAN COLLEGE OF SURGEONS DESIGNATION OF THE EMERGENCY DEPARTMENT?

☐ LEVEL I (TERTIARY) ☐ LEVEL II (COMPREHENSIVE) ☐ LEVEL III (BASIC) ☐ OTHER _____

2. DOES THE EMERGENCY DEPARTMENT HAVE 24 HOUR IN-HOUSE PHYSICIAN COVERAGE? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

3. IS IT REQUIRED THAT ALL EMERGENCY DEPARTMENT PATIENTS BE SEEN BY A PHYSICIAN? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

4. IF A PATIENT IS ADMITTED, WHO SIGNS THE ADMISSION PAPERS? ☐ EMERGENCY ROOM PHYSICIAN ☐ ATTENDING PHYSICIAN

5. IS THE EMERGENCY DEPARTMENT STAFFED BY A CONTRACT GROUP OR EMPLOYEES? ☐ CONTRACT GROUP ☐ EMPLOYEES

IF **EMPLOYEES**, GO TO QUESTION 10.

IF **CONTRACT GROUP**, WHAT IS THE NAME OF THE GROUP? _____

NAME OF GROUPS' INSURANCE CARRIER: _____

6. DOES THE GROUP PROVIDE A HOLD HARMLESS AGREEMENT IN FAVOR OF THE HOSPITAL? ☐ YES ☐ NO

7. DO THEY ANNUALLY PROVIDE YOU A CERTIFICATE OF INSURANCE FOR PROFESSIONAL LIABILITY? ☐ YES ☐ NO

8. WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THE GROUP TO CARRY?

$ _____ PER MEDICAL INCIDENT $ _____ AGGREGATE

9. DO THE LIMITS APPLY ON AN INDIVIDUAL OR SHARED LIMITS BASIS? ☐ INDIVIDUAL ☐ SHARED LIMITS

10. ARE ALL EMERGENCY DEPARTMENT PHYSICIANS BOARD CERTIFIED IN EMERGENCY MEDICINE? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

TOTAL # ER PHYSICIANS: _____ # **NOT** BOARD CERTIFIED IN EMERGENCY MEDICINE: _____

VII. HOSPITAL SERVICES INFORMATION (CONTINUED)

E. HOSPITALISTS/INTENSIVIST SERVICES

1. IS THERE A DEDICATED HOSPITALIST/INTENSIVIST AT YOUR FACILITY? ☐ YES ☐ NO

IF YES, DO THEY PROVIDE: ☐ HOUSE COVERAGE ☐ CRITICAL CARE COVERAGE ☐ OTHER _____

2. ARE THEY: ☐ EMPLOYED ☐ STAFF PHYSICIANS ☐ CONTRACTED

3. IF CONTRACTED, DO THEY ANNUALLY PROVIDE A CERTIFICATE OF INSURANCE FOR PROFESSIONAL LIABILITY? ☐ YES ☐ NO

4. WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THEM TO CARRY?

$ _____ PER MEDICAL INCIDENT $ _____ AGGREGATE

F. OBSTETRICAL SERVICES

1. IS THE HOSPITAL A REGIONAL REFERRAL CENTER FOR HIGH-RISK PREGNANCIES OR NEWBORNS? ☐ YES ☐ NO

IF NO, IS THERE A WRITTEN PROCEDURE FOR TRANSFERRING ALL HIGH-RISK MOTHERS AND/OR BABIES THE HOSPITAL ISN'T QUALIFIED TO TREAT? ☐ YES ☐ NO

2. DO YOU PROVIDE ON-GOING TREATMENT FOR HIGH RISK PREGNANCIES OR NEWBORNS? ☐ YES ☐ NO

3. INDICATE THE LEVEL OF NURSERY CARE YOU PROVIDE AND THE CORRESPONDING NUMBER OF BASSINETS.

	NUMBER OF BASSINETS
☐ LEVEL I: WELL BABY	_____
☐ LEVEL II: INTERMEDIATE CARE	_____
☐ LEVEL III: NEONATAL INTENSIVE CARE	_____

IS A NEONATOLIGIST ON-SITE 24 HOURS A DAY? ☐ YES ☐ NO

4. IS THERE AN OBSTETRICIAN ON SITE 24 HOURS A DAY? ☐ YES ☐ NO

IF NO, IS THERE AN OBSTETRICIAN ON-CALL 24 HOURS A DAY? ☐ YES ☐ NO

IF YES, WHAT IS THE MAXIMUM AMOUNT OF TIME FOR ARRIVAL FOR THE ON-CALL PHYSICIAN? _____

IF NO, PLEASE EXPLAIN: _____

5. WHAT IS THE MAXIMUM AMOUNT OF TIME IT TAKES TO PERFORM AN EMERGENCY CESAREAN SECTION ONCE IT IS DETERMINED THAT ONE IS NECESSARY? _____

6. WHO PROVIDES ANESTHESIA DURING LABOR AND DELIVERY? _____

7. DOES A BOARD CERTIFIED OBSTETRICIAN CHAIR THE OB DEPARTMENT? ☐ YES ☐ NO

8. IN ADDITION TO OBSTETRICIANS, WHO ELSE CAN PERFORM DELIVERIES?

☐ FAMILY PRACTICE PHYSICIAN ☐ GENERAL MEDICINE PHYSICIAN ☐ OTHER _____

☐ RESIDENT (YEAR OF RESIDENCY) _____ ☐ NURSE MIDWIFE

9. WHAT IS THE TOTAL NUMBER OF PHYSICIANS THAT HAVE OB PRIVILEGES? _____

OF THOSE, HOW MANY ARE BOARD CERTIFIED/ELIGIBLE IN OB? _____

10. DO NURSE MIDWIVES PRACTICE IN LABOR AND DELIVERY? ☐ YES ☐ NO

IF YES, ARE WRITTEN PROTOCOLS FOR PRIVILEGES/SUPERVISION FOLLOWED? ☐ YES ☐ NO

HOW MANY DELIVERIES ARE PERFORMED BY MIDWIVES ANNUALLY? _____

DO MIDWIVES PERFORM HIGH RISK DELIVERIES? ☐ YES ☐ NO

HOW MANY ARE EMPLOYED? _____ HOW MANY ARE CONTRACTED? _____

IF EMPLOYED, DO THEY HAVE THEIR OWN PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

IF CONTRACTED, DO THEY PROVIDE A HOLD HARMLESS AGREEMENT IN FAVOR OF THE HOSPITAL? ☐ YES ☐ NO

WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THEM TO CARRY?

$ _____ PER MEDICAL INCIDENT $ _____ AGGREGATE

DO THE LIMITS APPLY ON AN INDIVIDUAL OR SHARED LIMITS BASIS? ☐ INDIVIDUAL ☐ SHARED LIMIT

DO THEY ANNUALLY FURNISH YOU A CERTIFICATE OF INSURANCE FOR PROFESSIONAL LIABILITY? ☐ YES ☐ NO

11. DOES YOUR FACILITY HAVE A FORMAL WRITTEN PROCEDURE REGARDING OXYTOCINS? ☐ YES ☐ NO

IS AN ATTENDING PHYSICIAN REQUIRED TO SUPERVISE THE USE OF OXYTOCINS? ☐ YES ☐ NO

12. DO YOU SPONSOR ANY OFF SITE DELIVERY PROGRAMS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

13. IS ELECTRONIC FETAL MONITORING PERFORMED ON ALL PATIENTS IN ACTIVE LABOR? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

VII. HOSPITAL SERVICES INFORMATION (CONTINUED)

G. PHARMACEUTICAL SERVICES

1. DOES A FULL-TIME REGISTERED PHARMACIST DIRECT THE PHARMACY? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

2. IS THE PHARMACY STAFFED IN WHOLE OR IN PART BY A CONTRACT GROUP? ☐ YES ☐ NO

IF YES, WHAT IS THE NAME OF THE GROUP? _____

NAME OF THE GROUPS' INSURANCE CARRIER: _____

DOES THE GROUP FURNISH A HOLD HARMLESS AGREEMENT IN FAVOR OF THE HOSPITAL? ☐ YES ☐ NO

WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THE GROUP TO CARRY?

