Hospital Liability

I. PRODUCER PROFILE

A. Company Name	B. Telephone Number	C. Facsimile Number
D. Business Address	E. City, State, Zip	F. Email Address
G. Surplus Lines Agent Name and Telephone Number	H. Surplus Lines Agent's License Number	I. State in which Surplus Lines Tax is Filed
J. Surplus Lines Agent's Business Address	K. City, State, Zip	L. New Jersey – Surplus Lines Trans Number

II. APPLICANT PROFILE

A. Hospital Name	B. Website	
C. Business Address	D. County	
E. City, State, Zip	F. Telephone Number	G. Facsimile Number

H. Any subsidiaries or other entities?

☐ Yes ☐ No

If yes, provide a list of subsidiaries/other entities and a description of their operations on a separate sheet of paper. Please indicate which entities are to be included for coverage. Complete Section IV for each location.

I. Type of Hospital

- ☐ Children's
- ☐ Convalescent/LTC
- ☐ General
- ☐ Geriatric
- ☐ Psychiatric
- ☐ Rehabilitation
- ☐ Teaching
- ☐ Women's
- ☐ Other: (Describe)

- ☐ Individual
- ☐ Corporation
- ☐ Joint Venture
- ☐ Government
- ☐ Partnership

- ☐ For Profit
- ☐ Non-profit

- ☐ Accredited by JCAHO
- ☐ Accredited by AOA
- ☐ Accredited by CARF
- ☐ Licensed by State
- ☐ Medicare Approved
- ☐ Member of AHA

J. Facilities/Services Provided

- ☐ Abortions
- ☐ Bariatrics
- ☐ Blood Bank
- ☐ Burn Unit
- ☐ CCU
- ☐ Chemical Dependency
- ☐ Day Care

- ☐ Dialysis
- ☐ Drug/Alcohol
- ☐ Emergency
- ☐ Home Health Care
- ☐ ICU
- ☐ Long-term Care (Onsite or Freestanding)

- ☐ Medical School Affiliations (Attach details)
- ☐ Obstetrical
- ☐ Open Heart
- ☐ Outpatient Surgery Center – offsite
- ☐ Pharmacy

- ☐ Psychiatric
- ☐ Rehabilitation
- ☐ Trauma Center
- ☐ X-ray
- ☐ Other: (Describe) _____

K. Does hospital engage in any of the following research/experimental activities?

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

Provide details to any of above: _____

_____

III. COVERAGE/LIMITS/DEDUCTIBLES

A. Policy Effective Date	B. Policy Expiration Date	C. Are you currently enrolled in a Patient's Compensation Fund?
		☐ Yes ☐ No

D. Coverage Requested

			Retroactive Date
☐ Professional Liability			
☐ General Liability	☐ Claims Made	☐ Occurrence	
☐ Umbrella Liability			

If General Liability & Umbrella Liability is desired, please complete ACORD applications.

	E. Limits of Liability	F. Deductible/SIR
Hospital Professional Liability:	_____ Each Incident _____ Annual Aggregate	_____ Each Incident _____ Annual Aggregate
Physicians Professional Liability:	_____ Each Incident _____ Annual Aggregate	_____ Each Incident _____ Annual Aggregate
General Liability:	_____ BI & PD – Each Occurrence _____ PI & AI – Each Occurrence _____ Prod/Comp Ops – Aggregate _____ Annual Aggregate	_____ Each Incident _____ Annual Aggregate
Umbrella Liability:	_____ Each Incident _____ Annual Aggregate	_____ Annual Aggregate

G. Self-Insured Retention (SIR), if applicable

1. How are loss adjustment expenses handled? ☐ Within SIR limit ☐ Outside SIR limit
2. Is there a dedicated trust? ☐ Yes ☐ No
3. What financial institution manages the trust? _____
4. Is there an independent actuarial review? ☐ Yes ☐ No

IV. PROFESSIONAL LIABILITY EXPOSURES - Complete this section for each facility.

Facility Name:

