

# Health Care Professional Liability and General Liability Application for Hospitals

The following additional information is required to be submitted along with the attached application:

- 1. Loss Information:** Current loss runs for the last ten (10) years. If ten (10) years is unavailable, please provide as many years as possible – no less than five (5) years minimum.  
Losses must be valued no older than three (3) months from the policy expiration or renewal date. Please include paid and reserved losses and claim details. Loss runs from prior carriers are preferred.
- 2. Copies of Latest JCAHO Report:** If not available, or not applicable, please provide a copy of the most recent state licensure survey.
- 3. Current Audited Financial Information:** If an audited financial statement is not available, please provide the most current financial information available.
- 4. Copy of the Medical Staff By Laws:** Please include all amendments that may have been made to the Bylaws.
- 5. Copy of Organizational Chart:** Please show legal entities only; not personnel.
- 6. Copy of Contracts:** Please provide copies of management agreements, hold harmless agreements, etc.
- 7. Changes in Operations or Ownership:** If the operations or ownership have changed in the past or if the operations or ownership will be changing in the future, please provide an explanation of the changes.

**Please report all known incidents that could lead to a claim to your existing insurance carrier. It will be excluded under the insurance policy to which you are applying for coverage.**

**I. Applicant Information**

1. Name of Applicant (first named insured): \_\_\_\_\_  
\_\_\_\_\_
2. Street Address: \_\_\_\_\_  
\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
3. Mailing Address: \_\_\_\_\_  
\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_
4. Person to Contact for Survey: \_\_\_\_\_  
Title: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Email: \_\_\_\_\_
5. Additional **Named Insured(s)** (Please provide retroactive dates, addresses, and relationship to first named insured. Please list exactly as it should appear on the policy. Use a separate page if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**II. Professional Liability Information**

1. Type of Facility (please check all that apply):  
 For Profit  Not For Profit  Governmental  Critical Access Center
2. Entity is:  Individual  Partnership  Corporation  Joint Venture
3. Brief Description of Operations (specialty): \_\_\_\_\_
4. Years in Business? \_\_\_\_\_ Employer Fed ID #: \_\_\_\_\_
5. Effective date of coverage desired: \_\_\_\_\_
6. Deductible on Current Insurance: \_\_\_\_\_ Deductible Requested: \_\_\_\_\_
7. Retroactive Date: \_\_\_\_\_ Limits Requested: \_\_\_\_\_
8. Prior Insurance History (please provide five (5) years of PL & excess/umbrella information):

Policy Period	Carrier	Limits	Coverage	Deductible	Premium

9. Has there been any change in management, ownership, or change in operations during the past five (5) years?  Yes  No  
If yes, please describe the change: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Are any management services provided for others?  Yes  No  
 If yes, please describe: \_\_\_\_\_

11. Is your facility managed by a management company?  Yes  No  
 If yes, please describe: \_\_\_\_\_

*(Please provide a copy of the management contract)*

12. Do you provide telemedicine services?  Yes  No  
 If yes, please describe: \_\_\_\_\_

**III. Facilities and Services**

1. Services provided by your facility (please check all that apply):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> abortion clinic   | <input type="checkbox"/> ambulance          | <input type="checkbox"/> blood bank               |
| <input type="checkbox"/> burn unit         | <input type="checkbox"/> cancer therapy     | <input type="checkbox"/> CCU                      |
| <input type="checkbox"/> day care          | <input type="checkbox"/> dialysis           | <input type="checkbox"/> dietary                  |
| <input type="checkbox"/> emergency         | <input type="checkbox"/> gift shop          | <input type="checkbox"/> hyperbaric chamber       |
| <input type="checkbox"/> ICU               | <input type="checkbox"/> inhalation therapy | <input type="checkbox"/> long-term care           |
| <input type="checkbox"/> morgue            | <input type="checkbox"/> NICU               | <input type="checkbox"/> nursery                  |
| <input type="checkbox"/> obstetrical       | <input type="checkbox"/> operating rooms    | <input type="checkbox"/> pathology                |
| <input type="checkbox"/> pharmacy          | <input type="checkbox"/> physical therapy   | <input type="checkbox"/> psychiatric therapy      |
| <input type="checkbox"/> radiology         | <input type="checkbox"/> restaurant         | <input type="checkbox"/> self-care/rehabilitation |
| <input type="checkbox"/> teaching facility | <input type="checkbox"/> trauma center      | <input type="checkbox"/> wellness center          |

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

<b>Description</b>	<b>Full-time</b>	<b>Full-time Equivalents</b>
Employed Physicians/Surgeons	_____	_____
Interns/Residents	_____	_____
Dentists/Oral Surgeons	_____	_____
Podiatrists	_____	_____
Optometrists	_____	_____
Physician Assistants/Nurse Practitioners	_____	_____
Registered Nurses	_____	_____
LPNs	_____	_____
Student Nurses	_____	_____
Student CRNAs	_____	_____
X-Ray Technicians	_____	_____
Lab Technicians	_____	_____
Pharmacists	_____	_____
Profusionists	_____	_____
Paramedics	_____	_____
CRNAs	_____	_____
Midwives	_____	_____
Other Employees	_____	_____
Volunteers	_____	_____