$ _____ PER MEDICAL INCIDENT $ _____ AGGREGATE

DO THE LIMITS APPLY ON AN INDIVIDUAL OR SHARED LIMITS BASIS? ☐ INDIVIDUAL ☐ SHARED LIMIT

DO THEY ANNUALLY FURNISH YOU A CERTIFICATE OF INSURANCE FOR PROFESSIONAL LIABILITY? ☐ YES ☐ NO

3. DOES THE PHARMACY USE A BAR CODING SYSTEM FOR DISPENSING MEDICINE? ☐ YES ☐ NO

4. DOES THE PHARMACY USE A UNIT–DOSE SYSTEM OF DISPENSING MEDICINE? ☐ YES ☐ NO

5. IS THE PHARMACY STAFFED 24 HOURS A DAY? ☐ YES ☐ NO

IF NO, HOW ARE MEDICATIONS OBTAINED WHEN THE PHARMACY IS CLOSED? _____

H. RADIOLOGY

1. IS THE RADIOLOGY DEPARTMENT STAFFED IN WHOLE OR IN PART BY A CONTRACT GROUP? ☐ YES ☐ NO

IF YES, WHAT IS THE NAME OF THE GROUP? _____

NAME OF THE GROUPS' INSURANCE CARRIER: _____

DOES THE GROUP FURNISH A HOLD HARMLESS AGREEMENT IN FAVOR OF THE HOSPITAL? ☐ YES ☐ NO

WHAT ARE THE MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THE GROUP TO CARRY?

$ _____ PER MEDICAL INCIDENT $ _____ AGGREGATE

DO THE LIMITS APPLY ON AN INDIVIDUAL OR SHARED LIMITS BASIS? ☐ INDIVIDUAL ☐ SHARED LIMIT

DO THEY ANNUALLY FURNISH YOU A CERTIFICATE OF INSURANCE FOR PROFESSIONAL LIABILITY? ☐ YES ☐ NO

2. NUMBER OF RADIOLOGISTS: _____

HOW MANY ARE EMPLOYEES? _____ HOW MANY ARE CONTRACTORS? _____

3. DO YOU REQUIRE A RADIOLOGIST BE ON SITE 24 HOURS A DAY? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

4. ARE ALL RADIOLOGY EXAMINATIONS AND REPORTS RENDERED TO AND INTERPRETED BY A RADIOLOGIST? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

5. ARE ALL RADIOLOGIST REQUIRED TO BE BOARD CERTIFIED/ELIGIBLE IN RADIOLOGY AND/OR NUCLEAR MEDICINE? ☐ YES ☐ NO

6. DOES THE HOSPITAL USE TELE-RADIOLOGY? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE: _____

7. DO X-RAY TECHNICIANS ADMINISTER CONTRAST MEDIA? ☐ YES ☐ NO

IF YES, ARE THEY REQUIRED TO BE LICENSED? ☐ YES ☐ NO

I. SURGICAL

1. IS INFORMED CONSENT DOCUMENTED IN THE MEDICAL RECORDS? ☐ YES ☐ NO

2. DOES THE INFORMED CONSENT INDICATE THAT THE PATIENT WAS ADVISED OF THE SURGICAL PROCEDURES TO BE DONE, THE POSSIBLE RISKS OF THE PROCEDURE(S) AND ALTERNATIVE MODALITIES OF TREATMENT? ☐ YES ☐ NO

3. ARE SPONGE AND INSTRUMENT COUNTS PERFORMED AND DOCUMENTED IN THE MEDICAL RECORD? ☐ YES ☐ NO

4. CAN RESIDENTS PERFORM SURGERY WITHOUT AN ATTENDING PHYSICIAN PRESENT? ☐ YES ☐ NO

5. HOW MANY OF THE FOLLOWING TYPES OF SURGERIES WERE PERFORMED AT YOUR FACILITY LAST YEAR AND HOW MANY ARE ANTICIPATED THIS YEAR?

	LAST YEAR	THIS YEAR
NEUROSURGERIES		
NON-FDA APPROVED SURGERIES		
OPEN HEART SURGERIES		
ORGAN TRANSPLANTS		
SEX CHANGE OPERATIONS		

VII. HOSPITAL SERVICES INFORMATION (CONTINUED)

J. BARIATRIC SURGERY

1. DO YOU PROVIDE BARIATRIC SURGERY? ☐ YES ☐ NO

IF NO, DO YOU PLAN TO OFFER THESE SERVICES THIS YEAR? ☐ YES ☐ NO

IF YOU ANSWERED YES TO EITHER OF THE ABOVE QUESTIONS, PLEASE COMPLETE A SEPARATE BARIATRIC SURGERY SUPPLEMENTAL QUESTIONNAIRE (FACILITIES).

VIII. INDEPENDENT MEDICAL STAFF

1. NUMBER OF ACTIVE MEMBERS ON THE MEDICAL STAFF: _____

2. ARE CREDENTIALS OF NEW STAFF PHYSICIANS REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE BOARD OF TRUSTEES PRIOR TO GRANTING PRIVILEGES? ☐ YES ☐ NO

3. ARE PRIVILEGES PROBATIONARY FOR AT LEAST 6 MONTHS FOR ALL NEW STAFF MEMBERS? ☐ YES ☐ NO

4. IS A NEW STAFF PHYSICIAN'S WORK EVALUATED BY THE DEPARTMENT CHIEF? ☐ YES ☐ NO

IF YES, IS IT DONE IN WRITING? ☐ YES ☐ NO

5. IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBER'S CLINICAL WORK? ☐ YES ☐ NO

6. IS CLINICAL STAFF RE-APPOINTED AT LEAST EVERY TWO YEARS, WITH REAPPOINTMENT BASED ON EVALUATION OF CLINICAL PRACTICE BY THE DEPARTMENT CHIEF? ☐ YES ☐ NO

IF YES, IS IT DONE IN WRITING? ☐ YES ☐ NO

7. ARE THE PROCEDURES FOR EVALUATING STAFF PHYSICIANS IN WRITING? ☐ YES ☐ NO

8. DO THE MEDICAL STAFF BYLAWS REQUIRE EACH STAFF PHYSICIAN TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

IF YES, WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED? $ _____ (PER MEDICAL INCIDENT) / $ _____ (AGGREGATE)

ARE CERTIFICATES OF INSURANCE OBTAINED ANNUALLY TO VERIFY COVERAGE? ☐ YES ☐ NO

9. HAS THE LICENSE OF ANY STAFF PHYSICIAN BEEN RESTRICTED, REVOKED OR SUSPENDED DURING THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

10. HAVE YOU MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK REGARDING ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL/DENTAL STAFF DURING THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

IX. MEDICAL SCHOOL AFFILIATIONS

1. DO YOU HAVE ANY FORMAL RELATIONSHIPS, WITH A MEDICAL SCHOOL FOR THE PURPOSE OF TRAINING OR EDUCATING RESIDENTS, MEDICAL OR NURSING STUDENTS, CRNAS OR OTHER ALLIED HEALTH PROFESSIONALS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAME AND LOCATION OF THE SCHOOL AND A DESCRIPTION OF EACH PROGRAM.

