



Physicians' Reciprocal Insurers

Healthcare Facility (Renewal)

Professional Liability Insurance Renewal Application

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

1800 Northern Blvd
Roslyn, New York 11576
Telephone: (516) 365-6690 Fax: (516) 775-4224



**PHYSICIANS' RECIPROCAL INSURERS
HEALTHCARE FACILITY (Renewal)
PROFESSIONAL LIABILITY INSURANCE RENEWAL APPLICATION**

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

1. Name of Facility: _____

2. D/B/A: _____

3. Main Location: _____

4. City/State/Zip: _____

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

6. Facility 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. Operating as: For Profit Non Profit

11. 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?

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 III - SERVICES PROVIDED

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

***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.

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

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			Family Planning		
Anesthesia – General			Gynecology		
Moderate Sedation			Mammography		
Audiology			Obstetrics		
Dental			Ophthalmology		
Dermatology			Orthopedics		
Dialysis - Treatment			Pediatrics		

Diabetes			Podiatry		
Urgent Care			Radiology		
Blood Bank - Donation			STD's		
ENT			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	\$	\$			

2. Has the following occurred within the last 12 months or is the following planned within the next 12 months?

a. Discontinued Services: Yes No

If yes, please describe:



b. Planning to introduce new services: Yes No

If yes, please describe:

c. Signed **new** contracts for services to be provided or to provide services: Yes No

If yes, please describe:

3. Is the Applicant participating in any **new** clinical research trials? Yes No

If so, please describe:

4. 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:

5. Are non-clinic patients admitted and treated by your physicians?

If "Yes", describe:

PART IV - ADMINISTRATIVE/PROFESSIONAL STAFF

1. Name of Medical Director (If changed from last year): _____

***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	F/T	P/T	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. If your current JCAHO/CARF/OASAS/CAP/AAAH/OTHER accreditation is expiring, are you seeking re-accreditation? Yes No

If not, please explain reason: _____

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

If "Yes", please explain: _____

3. Have you filed for protection under Chapters 11 or 7 of the Bankruptcy code in the past 12 months? Yes No

PART VI - 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Is there a formal written performance improvement/QA plan?			<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Are the national patient safety goals addressed in the RM or QA plans? If no provide details on separate sheet.			<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Is there a formal, documented peer review and credentialing process in place?			<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Is the risk manager solely accountable and responsible for risk management?			<input type="checkbox"/> Yes <input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Does the risk manager participate in or maintain the following:			
Claims Management	<input type="checkbox"/> Yes <input type="checkbox"/> No	IRB Committee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contract Review and Evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Satisfaction Results	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disclosure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy and Procedure Development/Review	<input type="checkbox"/> Yes <input type="checkbox"/> No
Staff Education	<input type="checkbox"/> Yes <input type="checkbox"/> No	Risk Management Committee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formal link to quality management	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient Safety Program and Committee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Incident/Occurrence reporting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sentinel Event Investigation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infection Control Committee	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Preparedness	<input type="checkbox"/> Yes <input type="checkbox"/> No



PART VII – CONTACT INFORMATION

Please provide **updated** contact information for the following:

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

PART VIII - 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/AAAHC accreditation report.
3. Updated copies of Certificates of Insurance for physicians covered under individual policies.
4. If applicable, completed PRI applications for all physicians to be covered under the facility policy.
5. Copies of any new contracts with independent physician groups.
6. Current annual audited financial reports.
7. New or Revised Public relations materials, brochures, etc.
8. Copies of any new hold harmless agreements.
9. Copy of currently valued loss runs for the last ten (10) years from prior carriers.

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: _____