Physicians' Reciprocal Insurers

Healthcare Facility

Professional Liability Insurance Application

IMPORTANT: Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

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ACI-1 (5/95), Rev. 10/98, Rev. 4/01, Rev. 6/02, Rev. 11/02, Rev. 3/04, Rev. 1/11, Rev. 3/14, 11/16

PHYSICIANS' RECIPROCAL INSURERS
HEALTHCARE FACILITY
PROFESSIONAL LIABILITY INSURANCE APPLICATION

PART I - APPLICANT (*If more than one location, please list on separate sheet)*

1 *Name of Facility*: _____

2. *D/B/A*: _____

3. M*ain Location:* _____

4. *City/State/Zip*: _____

5. N*umber of Years in Business*: _____ 5a. *Number of years under current management* _____

6. Fa*cility Tax I.D. Number*: _____

7. Additional locations to be covered: _____

8. Are there plans to add on to the present location or add other locations within the next 3 years?
If "Yes", please describe:

_____

_____

9. Type of ownership: Partnership ☐ Corp. ☐ Sole Proprietorship ☐ P.C. ☐ Other ☐

10. Are you applying as a physician group? ☐ Yes ☐ No

11. Operating as: For Profit ☐ Non Profit ☐

12. Named Insureds: List all subsidiaries, date acquired, description of operation, ownership in percentage and if coverage is desired.

Subsidiaries	Date Acquired	Description Of Operation	% of Ownership	Coverage Requested?

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PART II – REQUESTED LIABILITY LIMIT AND DEDUCTIBLE OPTIONS

1. Primary ☐
   Excess ☐

2. Claims-Made ☐ Coverage Period: ___________________ Retroactive Date: __________________
   Occurrence ☐ Coverage Period: ___________________

3. Requested Liability Limits:

   a. **Facility**

   Per Occurrence: _______________________________ Aggregate: ___________________________

   b. **Physicians -** (if coverage is being requested for employed physicians under the facility policy):
   Shared limit option ☐ Yes ☐ No

   Individual Limit option with a **total policy basket aggregate** of:
   $6,000,000 ☐
   $9,000,000 ☐
   $12,000,000 ☐
   $15,000,000 ☐

4. Requested Deductible (Check only one):
   ☐ No deductible.
   ☐ $25,000 ☐ $75,000 ☐ Other $__________________
   ☐ $50,000 ☐ $100,000

PART II A - INSURANCE PROFILE (FIVE YEARS)

Failure to complete will delay the process of the application.

1. **Primary Professional Liability**

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability	Premium
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$

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2. **Excess Professional Liability Coverage**

Policy Period	Carrier	Limits of Liability	Deductible/SIR	Claims Made or Occurrence	Retro Date, if applicable	Are ALAE included in Limits of Liability	Premium
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$
			☐Ded ☐SIR	☐CM ☐Occ		☐Yes ☐No	$

3. Has the Applicant's policy or coverage ever been declined, cancelled or non-renewed during the past five (5) years? If yes, please explain: ____

____

PART III - SERVICES PROVIDED

1. Number of current annual outpatient visits/treatments/revenue: ______________________________

1a. Number of projected annual outpatient visits/treatments/revenue in next 12 months: _______________

***Visits** – Use a threshold count. Count each patient each time they enter your facility for health related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.

***Gross Revenue** – This figure can be found on your financial statement. Do not adjust this figure for items such as profit, uncollectible accounts or amounts billed but not paid by third party payers. This number must represent the annual gross figure.

2. Do you provide telemedicine services? ☐ Yes ☐ No
If yes, please answer a – d below:

   a. Where do you provide the telemedicine services? ___________________________________

   b. Do you provide telemedicine to patients other than in New York? ☐ Yes ☐ No

   If yes, please explain: ____

   c. How many physicians provide telemedicine services? _______________

   d. Are all physicians licensed in the state where the telemedicine services are rendered?

   ☐ Yes ☐ No

   If no, please explain: ____

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Please note: Total of all services should match the total number of current and estimated visits/treatments/revenue indicated in question 1 and 1a.