_____

_____

INDICATE BY PROGRAM TYPE, HOW MANY STUDENTS ARE INVOLVED. _____

_____

_____

2. WHO SUPERVISES THE STUDENTS? _____

3. ARE YOU REQUIRED TO PROVIDE PROFESSIONAL LIABILITY COVERAGE FOR THE RESIDENTS OR STUDENTS AS PART OF THEIR RESIDENCY OR TRAINING PROGRAM? ☐ YES ☐ NO

X. RISK MANAGEMENT

1. IS THERE A FORMAL WRITTEN RISK MANAGEMENT PROGRAM? ☐ YES ☐ NO

IF YES, HAS THE PROGRAM BEEN COMMUNICATED TO ADMINISTRATIVE AND MEDICAL STAFF? ☐ YES ☐ NO

2. IS THE PROGRAM PERIODICALLY REVIEWED FOR EFFECTIVENESS AND NECESSARY CHANGES MADE? ☐ YES ☐ NO

3. IS THERE A FULL TIME RISK MANAGER? ☐ YES ☐ NO

IF NO, WHAT ARE THE OTHER RESPONSIBILITIES OF THE RISK MANAGER? _____

_____

4. NAME AND TITLE OF THE PERSON RESPONSIBLE FOR RISK MANAGEMENT:

_____ (NAME) _____ (TITLE) _____ (YEARS IN POSITION)

5. TO WHOM DOES THIS RISK MANAGER REPORT?

_____ (NAME) _____ (TITLE)

X. RISK MANAGEMENT (CONTINUED)

6. IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS? ☐ YES ☐ NO

7. IS THERE A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ YES ☐ NO

IF YES, DOES THIS PROCEDURE REQUIRE REVIEW AND APPROPRIATE CORRECTIVE ACTION BE TAKEN? ☐ YES ☐ NO

IS FOLLOW-UP MADE TO ASSURE COMPLIANCE? ☐ YES ☐ NO

8. IS THERE A FORMAL QUALITY ASSURANCE (QA) COMMITTEE? ☐ YES ☐ NO

IF YES, IS THE RISK MANAGER A MEMBER OF THE COMMITTEE? ☐ YES ☐ NO

TO WHOM IS THE QA COMMITTEE ACCOUNTABLE? _____

9. IS THERE A FULL TIME PATIENT ADVOCATE? ☐ YES ☐ NO

10. IS THERE A MEDICAL AUDIT SYSTEM, WHICH INCLUDES SURGICAL PROCEDURES AND TIES INTO THE PHYSICIAN CREDENTIALING PROCESS? ☐ YES ☐ NO

11. IS THERE A FORMAL CONTINUING EDUCATION PROGRAM FOR:

NURSING STAFF ☐ YES ☐ NO

MEDICAL STAFF ☐ YES ☐ NO

ALLIED HEALTH PROFESSIONALS ☐ YES ☐ NO

12. NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:

_____ NAME _____ TITLE

XI. PHYSICAL PLANT

PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY YOU. ALSO INCLUDE INFORMATION ON PROPERTY THAT YOU OWN THAT IS LEASED TO OTHERS. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.

ADDRESS OF PROPERTY TO BE INSURED	USE/OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	FIRE PROTECTION*
PATIENT CARE BUILDINGS:						
OTHER BUILDINGS:						

* FOR EACH BUILDING INDICATE IF THERE IS A: SPRINKLER SYSTEM – FULL, PARTIAL OR NO SPRINKLER SYSTEM, SMOKE DETECTOR, HEAT DETECTOR, FIRE ALARM – CENTRAL STATION OR LOCAL ALARM

1. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION STANDARDS (NFPA)? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

2. DO ANY OF THE FACILITIES HAVE A HIGHLY PROTECTED RISK (HPR) DESIGNATION? ☐ YES ☐ NO

IF YES, WHICH ONES? _____

XII. OTHER LIABILITY AND RATING EXPOSURES

GENERAL OPERATIONS

1. WHAT IS YOUR TOTAL ANNUAL PAYROLL? _____ **TOTAL ANNUAL RECEIPTS?** _____

2. PLEASE DESCRIBE ANY NEW GROWTH, CONSTRUCTION OR RENOVATION PLANNED DURING THE NEXT 12 MONTHS. ALSO PLEASE INCLUDE THE TIMEFRAME AND ESTIMATED COST.

_____

_____

_____

_____

XII. OTHER LIABILITY AND RATING EXPOSURES (CONTINUED)

3. PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJECTED NUMBER OR AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS:

☐ DAYCARE CENTER: INDICATE: ☐ CHILD ☐ ADULT

NUMBER OF CHILDREN/ADULTS PER WEEK _____ CHILDREN _____ ADULTS

ARE REFERENCES CHECKED PRIOR TO HIRING EMPLOYEES AND ON ALL VOLUNTEERS? ☐ YES ☐ NO

ARE THESE SERVICES OFFERED TO: ☐ EMPLOYEES ONLY ☐ OPEN TO THE PUBLIC

WHAT IS THE STAFF TO PARTICIPANT RATIO? _____ STAFF _____ CHILDREN/ADULT PARTICIPANTS

☐ HABITATIONAL RISK: INDICATE: ☐ APARTMENT ☐ DWELLING ☐ HOTEL

NUMBER OF UNITS: _____ YEAR BUILT: _____

ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER? ☐ YES ☐ NO

FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? ☐ YES ☐ NO

☐ PAY PARKING: RECEIPTS PER YEAR: _____

☐ RESTAURANT: RECEIPTS PER YEAR: _____

IS THE RESTAURANT STAFF CONTRACTED OR EMPLOYED? ☐ CONTRACTED ☐ EMPLOYED

IF CONTRACTED, DO YOU REQUIRE THEM TO CARRY A GENERAL LIABILITY INSURANCE POLICY WITH A LIMIT OF AT LEAST $1,000,000 PER OCCURRENCE? ☐ YES ☐ NO

ARE CERTIFICATES OF INSURANCE OBTAINED ANNUALLY TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

IS THE HOSPITAL ADDED AS AN ADDITIONAL INSURED ON THEIR GL POLICY? ☐ YES ☐ NO

DOES THE RESTAURANT COMPLY WITH ALL STATE AND LOCAL CODES AND REGULATIONS? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

DID ANY INSPECTOR WHO VISITED THE RESTAURANT DURING THE LAST 12 MONTHS INDICATE ANY VIOLATIONS OR MAKE RECOMMENDATIONS FOR CHANGE? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE A COPY OF THE VIOLATION/RECOMMENDATION AND INDICATE THE CORRECTIVE ACTIONS TAKEN.

☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS: RECEIPTS PER YEAR: _____

DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED.

_____

☐ SWIMMING POOL:

IS IT OPEN TO THE PUBLIC? ☐ YES ☐ NO

IF YES, INDICATE THE RECEIPTS _____

IF YES, IS THERE A LIFE GUARD ON DUTY AT ALL TIMES? ☐ YES ☐ NO

HOW DEEP IS THE POOL? _____

IS THERE A DIVING BOARD? ☐ YES ☐ NO

4. DO YOU LEASE SPACE TO OTHERS? ☐ YES ☐ NO

IF YES, INDICATE THE ADDRESS, SQUARE FOOTAGE AND THE OCCUPANCY/USE OF THE SPACE.