A. Employed Physicians, Surgeons and Other Health Care Providers

Position	Number of Employees	Full-Time Equivalents	Position	Number of Employees	Full-Time Equivalents
Employed physicians*			LPNs		
Employed surgeons*			Paramedics		
Interns*			Pharmacists		
Residents*			Physician assistants		
Midwives*			Registered Nurses		
CRNA's*					

***If coverage is requested, complete Appendix I.**

Please Enter Total Number of Employees :_____

B. Blood Banks

1. Does the hospital own/operate a blood bank that sells to third parties? If yes, please describe, and include the customer revenue and number of units: _____

C. Pharmacy

2. The pharmacy is staffed by: ☐ Hospital Employees ☐ Contract Group
   If contract group, name of group: _____
3. Does the pharmacy dispense medicine to non-patients? ☐ Yes ☐ No
   If yes, what are the annual receipts for non-patient medications: $_____
4. Does your facility utilize a bar coding system for dispensing medicine? ☐ Yes ☐ No
5. Does your facility utilize computerized physician order entry (CPOE)? ☐ Yes ☐ No
6. Has your facility eliminated the use of IV infusion pumps that allow 'Free Flow' of IV solutions? ☐ Yes ☐ No

D. Medical Staff

1. Do hospital by-laws require staff doctors to carry medical malpractice insurance? ☐ Yes ☐ No
   If yes, what limits are required _____Each Incident
   _____Aggregate
   How often is it verified? ☐**Annually** ☐ **Other (describe):** _____
2. Does the credentialing (re-credentialing) process include the following?
   a. Malpractice History ☐ Yes ☐ No
   b. Employment History ☐ Yes ☐ No
   c. Reference Checks ☐ Yes ☐ No
   d. License ☐ Yes ☐ No
   e. National Practitioner Databank ☐ Yes ☐ No
3. Has the license of any physician/surgeon ever been restricted or suspended? ☐ Yes ☐ No
   If yes, provide details: _____
4. Has the hospital been required to notify the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff? ☐ Yes ☐ No
   If yes, provide details: _____
5. Are all privileges granted to staff doctors detailed in writing? ☐ Yes ☐ No
6. Total number of all medical staff (active, Consulting, Associate, etc.)? _____
7. Do you have dedicated hospitalists/intensivists? ☐ Yes ☐ No
   If yes, are they: ☐ Employed ☐ Contract Group ☐ Staff
   ☐Other: _____

E. Nurse Staffing

1. What was the average RN vacancy rate for the past 12 months? _____
2. What percent of nursing shifts/month were staffed by agency personnel (average for past 12 months)? _____%

F. Anesthesia

1. The anesthesiology department is staffed by:
   ☐ Employed Physicians ☐ Contract Physicians ☐ Staff Physicians
   ☐ Employed CRNA's ☐ Contract CRNA's
   If contract group,
   a. Name of group: _____
   b. Are Certificates of Insurance required? ☐ Yes ☐ No
   c. If yes, what limits are required? _____Each Incident
      _____Aggregate
2. Number of Anesthesiologists: _____
3. Percent of those physicians who are Board Certified. _____%
4. Number of CRNAs: _____
5. If you employee CRNA'S, please explain how their care is supervised/reviewed:
   _____
   _____
   _____

G. Emergency Department

1. Please indicate how your Emergency Department is classified:
   ☐ Level I (Tertiary) ☐ Level II (Comprehensive) ☐ Level III (Basic) ☐ Other
2. The Emergency Department is staffed by:
   ☐ Employed Physicians ☐ Staff Physicians ☐ Contract Group ☐ Residents
   If contract group,
   a. Name of group: _____
   b. Are Certificates of Insurance required? ☐ Yes ☐ No
   c. If yes, what limits are required? _____Each Incident
      _____Aggregate
3. Number of Emergency Department physicians: _____
4. Do you use clinical practice guidelines/pathways or protocols for caring for patients with:
   a. Trauma ☐ Yes ☐ No
   b. Fever in children ☐ Yes ☐ No
   c. Chest pain ☐ Yes ☐ No
   d. Abdominal pain ☐ Yes ☐ No
   e. Headache ☐ Yes ☐ No
5. Do you staff with non-E.D. Physicians? ☐ Yes ☐ No
6. Number of Nurse Practitioners/Physician Assistants: _____
7. What is the percent of physicians who are Board Certified in Emergency Medicine? _____%