Treatments/ Visits*	**Current # of Treatments or Visits**	**Estimated # of treatments or visits**	**Treatments/ Visits***	**Current # of Treatments or Visits**	**Estimated # of treatments or visits**
Anesthesia – Local			ENT		
Anesthesia – General			Family Planning		
Moderate Sedation			Gynecology		
Audiology			Mammography		
Dental			Obstetrics		
Dermatology			Ophthalmology		
Dialysis - **Treatment**			Orthopedics		
Diabetes			Pediatrics		
Urgent Care			Podiatry		
Blood Bank - **Donation**			Radiology		
			STD's		
			Urology		
Other- specify:			**Other- specify:**		
Other- specify:			**Other- specify:**		
Other- specify:			**Other- specify:**		
Counseling and Rehabilitation	**Current # of Treatments or Visits**	**Estimated # of treatments or visits**	**Procedures**	**Current # of Procedures**	**Estimated # of Procedures**
Physical Rehabilitation			Abortion		
Developmental Disability			Surgery – Major		
Mental Health			Surgery – Minor		
Cardiac Rehabilitation			Surgery – LASIK		
Substance Abuse Counseling			Surgery - Plastic		
Trauma Rehabilitation			Surgery – Oral		
Other – specify:			Pain Mgt/ESI		
Laboratory	**Current Gross Revenue**	**Estimated Gross Revenue**	**Other services not listed:**	**Current**	**Estimated**
Laboratory	$	$			
Pharmacy	$	$			
Pathology	$	$			
Optical Establishment	$	$			
Organ Banks	$	$			

3. Are there plans to add new services within the next three (3) years? If "Yes", please describe:

   _____

   _____

4. Does the Applicant participate in clinical research trials? If so, please describe:

   _____

5. Do any clinic physicians provide in-patient care for your clinic patients or does the entity (wholly or in part) own, operate or administer any facility that provides such inpatient services? If "Yes", describe:

_____

PART IV - ADMINISTRATIVE/PROFESSIONAL STAFF

1. Name of Medical Director: _____

***Please note that above referenced physician will only be covered for administrative duties, no clinical activities or direct patient care coverage will be afforded.**

2. Please list Employed Physicians (include Medical Directors and Dentists). Attach separate sheet, if necessary.

Name	Specialty	Board Certified	Total Number of Hours worked per week	Years Employed at Facility	Has Own Insurance Yes or No	Coverage Requested Yes or No

2a. Is medical malpractice coverage for the facility provided under the Federal Tort Claims Act (FTCA)?

☐ Yes ☐ No

If "Yes", please provide a list of physicians that are covered by the FTCA and submit letter with proof of current deemed status.

3. Please list Professional/Support Staff:

Title	Total Number	F/T	P/T	Title	Total Number	F/T	P/T
CNP				Optometrist			
CRNA				O.R. Technician			
Clerical				Pharmacist			
Midwife				Phlebotomist			
Physicians Assistant				Physical Therapist			
RN				Psychologist			
LPN				Occupational Therapist			
HHA				Speech Therapist			
PCA				Radiology Technician			
Medical Assistant				Social Worker			
				Dialysis Technician			
Other – Specify:							

PART V - LICENSING/ACCREDITATION

1. Is the facility JCAHO/CARF/OASAS/CAP/AAAHC accredited? Yes☐ No☐

   Accreditation period: _____ to _____

   If "No", when does the facility expect to get accredited? _____

2. Is the facility licensed under Article 28 of the New York State Public Health Law? Yes☐ No☐

   If "No", under what Article of the PHL is the facility operating under?_____

3. Has the Applicant's license ever been revoked/suspended/refused/canceled/voluntarily surrendered or subject to enforcement action? Yes☐ No☐

   If "Yes", please explain:_____

   _____

4. Do you have any pending investigations being conducted by any city, state or federal agency? Yes☐ No☐

   If "Yes", please explain:_____

   _____

5. Have you ever filed for protection under Chapters 11 or 7 of the Bankruptcy code? Yes☐ No☐

6. Do the Applicant's financial statements indicate an ongoing concern? Yes☐ No☐

PART VI – CONTRACTUAL AGREEMENTS

1. Are there contractual agreements in place, whereby the facility either receives or provides medical services? Yes☐ No☐

   If "Yes", please provide a copy of each agreement.