_____

DOES YOUR LEASE REQUIRE THE TENANT TO CARRY GENERAL LIABILITY INSURANCE WITH A MINIMUM LIMIT OF $1,000,000 PER OCCURRENCE? ☐ YES ☐ NO

DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

IS THE TENANT REQUIRED TO LIST YOU AS AN ADDITIONAL INSURED ON THEIR GL POLICY? ☐ YES ☐ NO

5. IS THERE AN EMPLOYEE OR CONTRACT SECURITY SERVICE? ☐ YES ☐ NO

IF YES, DO THEY CARRY GUNS? ☐ YES ☐ NO

6. IS THERE A HELIPORT/HELIPAD ON THE PREMISES? ☐ YES ☐ NO

IF YES, IS IT FAA APPROVED? ☐ YES ☐ NO

WHAT IS THE ESTIMATED NUMBER OF LANDINGS PER YEAR? _____

IS THERE A SEPARATE INSURANCE POLICY IN PLACE COVERING THIS EXPOSURE? ☐ YES ☐ NO

IF YES, WHAT ARE THE LIABILITY LIMITS? _____

PLEASE PROVIDE A COPY OF THE DECLARATIONS PAGE AND LOSS RUNS.

7. PROVIDE THE NUMBER AND TYPE OF OWNED, NON-OWNED, LEASED OR CHARTERED WATERCRAFT.

_____

GIVE A BRIEF EXPLANATION OF USE: _____

ARE ANY OF THE WATERCRAFT OVER 26 FEET? ☐ YES ☐ NO

IF YES, PROVIDE A DESCRIPTION OF THE CRAFT AND IT'S LENGTH. _____

IS THERE A SEPARATE INSURANCE POLICY IN PLACE COVERING THIS WATERCRAFT EXPOSURE? ☐ YES ☐ NO

IF YES, WHAT ARE THE LIABILITY LIMITS? _____

PLEASE PROVIDE A COPY OF THE DECLARATIONS PAGE AND LOSS RUNS.

XII. OTHER LIABILITY AND RATING EXPOSURES (CONTINUED)

8. ENVIRONMENTAL EXPOSURES

IS THE LIMITED POLLUTION SHORT-TERM EVENT COVERAGE OPTION DESIRED? ☐ YES ☐ NO

IF NO, GO TO QUESTION 9.

IF YES, DO YOU WANT THE LIMITED POLLUTION SHORT-TERM EVENT COVERAGE OPTION WITH UNDERGROUND STORAGE TANKS? ☐ YES ☐ NO

IF YES, COMPLETE THE QUESTIONS AND THE UNDERGROUND TANKS TABLE BELOW.

DO YOU HAVE A HAZARDOUS WASTE MANAGEMENT/ENVIRONMENTAL SAFETY PROGRAM? ☐ YES ☐ NO

DO YOU HAVE A PROGRAM IN PLACE FOR MONITORING YOUR ENVIRONMENTAL EXPOSURES ON AN ONGOING BASIS? ☐ YES ☐ NO

SUBMIT THE FOLLOWING ITEMS:

1. COPIES OF ANY GOVERNMENTAL SANCTIONS OR CITATIONS.
2. DOCUMENTATION OF ANY VOLUNTARY CLEANUP FROM RELEASES OR SPILLS (OVER $50,000), WHETHER OR NOT REPORTED TO YOUR INSURANCE CARRIER.

IS PREVENTATIVE MAINTENANCE ON ALL ABOVE GROUND AND UNDERGROUND TANKS PERFORMED BY OUTSIDE CONTRACTORS? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN. _____

_____

HOW OFTEN ARE TANKS TESTED? _____

DO YOU HAVE WRITTEN SPILL PREVENTION AND SPILL CONTROL PROGRAMS IN PLACE? ☐ YES ☐ NO

UNDERGROUND TANKS ☐ OPTION NOT DESIRED

IF THE LIMITED POLLUTION SHORT-TERM EVENT OPTION WITH UNDERGROUND TANKS IS DESIRED, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH UNDERGROUND TANK. OTHERWISE, SKIP TO QUESTION 9.

IF YOU HAVE MORE THAN TWO TANKS, ATTACH A SEPARATE PAGE INDICATING THE INFORMATION BELOW FOR EACH TANK.

REGISTRATION NUMBER OR IDENTIFIER		
AGE		
CONTENTS		
CAPACITY IN GALLONS		
CONSTRUCTION TYPE:	☐ FIBERGLASS STEEL COATS ☐ CATHODICALLY PROTECTED STEEL ☐ FIBERGLASS ☐ FIBERGLASS LINED STEEL TANK ☐ UNPROTECTED ☐ OTHER (DESCRIBE) _____	☐ FIBERGLASS STEEL COATS ☐ CATHODICALLY PROTECTED STEEL ☐ FIBERGLASS ☐ FIBERGLASS LINED STEEL TANK ☐ UNPROTECTED ☐ OTHER (DESCRIBE) _____
SINGLE OR DOUBLE WALL CONSTRUCTION?	☐ SINGLE ☐ DOUBLE	☐ SINGLE ☐ DOUBLE
IS THE TANK IN A VAULT?	☐ YES ☐ NO	☐ YES ☐ NO
IS THERE A LEAK DETECTION SYSTEM IN PLACE?	☐ YES ☐ NO IF YES, INDICATE TYPE: ☐ AUTOMATIC TANK GAUGING ☐ VAPOR MONITORING SYSTEMS (ALARM) ☐ INTERSISTAL MONITORING (LIQUID/VAPOR MONITORING WITHIN THE WALL OF THE TANK - ALARM) ☐ GROUND WATER MONITORING ☐ OTHER: (DESCRIBE) _____	☐ YES ☐ NO IF YES, INDICATE TYPE: ☐ AUTOMATIC TANK GAUGING ☐ VAPOR MONITORING SYSTEMS (ALARM) ☐ INTERSISTAL MONITORING (LIQUID/VAPOR MONITORING WITHIN THE WALL OF THE TANK - ALARM) ☐ GROUND WATER MONITORING ☐ OTHER: (DESCRIBE) _____
WHEN WAS THE LAST TIGHTNESS TEST PERFORMED? DID THE TANK PASS OR FAIL? IF IT FAILED, PROVIDE DETAILS IN THE COMMENTS SECTION BELOW.	DATE _____ ☐ PASS ☐ FAIL	DATE _____ ☐ PASS ☐ FAIL
IS THE TANK EQUIPPED WITH SPILL PROTECTION? OVER-FILL PROTECTION?	☐ YES ☐ NO ☐ YES ☐ NO	☐ YES ☐ NO ☐ YES ☐ NO
ARE THE TANKS IN COMPLIANCE WITH ALL GOVERNMENTAL REGULATIONS FOR LEAK DETECTION, OVERFLOW PROTECTION AND CORROSION PROTECTION? IF NO, PROVIDE DETAILS IN THE COMMENTS SECTION BELOW.	☐ YES ☐ NO	☐ YES ☐ NO

COMMENTS: _____

_____

_____

XII. OTHER LIABILITY AND RATING EXPOSURES (CONTINUED)

9. DO YOU MANUFACTURE, PRODUCE, MODIFY, CUSTOMIZE, SERVICE OR ASSEMBLE ANY DURABLE MEDICAL EQUIPMENT OR ANY OTHER PRODUCTS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE AND PROVIDE A COPY OF YOUR BROCHURES. _____

_____

DO YOU SELL, RENT OR LEASE ANY MEDICAL EQUIPMENT TO OTHERS? ☐ YES ☐ NO

PLEASE PROVIDE A COPY OF YOUR EQUIPMENT LIST OR CATALOG OF PRODUCTS AVAILABLE.