H. Surgery

1. Have you implemented the JCAHO/AORN Universal Protocol to promote Correct Site Surgery? ☐ Yes ☐ No

I. Radiology

1. The Radiology is staffed by:
   ☐ Employed Physicians ☐ Staff Physicians ☐ Contract Group
   If contract group,
   a. Name of group: _____
   b. Are Certificates of Insurance required? ☐ Yes ☐ No
   c. If yes, what limits are required? _____Each Incident _____Aggregate
2. Are all physicians required to be Board Certified or eligible in Radiology? ☐ Yes ☐ No
3. Are all radiographs, scans, MRI's, etc. over read by the radiologist? ☐ Yes ☐ No
   If no, please explain: _____

J. Obstetrics

1. Percentage of C-Sections: _____%
2. Number of V-BAC's _____
3. Is this hospital a regional referral center for high-risk pregnancies or newborns? ☐ Yes ☐ No
4. What is the hospital's requirement of the Obstetrician during inductions?
   _____
5. Is there a chain of command policy for the labor/delivery nurses to follow with 100% compliance? ☐ Yes ☐ No
6. At a minimum, do you require that all OB nurses complete an annual electronic fetal monitoring and competency test? ☐ Yes ☐ No
7. Do midwives practice at your hospital? ☐ Yes ☐ No
   If yes, do they only practice in collaboration with the Obstetrician? ☐ Yes ☐ No
8. Is an anesthesiologist or CRNA available in-house 24 hours per day for the obstetrical suite? ☐ Yes ☐ No
9. Is an obstetrician available in-house 24 hours per day for the obstetrical suite? ☐ Yes ☐ No
10. Number of labor rooms _____
11. Number of delivery rooms _____
12. Do you have a separate birthing center? ☐ Yes ☐ No
13. Is delivery room suite separate from surgical suite? ☐ Yes ☐ No
    If yes, please describe the location of the operating room in relation to the delivery room.
    _____
14. Can Cesarean sections be performed within 30 minutes at all times? ☐ Yes ☐ No
15. Does policy require the OR and Anesthesia staff as well as the obstetrician to be in-house and readily available for V-Bac's? ☐ Yes ☐ No
16. How many physicians have OB privileges? _____
17. How many are Board Certified in OB? _____
18. How many Family Practitioners with OB privileges are on your staff? _____
19. How many Family Practitioners have privileges to perform C-sections? _____

V. GENERAL LIABILITY/AUTOMOBILE EXPOSURES

A. Locations

Please complete an ACORD General Liability Application.

B. Contractual Agreements

1. Who has the authority to execute contracts, including hold harmless agreements?
   _____
   _____
   _____
2. Does the hospital's attorney review all contracts before they are signed? ☐ Yes ☐ No

C. Day Care

1. Do you operate a children's Day Care? ☐ Yes ☐ No
   If yes, provide the following details:
   a. Number of children _____
   b. Number of days per week _____
   c. Is the center on hospital premises? ☐ Yes ☐ No
   d. Is the center open to the public? ☐ Yes ☐ No
      If yes, % of public?: _____%
2. Do you conduct background checks (Criminal, Abuse/neglect, references etc.) on all day care employees? ☐ Yes ☐ No

D. Incidental Exposures

1. Has the hospital planned or is it engaged in any new construction for the next 12 months? ☐ Yes ☐ No
   If yes, provide details including purpose, estimated cost, square footage, and completion date: _____
   _____
   _____
2. Does the hospital have a heliport? ☐ Yes ☐ No
   If yes, what are your approximate annual landings? _____