Exposure Basis	# Licensed Beds (for file only)	Next 12 Months	Expiring year	Prior 2 <sup>nd</sup> yr	Prior 3 <sup>rd</sup> yr	Prior 4 <sup>th</sup> yr	Prior 5 <sup>th</sup> yr
# Births	Total # for all Births/all Types						
# Cesarean Section Births	# C-section only						
Pharmacy (not portion of sales to patients)	Receipts Sold to Public						
# Attendees in Day Care							
Other Exposures <b>Not</b> Listed Above:							

Note: A visit is the number of times a patient comes to the hospital/clinic to have procedures done, not the number of procedures (for instance – a person may have several procedures done in one day, but it will only count as one visit for that day).

4. Additional Information:

a. Criteria for qualifications of employed Physicians:

1. Is history of previous employment verified?  Yes  No
2. Are references checked?  Yes  No
3. Has the license of any employed physician ever been revoked, restricted, or suspended?  Yes  No

If yes, please explain: \_\_\_\_\_

4. Do the employed physicians carry their own insurance or do they share limits with the facility? \_\_\_\_\_  
If they carry their own, what limits are required? \_\_\_\_\_

b. Staff Privileges of Private Practitioners:

1. Are credentials of doctors approved by the medical staff &/or hospital review board before privileges are granted?  Yes  No
2. Is there a probationary period of at least six months for all staff doctors?  Yes  No
3. Are all staff doctors' performances periodically reviewed by the medical staff and/or hospital review board?  Yes  No
4. Do hospital staff bylaws require staff doctors to carry medical malpractice insurance?  Yes  No  
If yes, what limits are required? \_\_\_\_\_ per claim \_\_\_\_\_ aggregate
5. Are all privileges granted to staff doctors detailed in writing?  Yes  No
6. Has the license of any staff physician ever been restricted or suspended?  Yes  No

If yes, please explain: \_\_\_\_\_

c. Anesthesiology:

1. Anesthesiology department is staffed by:  
 Employed Physicians  Employed CRNAs  Staff Physicians  
 Contract Group If contract group, name: \_\_\_\_\_  
Are certificates of insurance required?  Yes  No  
If yes, what limits are required? \_\_\_\_\_ per claim \_\_\_\_\_ aggregate
2. Are all anesthesiologists required to be board certified or eligible in anesthesiology?  Yes  No
3. Is the anesthesiology care performed by CRNAs supervised and reviewed by the anesthesiologist?  Yes  No

If no, please explain: \_\_\_\_\_

d. Radiology:

1. Radiology department is staffed by:

Employed Physicians  Staff Physicians  Contract Group

If contract group, name: \_\_\_\_\_

Are certificates of insurance required?  Yes  No

If yes, what limits are required? \_\_\_\_\_ per claim \_\_\_\_\_ aggregate

3. Are all radiologists required to be board certified or eligible in radiology and/or nuclear medicine?  Yes  No

e. Emergency Department:

1. How is the emergency department classified?  Level I (tertiary)  Level II (comprehensive)

Level III (basic)  Other: \_\_\_\_\_

2. Emergency Department is staffed by:

Employed Physicians  Rotating Staff  Contract Group

If contract group, name: \_\_\_\_\_

Are certificates of insurance required?  Yes  No

If yes, what limits are required? \_\_\_\_\_ per claim \_\_\_\_\_ aggregate

Are the physicians on site or is care provided via telemedicine? \_\_\_\_\_

3. Are all physicians required to be board certified or eligible in emergency medicine?  Yes  No  
If no, what are the specialties of the ER physicians (please list on separate page if necessary)?  
\_\_\_\_\_  
\_\_\_\_\_

4. Does the facility provide ambulance service?  Yes  No

If yes, please explain ambulance use (ex: transport only, first responder, second responder, 911 dispatch service): \_\_\_\_\_  
\_\_\_\_\_

Number of ambulances: \_\_\_\_\_ Number of runs per month: \_\_\_\_\_

f. Obstetrics:

1. Does the facility have a written procedure for transferring all high-risk mothers and/or babies which the hospital is not qualified to treat?  Yes  No

2. Do you have the following nurseries:

Level I (Well baby)  Level II (Intermediate Care)  Level III (Neonatal Intensive Care)