IS THERE A PREVENTIVE MAINTENANCE PLAN IN PLACE ON THIS EQUIPMENT? ☐ YES ☐ NO

IF YES, IS IT PERFORMED BY A QUALIFIED BIOMEDICAL TECHNICIAN? ☐ YES ☐ NO

10. DO YOU USE AN ADVERTISING AGENCY? ☐ YES ☐ NO

IF YES, WHAT PROFESSIONAL LIABILITY INSURANCE LIMITS DO YOU REQUIRE THEM TO CARRY?

$ _____ PER OCCURRENCE $ _____ AGGREGATE

DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

ARE YOU INCLUDED AS AN ADDITIONAL INSURED ON THE AGENCY'S INSURANCE POLICY? ☐ YES ☐ NO

IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF THE HOSPITAL? ☐ YES ☐ NO

11. IS THERE A PREVENTATIVE MAINTENANCE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR MEDICAL EQUIPMENT AT THE FACILITY? ☐ YES ☐ NO

IF YES, DO YOU ADHERE TO EACH MANUFACTURE'S ESTABLISHED GUIDELINES AND STANDARDS FOR ALL MEDICAL EQUIPMENT? ☐ YES ☐ NO

XIII. CONTRACTUAL/HOLD HARMLESS/ INDEMNIFICATION AGREEMENTS

1. ARE THE MANAGEMENT SERVICES OF YOUR FACILITY PROVIDED BY A MANAGEMENT COMPANY? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE HOSPITAL MANAGEMENT COMPANY AND INDICATE THE OPERATIONAL POSITIONS PROVIDED. _____

_____

DOES THE MANAGEMENT COMPANY CARRY GENERAL LIABILITY AND DIRECTORS AND OFFICERS LIABILITY INSURANCE WITH LIMITS OF $1,000,000 PER OCCURRENCE OR GREATER? ☐ YES ☐ NO

DO YOU REQUIRE A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

2. DO YOU MANAGE OTHER ENTITIES? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

3. DO YOU OFFER PEER REVIEW OR POST CARE REVIEW SERVICES FOR OTHERS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

IS MANAGED CARE COVERAGE DESIRED? ☐ YES ☐ NO

IF COVERAGE IS DESIRED, COMPLETE A SEPARATE MANAGED CARE ORGANIZATION LIABILITY INSURANCE APPLICATION.

4. DO YOU OWN A MANAGED CARE ORGANIZATION? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

IS MANAGED CARE COVERAGE DESIRED? ☐ YES ☐ NO

IF COVERAGE IS DESIRED, COMPLETE A SEPARATE MANAGED CARE ORGANIZATION LIABILITY INSURANCE APPLICATION.

5. DO YOU RENT OR LEASE EQUIPMENT FROM OTHERS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? _____

6. DO YOU HAVE ANY OTHER HEALTHCARE RELATED SERVICE CONTRACTS IN PLACE, NOT PREVIOUSLY DISCUSSED IN THIS APPLICATION? ☐ YES ☐ NO

IF YES, WHAT SERVICES ARE PROVIDED? _____

XIV. EXCESS LIABILITY

IF EXCESS COVERAGE IS DESIRED, PLEASE COMPLETE THIS SECTION. OTHERWISE SKIP TO PART XV.

PLEASE COMPLETE THE "SCHEDULE OF CURRENT PRIMARY POLICIES AND COVERAGES". ALSO PLEASE PROVIDE A COPY OF THE DECLARATIONS PAGE FOR EACH OF YOUR CURRENT PRIMARY POLICIES. INCLUDE A COPY OF YOUR PRIMARY AND EXCESS LOSS RUNS FOR THE LAST TEN FULL YEARS.

1. HAVE EXCESS LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, INDICATE THE TYPE OF COVERAGE, PRIOR LIMIT AND WHEN IT WAS INCREASED. _____

2. PROVIDE THE NUMBER AND TYPE OF OWNED, NON-OWNED, LEASED OR CHARTERED AIRCRAFT. _____

_____

3. GIVE A BRIEF EXPLANATION OF THE USE OF EACH AIRCRAFT AND INDICATE THE PASSENGER CAPACITY.

_____

IS THERE AN INSURANCE POLICY IN PLACE THAT COVERS EACH AIRCRAFT? ☐ YES ☐ NO

IF YES, WHAT ARE THE LIABILITY LIMITS? _____

IF NO, PLEASE EXPLAIN: _____

XIV. EXCESS LIABILITY (CONTINUED)

4. INDICATE THE NUMBER AND TYPE OF AUTOS OWNED OR LEASED BY THE HOSPITAL:

	NUMBER OF AUTOS
☐ AMBULANCE - EMERGENCY USE	
☐ AMBULANCE - NON-EMERGENCY USE	
☐ PUBLIC SERVICE AUTO/BUS	
☐ PRIVATE PASSENGER	
☐ TRUCKS/TRUCK TRACTORS	

PASSENGER CAPACITY OF EACH _____

PLEASE PROVIDE A COPY OF THE SCHEDULE OF VEHICLES FROM EACH OF THE CURRENT PRIMARY AUTO POLICIES.

5. ARE EACH OF THE ABOVE VEHICLES INSURED ON CURRENT UNDERLYING POLICIES? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

6. DO YOU PROVIDE VALET SERVICE TO YOUR PATIENTS? ☐ YES ☐ NO

7. WHAT CRITERIA DO YOU USE TO DETERMINE IF AN INDIVIDUAL WILL BE ALLOWED TO DRIVE YOUR VEHICLES?

_____

_____

8. DO YOU CHECK MVR'S (MOTOR VEHICLE RECORDS) ANNUALLY ON EACH INDIVIDUAL DRIVING YOUR VEHICLES? ☐ YES ☐ NO

9. ARE THERE ANY DRIVERS WITH MORE THAN THREE MOVING VIOLATIONS IN THE LAST THREE YEARS, MORE THAN TWO ACCIDENTS IN THE LAST FIVE YEARS OR AN OUI/DUI IN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE SUBMIT A COPY OF THE DRIVER'S MVR.

10. IF YOU OWN OR LEASE AMBULANCES, PUBLIC SERVICE AUTOS OR BUSSES, PLEASE ANSWER THE FOLLOWING QUESTIONS.

DESCRIBE THE TYPE OF TRAINING REQUIRED BEFORE EMPLOYEES CAN DRIVE THESE VEHICLES.

_____

_____

_____

_____

DESCRIBE YOUR VEHICLE MAINTENANCE PROGRAM. _____

_____

ARE DRIVERS REQUIRED TO DO VEHICLE CHECKS? ☐ YES ☐ NO

IF YES, HOW FREQUENTLY ARE CHECKS REQUIRED AND WHAT ITEMS ARE CONTAINED ON THE CHECKLIST? _____

_____

ARE THE VEHICLE CHECKS DOCUMENTED IN WRITING AND MAINTAINED? ☐ YES ☐ NO

XV. LOSS HISTORY

IF YOU HAVE BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE AND MARINE FOR LESS THAN TEN YEARS OR IF YOUR FACILITY PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS ACTIVITY DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE AND MARINE.