2. Does the Applicant rent or lease the premises? Yes☐ No☐

   If yes, do you rent or lease any medical or therapeutic supplies and/or equipment to others? Yes☐ No☐

PART VII - PROFESSIONAL STAFF HIRING/SCREENING AND EMPLOYMENT PROCEDURES

Please check all that apply:

Type	Pre-hire criminal background check	Educational Background or Residency	License Verification Suspension Revocation	OPMC/ OPD	OIG	Previous Employers and/or References	Sexual Offender Registry
Employees							
Contractors							
Volunteers							

PART VIII - QUALITY ASSURANCE/RISK MANAGEMENT

1. Risk Management			
a. Who coordinates the facility's risk management program:			
Name:		Title:	
Telephone #:	( )	Email:	
Years of experience:		Reports to:	
b. Is there a formal written risk management plan?			☐ Yes ☐ No
c. Is there a formal written performance improvement/QA plan?			☐ Yes ☐ No
d. Are the national patient safety goals addressed in the RM or QA plans? If no provide details on separate sheet.			☐ Yes ☐ No
e. Is there a formal, documented peer review and credentialing process in place?			☐ Yes ☐ No
f. Is the risk manager solely accountable and responsible for risk management?			☐ Yes ☐ No
If **no,** explain other responsibilities:			
g. Does the risk manager have access to legal counsel to discuss risk issues not directly related to a claim?			☐ Yes ☐ No
h. Does the risk manager participate in or maintain the following:			
Claims Management	☐ Yes ☐ No	IRB Committee	☐ Yes ☐ No
Contract Review and Evaluation	☐ Yes ☐ No	Patient Satisfaction Results	☐ Yes ☐ No
Disclosure	☐ Yes ☐ No	Policy and Procedure Development/Review	☐ Yes ☐ No
Staff Education	☐ Yes ☐ No	Risk Management Committee	☐ Yes ☐ No
Formal link to quality management	☐ Yes ☐ No	Patient Safety Program and Committee	☐ Yes ☐ No
Incident/Occurrence reporting	☐ Yes ☐ No	Sentinel Event Investigation	☐ Yes ☐ No
Infection Control Committee	☐ Yes ☐ No	Emergency Preparedness	☐ Yes ☐ No

PART IX – CONTACT INFORMATION

Please provide contact information for the following:

	Risk Manager	Claims Contact	Billing Contact
Name:			
Title:			
Telephone Number:			
Email Address:			
Mailing Address:			

PART X - ADDITIONAL INFORMATION AND DOCUMENTS TO ACCOMPANY APPLICATION

1. Copy of the most recent Department of Health survey, including the Plan of Correction.
2. Complete copy of the most recent JCAHO or AAAHC accreditation report.
3. Copy of current state license.
4. Copies of Certificates of Insurance for physicians covered under individual policies.
5. If applicable, completed PRI applications for all physicians to be covered under the facility policy.
6. Copies of any contracts with independent physician groups.
7. Current annual audited financials.
8. Public relations materials, brochures, etc.
9. Copies of any hold harmless agreements.
10. Copy of Certificate of Incorporation (Articles of Organization).
11. Copy of loss runs for the last ten (10) years.

APPLICATION IS NOT ACCEPTED WITHOUT SIGNATURE ON THE NEXT PAGE

NOTICE

Applicants considering claims-made coverage must take note of the following:

A claims-made policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy.

The policy covers claims actually made against the insured and incidents reported while the policy remains in effect and all coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases additional extended reporting period coverage which will provide coverage for an unlimited time period without any gap in coverage.

The rates for extended reporting period coverage will be based on the rates in effect at the time of termination of coverage and such rate may be subject to substantial increase over the rates currently in effect. The average statewide percentage changes, and the effective dates, of each rate revision which PRI has implemented in this State during the five (5) year period immediately preceding the effective date of the policy will be provided upon the written request of the insured. Such past changes may or may not be indicative of future rate changes.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims-made or incidents reported after such period of sixty (60) days.

During the first few years of coverage on a claims-made basis, the annual rate is comparatively lower than occurrence rates, however, such annual rate increases significantly, independent of overall rate level increases, until the claims-made relationship reaches maturity.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

The answers to the foregoing questions are complete and correct to the best of my knowledge and belief.

Signature: _____

Name (please print): _____

Title: _____

Date: _____

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