E. Automobile Exposures

1. Does the hospital operate an ambulance service? ☐ Yes ☐ No
   If yes, provide number of vehicles: _____
2. Total number of Owned or leased vehicles: _____
3. List the number of and provide details on the following vehicles:
   a. Private Passenger: _____
   b. Trucks: _____
   c. Heavy Tractors: _____
   d. Ambulance/Medical Transport: _____
   e. Social Service (1-8 passengers) _____
   f. Social Service (9-20 passengers) _____
   g. Social Service (21 or more passengers) _____
   h. Bus _____
   i. Van _____
   j. Owned, leased or non-owned watercraft: _____
   k. Owned, leased or non-owned aircraft: _____
4. Does the hospital dispatch emergency vehicles for others? ☐ Yes ☐ No
   If yes, provide details: _____

VI. RISK MANAGEMENT

1. How often does the risk manager report to the governing board on risk management activities?
   ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____
2. Who coordinates your Risk Management program?
   Name: _____ Telephone Number: _____
   Title: _____ Email Address: _____

3. Please check all those activities that the risk manager is involved:
   ☐ Claim Reviews ☐ IRB Committee ☐ Policy/Procedure Development
   ☐ Contract Review ☐ Incident Reporting ☐ Quality Management
   ☐ Safety Committee ☐ Infection Control ☐ Patient Disclosure
   ☐ Staff Education on Risk ☐ Other (Describe): _____

VII. CLAIM MANAGEMENT

1. Who is responsible for managing claims?
   Name: _____ Title: _____

2. Do you use a third party administrator? ☐ Yes ☐ No
   If yes, please provide the name of the organization: _____

3. Please list the law firm(s) who handle your medical malpractice cases:
   _____
   _____

VIII. POLICY AND LOSS INFORMATION

Provide 10 years of loss information OR complete the Arch Healthcare Claim Input Spreadsheet

IX. NOTICE TO APPLICANT

NOTICE: ANY PERSON WHO, KNOWINGLY OR WITH INTENT TO DEFRAUD OR TO FACILITATE A FRAUD AGAINST ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AN APPLICATION OR FILES A CLAIM FOR INSURANCE CONTAINING FALSE, DECEPTIVE OR MISLEADING INFORMATION MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ARKANSAS, 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 fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an Insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: Warning, it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in

the third degree.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

NOTICE TO MAINE APPLICANTS: It is a crime to 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 NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claims 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 each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance or statement of claim containing any fact 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 PUERTO RICO APPLICANTS: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps, or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousand dollars ($5,000) no more than ten thousand dollars ($10,000); or imprisonment for a fixed term of three , or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

NOTICE TO TENNESSEE & 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 include imprisonment, fines and denial of insurance benefits.

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.

Applicant Signature:	**Producer Signature:**
Print Name:	**Print Name:**
Title:	**Date:**
Date:	

X. ATTACHMENT CHECKLIST

PLEASE ATTACH THE FOLLOWING INFORMATION, CHECKING THE CORRESPONDING BOX:

- ☐ Completed, signed and dated application
- ☐ Completed Acord GL Application (If GL and Umbrella Liability coverage is requested)
- ☐ Loss History: Using the attached template, please provide 10 years of individual claim detail. All requested fields should be completed in the format specified.
- ☐ Current accrediting agency (JCAHO, AOA, CARF, State Surveys etc.) report with recommendations and the institution's response to any contingencies
- ☐ List of all subsidiaries/other entities to be covered
- ☐ Appendix I – Employed Physicians, Surgeons and Other Health Care Providers for whom coverage is requested
- ☐ Appendix II – Professional Liability Inpatient/Outpatient Exposures
- ☐ Risk Management and Quality Improvement Plan with last year's and current initiatives
- ☐ Organizational Charts (Corporate and Risk Management)
- ☐ Job Description and Resume of the Risk Manager
- ☐ Copy of Medical Staff By-Laws
- ☐ Current audited Financial Statement

For Self-Insured Programs:

- ☐ Copy of Trust Financial Agreement
- ☐ Copy of Trust Coverage wording
- ☐ Financial Statement of Trust Fund
- ☐ Recent actuarial review supporting the funding of the Self-Insured Retention
- ☐ Claim Management Underwriting Questionnaire