THE LOSS INFORMATION SHOULD ADDRESS BOTH YOUR PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

XV. LOSS HISTORY (CONTINUED)

PLEASE COMPLETE THE QUESTIONS BELOW FOR ALL ***(1) OPEN AND; (2) CLOSED CLAIMS WITH COMBINED PAID AND RESERVED AMOUNTS OF $50,000 OR MORE INCLUDING EXPENSES***. *IF ADDITIONAL SPACE IS NEEDED PLEASE ATTACH A SEPARATE PAGE.*

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION. *ALL FIELDS MUST BE COMPLETED.*

CLAIM NUMBER: _____

1. **CLAIMANT NAME:** _____ **AGE:** _____
2. **DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU.** _____ (MM/YYYY)
3. **DATE CLAIM/INCIDENT NOTICE RECEIVED.** _____ (MM/YYYY)
4. **NAME OF DOCTOR(S), HEALTH CARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLVED IN THE CLAIM OR SUIT:**

   _____
5. **DEFENDING INSURANCE CARRIER NAME:** _____
6. **WAS A CLAIM MADE OR A SUIT FILED?** ☐ YES ☐ NO
7. **DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT:** ☐ OPEN ☐ CLOSED

   IF CLOSED, DATE OF CLOSING/SETTLEMENT OR AWARD: _____ (MM/YYYY)

   IF CLOSED, WAS PAYMENT MADE? ☐ YES ☐ NO

   IF NO, WAS CLAIM OR SUIT WITHDRAWN? ☐ YES ☐ NO

   AMOUNT PAID ON YOUR BEHALF (IN $) _____

   WAS THIS MATTER CLOSED WITH YOUR CONSENT? ☐ YES ☐ NO

   IF OPEN, HAS SETTLEMENT BEEN OFFERED? ☐ YES ☐ NO

   IF OPEN, HAS TRIAL DATE BEEN SET? ☐ YES ☐ NO TRIAL DATE _____ (MM/DD/YYYY)
8. **NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:**

   CONDITION TREATED: _____

   TREATMENT PROVIDED: _____

   ALLEGED NEGLIGENCE: _____

   ALLEGED INJURY: _____
9. **PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY; YOUR LEVEL OF INVOLVEMENT.)**

XVI. INSURANCE HISTORY

NOTE: QUESTION 1 IS NOT TO BE COMPLETED BY APPLICANTS IN THE STATE OF MISSOURI.

1. HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER YOU INSURANCE COVERAGE? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

2. PLEASE CHECK WHICH TYPE OF NOTICE YOUR PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE THEY WILL FORMALLY RECOGNIZE A CLAIM UNDER THEIR POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER

☐ WRITTEN NOTICE FROM YOU THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

3. HAVE ALL KNOWN CLAIMS, AS WELL AS INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS, BEEN REPORTED TO PAST OR CURRENT INSURERS? ☐ YES ☐ NO

4. HAVE YOU CONDUCTED A RECENT REVIEW OF SUCH INCIDENTS AND OTHER POTENTIAL CLAIMS AND HAVE YOU FORWARDED THEM TO YOUR CURRENT INSURER? ☐ YES ☐ NO

IF YES, WHEN? _____ BY WHOM? _____

5. PLEASE PROVIDE YOUR INSURANCE HISTORY FOR THE LAST FIVE YEARS. PLEASE LIST CURRENT YEAR FIRST:

INSURANCE TYPE **YEAR NUMBER**	**CARRIER**	**POLICY PERIOD**	**COVERAGE TYPE** **(OCCURRENCE OR CLAIMS MADE)**	**LIMITS**
PROFESSIONAL LIABILITY CURRENT YEAR PREMIUM $ _____				
YEAR 2				
YEAR 3				
YEAR 4				
YEAR 5				
GENERAL LIABILITY CURRENT YEAR PREMIUM $ _____				
YEAR 2				
YEAR 3				
YEAR 4				
YEAR 5				
UMBRELLA/EXCESS LIABILITY CURRENT YEAR PREMIUM $ _____				
YEAR 2				
YEAR 3				
YEAR 4				
YEAR 5				

XVII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION BEFORE AN INSURANCE PROGRAM CAN BE QUOTED.

1. **JCAHO REPORT.**
2. **FINANCIAL INFORMATION.** LAST THREE (3) YEARS AUDITED FINANCIAL STATEMENTS AND ANNUAL REPORTS INCLUDING THE AUDITOR'S OPINION.
3. **AMERICAN HOSPITAL ASSOCIATION ANNUAL SURVEY.**
4. **MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.**
5. **LOSS INFORMATION.** RECENTLY VALUED LOSS RUNS FROM INSURANCE CARRIERS COVERING THE LAST TEN (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS. COMPLETE DETAILS MUST BE PROVIDED FOR ALL OPEN AND CLOSED CLAIMS WITH A COMBINED PAID AND RESERVED AMOUNT OF $50,000 OR MORE INCLUDING EXPENSES.
6. **COPY OF YOUR CURRENT PROFESSIONAL LIABILITY POLICY AND ENDORSEMENTS.**
7. **DECLARATIONS PAGE** OF CURRENT GENERAL LIABILITY, HELIPAD, AIRCRAFT, WATERCRAFT, AUTO AND UMBRELLA/EXCESS LIABILITY POLICIES.
8. **ANNUAL REPORT** IF ONE IS PUBLISHED.
9. **ALL ADVERTISING MATERIALS** IN YOUR CURRENT ADVERTISING CAMPAIGN.
10. **ORGANIZATIONAL CHART** INCLUDING THE NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.
11. **CATALOG OR LIST OF DURABLE MEDICAL EQUIPMENT** THAT IS MANUFACTURED, LEASED, RENTED OR SOLD TO OTHERS.

XVIII. IMPORTANT NOTICE

THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE. PLEASE READ AND REVIEW THE POLICY CAREFULLY.

XVIX. PLEASE READ AND SIGN

APPLICANT SHALL IMMEDIATELY INFORM THE COMPANY IF ANY STATEMENTS MADE ON THIS APPLICATION (INCLUDING ATTACHMENTS) WERE INACCURATE OR MISLEADING WHEN SUBMITTED, OR ARE NO LONGER ACCURATE, OR HAVE BECOME MISLEADING. IN THE EVENT THAT THE APPLICANT'S STATEMENTS ARE REASONABLY DETERMINED BY THE COMPANY TO BE UNTRUE OR MISLEADING THEN IT SHALL HAVE THE RIGHT TO VOID THE POLICY AS OF THE DATE OF THE INCORRECT OR MISLEADING STATEMENT. IT SHALL ALSO HAVE THE RIGHT TO INCREASE THE PREMIUM, DEDUCTIBLES OR RETENTIONS CONSISTENT WITH HOW IT MIGHT HAVE RESPONDED IF FULLY ACCURATE AND NON-MISLEADING INFORMATION HAD BEEN SUBMITTED.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE OR OBLIGATE THE COMPANY TO OFFER COVERAGE. THE COMPANY'S RECEIPT OF APPLICANT'S ACCEPTANCE OF THE COMPANY'S QUOTATION IS REQUIRED BEFORE THE COVERAGE MAY BE BOUND AND THE POLICY ISSUED.

THE APPLICANT 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 APPLICANT UNDERTAKES IN MANAGING ITS PROFESSIONAL AND GENERAL LIABILITY INSURANCE EXPOSURES.

THE APPLICANT HEREBY AUTHORIZES AND DIRECTS ANY PERSON OR ORGANIZATION WHATSOEVER TO RELEASE AND FURNISH TO THE COMPANY, AND ITS AGENTS OR REPRESENTATIVES, ANY AND ALL INFORMATION REQUESTED WHICH MAY RELATE TO INSURABILITY UNDER THE POLICY. THE APPLICANT FURTHERMORE AUTHORIZES THE RELEASE OF ALL SUCH INFORMATION BY THE COMPANY AS REQUIRED BY LAW TO ANY GOVERNMENTAL AGENCY OR PROFESSIONAL SOCIETY OR ASSOCIATION.