3. Does the facility allow vaginal birth after C-section (VBAC)?  Yes  No

If so, how many in the previous 12 months? \_\_\_\_\_

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

If no, please explain: \_\_\_\_\_

5. Do nurse midwives practice at the facility?  Yes  No

If so, are they properly certified?  Yes  No

Do they deliver babies?  Yes  No

If so, where (patient's home or at facility or other)? \_\_\_\_\_

Are the nurse midwives under supervision of an OB/GYN?  Yes  No

6. Do family practitioners (FP) deliver babies?  Yes  No  
 If so, how many family practitioners are delivering babies? \_\_\_\_\_
7. Are ACOG standards incorporated into hospital protocols & procedures?  Yes  No
- g. Surgery:
1. Are any of the following procedures performed at your facility?
- |                                       |  |
|---------------------------------------|--|
| Neurosurgery (including back surgery) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Experimental Surgery                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Weight Reduction Surgery (bariatric)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Laser Assisted Surgery                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Surgery                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- If yes to any of the above, how many of each:
- a. Were done in the past 12 months? \_\_\_\_\_
- b. How many do you anticipate for the next 12 months? \_\_\_\_\_
2. If bariatric surgeries are performed, what changes in the facility and equipment have been made to accommodate the morbidly obese?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How many physicians perform bariatric surgery at the facility? \_\_\_\_\_  
 What are their qualifications? \_\_\_\_\_
3. Are sponge, needle, and instrument counts performed during the course of a surgical procedure?  Yes  No  
 If yes, at what intervals? \_\_\_\_\_
- h. Pharmacy:
1. Does the facility utilize a unit dose system of dispensing medicine?  Yes  No
2. Is the pharmacy for patients use only?  Yes  No
3. Does a contract group staff the pharmacy?  Yes  No  
 If contract group, name: \_\_\_\_\_
- i. Risk Management:
1. Who coordinates your risk management program?  
 Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_
2. Is there a formal risk management program in place?  Yes  No  
 If so, does the risk management program include the following?
- |  |  |
|--|--|
| Occurrence reporting                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Claim management                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Safety program and safety committee                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Review and participation in medical staff committees | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Contract review and evaluation                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sexual Harassment policy in place                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
3. Does the facility comply with all state and federal guidelines regarding the handling of blood borne pathogens?  Yes  No
- j. Claims History:
1. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit?  Yes  No
2. Do you have knowledge of any event(s) that could possibly lead to a claim, or suit?  Yes  No  
 If yes, have you reported it/them to your prior insurance carrier?  Yes  No

**IV. General Liability Information**

1. Insurance Information:

- a. Is current insurance coverage Claims-made? Yes No  
If yes, what is Retroactive Date? \_\_\_\_\_
- b. What limits of liability are requested? \_\_\_\_\_
- c. What deductible is requested? \_\_\_\_\_
- d. Prior Insurance History (please provide at least five (5) years of information):

Policy Period	Carrier	Limits	Coverage	Deductible	Premium

2. Incidental Exposures:

- a. Has the facility planned any new construction, expansion, closure, or change to the facility for this year? Yes No  
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_
- b. Are there any elevators or escalators on any premises owned, leased, or occupied by the insured? Yes No  
If yes, how many? \_\_\_\_\_  
Who is responsible for the maintenance? \_\_\_\_\_
- c. Does the facility have a helipad or heliport? Yes No
- d. Does the facility own, lease, or charter aircraft? Yes No  
If yes, does the hospital have separate insurance coverage for the heliport, owned, leased, or chartered aircraft? Yes No  
If yes, please provide details on a separate page of coverage for each to include carrier, limits, and policy periods.
- e. Please list the number and type of owned or leased vehicles (please use separate page if necessary):  
\_\_\_\_\_  
\_\_\_\_\_
- f. Please list all owned, leased, and non-owned watercraft (please use separate page if necessary):  
\_\_\_\_\_  
\_\_\_\_\_

3. Hold harmless and Indemnification Agreements:

- a. Has the facility agreed to hold harmless or indemnify others under contract? Yes No  
If yes, please provide copies of all contracts.
- b. Does the facility rent or lease equipment from others? Yes No  
If yes, please explain (please list the type of equipment and who is responsible for the maintenance. Use a separate page if necessary):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Employee Benefits Administration Liability:
- a. Do you currently have and/or want to purchase Employee Benefits Administration Liability Coverage?  Yes  No
  - b. Number of Employees: \_\_\_\_\_
  - c. What is the current or requested retroactive date? \_\_\_\_\_
  - d. Are employee benefits self administered?  Yes  No

**V. General Liability Exposure Information**

1. Please list all properties on the chart on page 13 (please use more than one page if necessary).

**VI. Applicant Authorization**

**NOTICE TO ARKANSAS APPLICANTS:** “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

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

**NOTICE TO 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 and insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.”

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

**NOTICE TO LOUISIANA 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 MAINE APPLICANTS:** “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.”

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

**NOTICE TO NEW MEXICO APPLICANTS:** “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.”

**NOTICE TO NEW YORK APPLICANTS:** “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”

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

**NOTICE TO 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” (365:15-1-10, 36 3613.1).

**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 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.”

The undersigned authorized officer of the organization declares that to the best of his/her knowledge, the statements set forth herein are true.

Signing of the applications does not bind the undersigned to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued.

\_\_\_\_\_  
Signature of Chief Executive Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

# Schedule of Locations

Fire Protection Key: AS = Approved Sprinkler S = Smoke Detectors H = Heat Detector A = Automatic Alarm

Location	Area	Age	Type of Construction	# of Floors	Type of Fire Protection	City	State	Insurance Requested?
<b>Patient Care Buildings:</b>								
<b>Other Buildings:</b>								
<b>Parking Lots:</b>								
<b>Vacant Lots:</b>								