APPENDIX I – EMPLOYED PHYSICIANS, SURGEONS AND OTHER HEATLH CARE PROVIDERS FOR WHOM COVERAGE IS REQUESTED												
A. Total Employed Physician FTE's	**Experience Period (mm/dd/yy – mm/dd/yy) Provide Current, Projected and 10 years previous experience**											
Specialty	Projected	Current										
Adolescents												
Allergy/Immunology												
Anesthesiology												
Burn Treatment												
Cardiology												
Cardiovascular Surgery												
Clinical Pharmacology												
Critical Care Medicine												
CRNA												
Dermatology												
Developmental Disorders												
Emergency Medicine												
Endocrinology												
Family Practice/General Medicine												
Gastroenterology												
General Surgery												
Genetics												
Geriatrics												
Gynecology												
Hematology/Oncology												
Infectious Disease												
Inflammatory Mechanism												
Intensivist/Hospitalist												
Internal Medicine												
Internists												
Midwives												
Molecular Cardiology												
Neonatology												
Nephrology												
Neurology												
Neurosurgery												
Nuclear Medicine												
Nurse Practitioner												
Obstetrics												
Ophthalmology												
Orthopedics												
Otolaryngology/ENT												
Pain Management												
Pathology												
Pediatric Surgery												

Specialty - continued	Experience Period (mm/dd/yy – mm/dd/yy) Provide Current, Projected and 10 years previous experience											
	Projected	Current	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Pediatrics												
Perfusionist												
Pneumatology												
Physical Medicine/Physiatry												
Podiatry												
Psychiatry												
Psychology												
Pulmonary Disease												
Radiology												
Urology												
TOTAL												

B. Total Resident/Fellow FTE's	Experience Period (mm/dd/yy – mm/dd/yy) Provide Current, Projected and 10 years previous experience											
Specialty	Projected	Current	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Adolescents												
Allergy/Immunology												
Anesthesiology												
Burn Treatment												
Cardiology												
Cardiovascular Surgery												
Clinical Pharmacology												
Critical Care Medicine												
CRNA												
Dermatology												
Developmental Disorders												
Emergency Medicine												
Endocrinology												
Family Practice/General Medicine												
Gastroenterology												
General Surgery												
Genetics												
Geriatrics												
Gynecology												
Hematology/Oncology												
Infectious Disease												
Inflammatory Mechanism												
Intensivist/Hospitalist												

Specialty - continued	Experience Period (mm/dd/yy – mm/dd/yy) Provide Current, Projected and 10 years previous experience											
	Projected	Current	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Internal Medicine												
Internists												
Midwives												
Molecular Cardiology												
Neonatology												
Nephrology												
Neurology												
Neurosurgery												
Nuclear Medicine												
Nurse Practitioner												
Obstetrics												
Ophthalmology												
Orthopedics												
Otolaryngology/ENT												
Pain Management												
Pathology												
Pediatric Surgery												
Pediatrics												
Perfusionist												
Pneumatology												
Physical Medicine/Physiatry												
Podiatry												
Psychiatry												
Psychology												
Pulmonary Disease												
Radiology												
Urology												
TOTAL												

APPENDIX II – PROFESSIONAL LIABILITY INPATIENT/OUTPATIENT EXPOSURES – Complete this Appendix for each facility.

Facility Name:

	Number of Occupied Beds									
Experience Period (mm/dd/yy – mm/dd/yy)	Acute Care	Bassinets	Psychiatric	Rehabilitation	Long Term Care – Acute Care	Long Term Care – Subacute	Long Term Care – Skilled	Long Term Care – Intermediate	Long Term Care – Acute Care	ICU/CCU
Current										
Projected										

	Number of Procedures/Visits				Other Outpatient Visits					
Experience Period (mm/dd/yy – mm/dd/yy)	Births	Inpatient Surgeries	Outpatient Surgeries	Emergency Room	Alcohol or Drug Abuse	Rehab/Therapy	Psych	Clinic	Home Health	Other
Current										
Projected										