THE APPLICANT FURTHERMORE RELEASES AND AGREES TO HOLD HARMLESS THE COMPANY, AND ALL OF ITS AGENTS AND REPRESENTATIVES, ANY PRIOR INSURER, GOVERNMENTAL AGENCY, OR PROFESSIONAL SOCIETY OR ASSOCIATION FROM ANY LIABILITY ARISING OUT OF THE RELEASE OR REVIEW OF ANY AND ALL INFORMATION RELEASED OR FURNISHED PURSUANT TO THIS AUTHORIZATION AND APPLICATION FOR INSURANCE, NOTWITHSTANDING THE FACT THAT THERE MAY BE ERRORS, OMISSIONS, OR MISTAKES CONTAINED IN SUCH RELEASED INFORMATION.

SIGNATURE OF AUTHORIZED INDIVIDUAL	TITLE	DATE

FRAUD NOTICE

UNDER THE LAWS OF YOUR STATE, IT MAY BE A CRIMINAL OFFENSE TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY. PENALTIES FOR FRAUD MAY RESULT IN ONE OR MORE OF THE FOLLOWING: IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

PLEASE INITIAL THE STATEMENTS ON THE FOLLOWING PAGES FOR THE STATES APPLICABLE TO THE COVERAGE BEING APPLIED FOR.

MANDATORY: ***ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING UNLESS IN ONE OF THE STATES BELOW:***

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, WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW.

INITIAL HERE

FRAUD NOTICE - STATE STATUTORY REQUIREMENT

MANDATORY: ***ALL MAINE APPLICANTS MUST READ AND INITIAL THE FOLLOWING:***

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 AND DENIAL OF INSURANCE BENEFITS.

INITIAL HERE

MANDATORY: ***ALL MARYLAND APPLICANTS MUST READ AND INITIAL THE FOLLOWING:***

ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

INITIAL HERE

MANDATORY: ***ALL NEW JERSEY APPLICANTS MUST READ AND INITIAL THE FOLLOWING:***

ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

INITIAL HERE

MANDATORY: ***ALL OHIO APPLICANTS MUST READ AND INITIAL THE FOLLOWING:***

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.

INITIAL HERE

MANDATORY: ***ALL OKLAHOMA APPLICANTS MUST READ AND INITIAL THE FOLLOWING:***

WARNING: 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.

INITIAL HERE

SUPPLEMENTAL FORM **(ATTACH A SEPARATE PIECE OF PAPER IF ADDITIONAL SPACE IS NEEDED)**

SCHEDULE OF CURRENT PRIMARY POLICIES AND COVERAGES

FOR EACH POLICY BELOW THAT EXCESS COVERAGE IS REQUESTED FOR, PLEASE PROVIDE A COPY OF THE DECLARATIONS PAGE AND THE PRIMARY AND UMBRELLA LOSS RUNS FOR THE LAST TEN YEARS. IF EXCESS AUTO COVERAGE IS DESIRED, ALSO PROVIDE A COPY OF THE SCHEDULE OF VEHICLES LISTED ON THE PRIMARY AUTO POLICY.

IF THE APPLICANT IS SELF-INSURED FOR ANY ITEMS DESCRIBED IN THE SCHEDULE BELOW, PLEASE ATTACH CURRENT SELF-INSURANCE TRUST DOCUMENTS AND THE MOST RECENT ACTUARIAL STUDY.

SCHEDULE OF CURRENT PRIMARY POLICIES AND COVERAGES

COVERAGE	CARRIER	POLICY NUMBER	POLICY PERIOD	LIMITS OF LIABILITY
HEALTHCARE PROFESSIONAL LIABILITY				
GENERAL LIABILITY				
EMPLOYERS LIABILITY (WORKERS COMPENSATION)				
AUTOMOBILE LIABILITY CHECK IF COVERED ☐ OWNED VEHICLES ☐ HIRED VEHICLES ☐ NON-OWNED VEHICLES				
AMBULANCE LIABILITY				
AIRCRAFT LIABILITY ☐ OWNED ☐ NON-OWNED				
HELIPAD/HELIPORT LIABILITY				
WATERCRAFT LIABILITY ☐ OWNED ☐ NON-OWNED				
OTHER (DESCRIBE) _____				
OTHER (DESCRIBE) _____				

SCHEDULE OF RELATED ENTITIES

LIST ALL ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLC'S, PARTNERSHIPS ETC.)

NAME OF ENTITY	DESCRIPTION OF OPERATIONS	DATE ACQUIRED, CREATED OR MERGED	OWNERSHIP PERCENTAGE (%) IN THIS ENTITY	COVERAGE DESIRED?

COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW.

COVERAGE	REQUESTED LIMITS	COVERAGE TYPE	DEDUCTIBLE/SIR
☐ PROFESSIONAL LIABILITY **FACILITY**	$ _____ PER EVENT $ _____ AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE **RETRO DATE:** _____	☐ NONE ☐ $25,000 ☐ $100,000 ☐ $10,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY AND EXPENSE ☐ INDEMNITY ONLY
☐ PROFESSIONAL LIABILITY **EMPLOYED OR CONTRACTED** PHYSICIANS, RESIDENTS, INTERNS, FELLOWS, SURGEONS, DENTISTS AND ORAL SURGEONS **SHARED LIMIT COVERAGE** ***COVERAGE IS RESTRICTED TO SERVICES PROVIDED ON BEHALF OF THE APPLICANT.***	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A "SCHEDULE OF MEDICAL PROFESSIONALS" OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL THAT COVERAGE IS DESIRED FOR. ***IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.***	THE COVERAGE TYPE, OCCURRENCE OR CLAIMS-MADE MUST BE THE SAME AS THAT PROVIDED FOR **PROFESSIONAL LIABILITY – FACILITY ABOVE.**	**SAME AS PROFESSIONAL LIABILITY DEDUCTIBLE INDICATED ABOVE**
☐ PROFESSIONAL LIABILITY **EMPLOYED OR CONTRACTED** CRNAS, NURSE MIDWIVES, NURSE PRACTITIONERS, PODIATRISTS, PHYSICIAN'S ASSISTANTS AND SURGICAL ASSISTANTS **SHARED LIMIT COVERAGE** ***COVERAGE IS RESTRICTED TO SERVICES PROVIDED ON BEHALF OF THE APPLICANT.***	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A "SCHEDULE OF MEDICAL PROFESSIONALS" OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. ***IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.***	THE COVERAGE TYPE, OCCURRENCE OR CLAIMS-MADE MUST BE THE SAME AS THAT PROVIDED FOR **PROFESSIONAL LIABILITY – FACILITY ABOVE.**	**SAME AS PROFESSIONAL LIABILITY DEDUCTIBLE INDICATED ABOVE**

COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (CONTINUED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW.

COVERAGE	REQUESTED LIMITS	COVERAGE TYPE	DEDUCTIBLE/SIR
☐ PROFESSIONAL LIABILITY **EMPLOYED OR CONTRACTED** PHYSICIANS, RESIDENTS, INTERNS, FELLOWS, SURGEONS, DENTISTS AND ORAL SURGEONS **SEPARATE LIMIT COVERAGE** ***COVERAGE IS RESTRICTED TO SERVICES PROVIDED ON BEHALF OF THE APPLICANT UNLESS 24-HOUR COVERAGE IS DESIRED.*** **24-HOUR COVERAGE IS NOT LIMITED TO THE DUTY AND SCOPE OF SERVICES PROVIDED AS PART OF THE NAMED INSURED'S OPERATION. COVERAGE APPLIES TO ALL ACTIVITIES OF THE PHYSICIAN THAT ARE CONSISTENT WITH THE INFORMATION DISCLOSED ON THE APPLICATION.** **IS 24-HOUR COVERAGE DESIRED?** ☐ YES ☐ NO	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A "SCHEDULE OF MEDICAL PROFESSIONALS" OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL THAT COVERAGE IS DESIRED FOR.	☐ OCCURRENCE ☐ CLAIMS MADE **RETRO DATE:** _____	☐ NONE ☐ $25,000 ☐ $100,000 ☐ $10,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY AND EXPENSE ☐ INDEMNITY ONLY
☐ PROFESSIONAL LIABILITY **EMPLOYED OR CONTRACTED** CRNAS, NURSE MIDWIVES, NURSE PRACTITIONERS, PODIATRISTS, PHYSICIAN'S ASSISTANTS AND SURGICAL ASSISTANTS **SEPARATE LIMIT COVERAGE** ***COVERAGE IS RESTRICTED TO SERVICES PROVIDED ON BEHALF OF THE APPLICANT.***	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A "SCHEDULE OF MEDICAL PROFESSIONALS" OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL THAT COVERAGE IS DESIRED FOR.	☐ OCCURRENCE ☐ CLAIMS MADE **RETRO DATE:** _____	☐ NONE ☐ $25,000 ☐ $100,000 ☐ $10,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY AND EXPENSE ☐ INDEMNITY ONLY

COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (CONTINUED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW.

COVERAGE	REQUESTED LIMITS	COVERAGE TYPE	DEDUCTIBLE/SIR
☐ GENERAL LIABILITY	$ _____ PER OCCURRENCE $ _____ AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE **RETRO DATE:** _____	☐ NONE ☐ $25,000 ☐ $100,000 ☐ $10,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY AND EXPENSE ☐ INDEMNITY ONLY
☐ EMPLOYEE BENEFITS LIABILITY	$ _____ PER WRONGFUL ACT $ _____ AGGREGATE	☐ CLAIMS MADE **RETRO DATE:** _____	☐ $1,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY AND EXPENSE ☐ INDEMNITY ONLY
☐ LIMITED POLLUTION SHORT TERM EVENT LIABILITY	☐ $100,000/$100,000 ☐ $200,000/$200,000 ☐ $300,000/$300,000	THE COVERAGE TYPE, OCCURRENCE OR CLAIMS MADE, MUST BE THE SAME AS THAT PROVIDED FOR THE **GENERAL LIABILITY SECTION ABOVE.**	**THE GENERAL LIABILITY DEDUCTIBLE APPLIES TO THIS COVERAGE.**
☐ EXCESS-PROFESSIONAL LIABILITY **IF COVERAGE IS DESIRED, COMPLETE THE "SCHEDULE OF CURRENT PRIMARY POLICIES AND COVERAGES".**	$ _____ PER EVENT $ _____ AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE **RETRO DATE:** _____	
☐ EXCESS-GENERAL LIABILITY **IF COVERAGE IS DESIRED, COMPLETE THE "SCHEDULE OF CURRENT PRIMARY POLICIES AND COVERAGES".**	$ _____ PER EVENT $ _____ AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE **RETRO DATE:** _____	

NOTE:
FIRE AND WATER DAMAGE LIABILITY COVERAGE IS AUTOMATICALLY PROVIDED AT A $50,000 LIMIT. IF HIGHER LIMITS ARE DESIRED, PLEASE CONTACT YOUR AGENT.
IF PATIENTS PROPERTY DAMAGE, MEDICAL PAYMENTS OR MANAGED CARE COVERAGE IS DESIRED PLEASE CONTACT YOUR AGENT.

SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, DENTISTS AND ORAL SURGEONS

PLEASE PROVIDE THE INFORMATION BELOW FOR EACH PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST AND ORAL SURGEON FOR WHOM COVERAGE IS TO BE PROVIDED UNDER THIS POLICY. SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED FOR. CLASSIFICATION AND RATING WILL BE BASED ON THE INFORMATION PROVIDED ON THE APPLICATION.

COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE START DATE WITH THE NAMED INSURED ENTITY. *IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE START DATE WITH THE NAMED INSURED, PRIOR ACTS COVERAGE NEEDS TO BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE INFORMATION CONTAINED IN THE APPLICATION.

EMPLOYMENT STATUS: (C)ONTRACT; (E)MPLOYED; (F)ACULTY; (R)ESIDENT

LIMITS:

(SH) : SHARED LIMITS WITH THE FACILITY, RESTRICTED TO THE NAMED INSURED'S OPERATIONS.

(SE) : SEPARATE LIMITS, RESTRICTED TO THE NAMED INSURED'S OPERATIONS.

(24): 24 HOUR COVERAGE - SEPARATE LIMITS THAT ARE NOT RESTRICTED TO THE NAMED INSURED'S OPERATIONS. COVERAGE APPLIES WHETHER OR NOT THE PROFESSIONAL SERVICES ARE PROVIDED AS PART OF THE NAMED INSURED'S OPERATIONS AS LONG AS ALL ACTIVITIES ARE CONSISTENT WITH THE INFORMATION DISCLOSED ON THE APPLICATION.

NAME OF MEDICAL PROFESSIONAL	STATUS: (C) (E) (F) (R)	TYPE OF PROFESSIONAL: - PHYSICIAN - SURGEON - DENTIST - ORAL SURGEON	SPECIALTY	SURGERY TYPE: - OB-NO SURGERY - MINOR SURGERY - MAJOR SURGERY	EMPLOYMENT DATE/HIRE DATE	RETRO DATE	NUMBER OF HOURS PER WEEK	LICENSE NUMBER	LIMITS (SH) (SE) (24)

SCHEDULE OF MEDICAL PROFESSIONALS - CRNAS, NURSE MIDWIVES, NURSE PRACTITIONERS, PHYSICIAN'S ASSISTANTS, PODIATRISTS AND SURGICAL ASSISTANTS

IF SHARED OR SEPARATE LIMITS COVERAGE IS DESIRED FOR THE ABOVE CLASSIFICATIONS OF OTHER HEALTH CARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION REQUESTED BELOW. SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT SEPARATE LIMITS COVERAGE IS REQUESTED FOR. CLASSIFICATION AND RATING WILL BE BASED ON THE INFORMATION PROVIDED ON THE APPLICATION.

COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE START DATE WITH THE NAMED INSURED ENTITY. *IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE START DATE WITH THE NAMED INSURED, PRIOR ACTS COVERAGE NEEDS TO BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE INFORMATION CONTAINED IN THE APPLICATION.

EMPLOYMENT STATUS: (C)ONTRACT; (E)MPLOYED; (F)ACULTY; (R)ESIDENT

LIMITS:

(SH) : SHARED LIMITS WITH THE FACILITY, RESTRICTED TO THE NAMED INSURED'S OPERATIONS.

(SE) : SEPARATE LIMITS, RESTRICTED TO THE NAMED INSURED'S OPERATIONS.

NAME OF MEDICAL PROFESSIONAL	STATUS: (C) (E) (F) (R)	TYPE OF PROFESSIONAL: - CRNA - NURSE MIDWIFE - NURSE PRACTITIONER - PHYSICIAN'S ASSISTANT - PODIATRIST - SURGICAL ASSISTANT	PRESCRIBE MEDICINE? Y=YES N=NO	EMPLOYMENT DATE/HIRE DATE	RETRO DATE	NUMBER OF HOURS PER WEEK	LICENSE NUMBER	LIMITS (SH) (SE)