Physicians' Reciprocal Insurers

Hospital

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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Roslyn, New York 11576
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PHYSICIANS' RECIPROCAL INSURERS
HOSPITAL
PROFESSIONAL LIABILITY INSURANCE APPLICATION

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

1. ***Name of Hospital***: _____

2. ***Main Location:*** _____

3. ***City/State/Zip***: _____

4. ***Mailing Address (If different from above):*** _____

5. ***Telephone Number***: _____ 5a. ***Number of years under current management*** _____

6. ***Facility Tax I.D. Number***: _____

TYPE OF HOSPITAL

1. ☐ General Hospital ☐ Children's Hospital
   ☐ Critical Access Hospital ☐ Teaching Hospital
   ☐ Psychiatric Hospital ☐ Other
   ☐ Specialty Hospital

2. ☐ For Profit ☐ Government
   ☐ Not for Profit ☐ Other _____

3. ☐ Accredited by JCAHO ☐ Accredited by AOA
   ☐ Accredited by CARF

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

Claims-Made ☐ Coverage Period: _____ Retroactive Date: _____
Occurrence ☐ Coverage Period: _____
Primary ☐ Limits: _____
Excess ☐ Limits: _____
Deductible ☐ Limits: _____
Self Insured Retention ☐ Limits: _____

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CURRENT LIABILITY COVERAGE

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	$

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	$

1. If Self Insured Retention is applicable:
   a. How are loss adjustment expenses handled? Within SIR limit ☐ Outside SIR Limit ☐
   b. Is there a dedicated trust? Yes ☐ No ☐
      If no, how is SIR secured? _____
   c. Is there an independent actuarial review? Yes ☐ No ☐
   d. Who handles the claims within the SIR?: _____

2. Has any insurance carrier ever canceled non-renewed or refused insurance coverage? Yes ☐ No ☐
   If yes, please explain_____

3. For claims made coverage, was an extended reporting period (tail coverage) purchased for any previous primary or excess policy? Yes ☐ No ☐

4. Has your hospital received any fines or sanctions or Statements of Deficiency imposed by regulatory agencies in the past 12 months? Yes ☐ No ☐

   If "Yes", please describe below. Attach, also, each Plan of Correction and Statement of Acceptance by the Regulatory agency.

   _____

PART III – PROFESSIONAL LIABILITY EXPOSURES

1. Type(s) of Services offered:

- ☐ General
- ☐ Alcohol dependency
- ☐ Dental
- ☐ Drug Addiction
- ☐ Geriatric
- ☐ Obstetrical
- ☐ Pharmacy
- ☐ Long Term Care (on or off site)
- ☐ Intensive Care
- ☐ Medical, General
- ☐ Medical, Specialty
- ☐ Outpatient
- ☐ Pediatric
- ☐ EMS/Ambulance
- ☐ Dialysis
- ☐ Psychiatric
- ☐ Rehabilitation
- ☐ Surgery, General
- ☐ Surgery, Specialty
- ☐ Transplant
- ☐ Trauma Center
- ☐ Bariatric Surgery

2. Hospital Beds:

	Projected Certified	Projected Year % Occupied	Current Year Certified	Current Year % Occupied	Previous Year Certified	Previous Year % Occupied
Medical/Surgical						
ICU/NICU/CCU						
Obstetrical						
Pediatric						
Psychiatric						
Physical Rehab						
Alcohol/Drug						
Long Term Care*						
Subacute Care						
LTC Assisted Living						
Other:						
Total Licensed Beds:						

* If located in a separate facility, please complete a separate Nursing Home Application

3. Surgical Procedures – Please provide the number of procedures performed:

	Projected Year	Current Year	Previous Year
Inpatient Surgery			
Ambulatory Surgery			
Deliveries			
a. C-Section			
b. Normal Vaginal			
c. % VBACs			
Total:			

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4. Outpatient Visits – please provide the number of visits:

	Projected Year	Current Year	Previous Year
Emergency Department			
Ambulatory Care			
Rehabilitation			
Psychiatric			
Home Healthcare			
Clinic Visits			
Dialysis			
Other			
Total:			

5. Ancillary Procedures - please provide the number of procedures:

	Projected Year	Current Year	Previous Year
Radiology			
Laboratory			
Other:			
Other:			
Total:			

6. Additional Services:

1. Will any new services, operations or locations be added in the next 12 months? ☐ Yes ☐ No
   If yes, please explain:_____

2. Will any services, operations or locations be discontinued in the next 12 months? ☐ Yes ☐ No
   If yes, please explain:_____

3. Have any services been discontinued in the last 12 months? ☐ Yes ☐ No
   If yes, please explain:_____

4. Please indicate the following special activities/exposures:

   a. Clinical Research ☐ Yes ☐ No
   b. Experimental Drugs Administration ☐ Yes ☐ No
   c. Bio-Medical Device Research ☐ Yes ☐ No
   d. Do you own or operate a helipad or heliport? ☐ Yes ☐ No

5. Does the hospital operate an urgent care center? If so, is it in compliance with The Emergency Medical Treatment and Labor Act (**EMTALA**) ☐ Yes ☐ No

7. Other Information

1. Has senior leadership been in place for the last 3 years? ☐ Yes ☐ No
2. Has Insured implemented a system-wide HER system? ☐ Yes ☐ No

PART IV – PROFESSIONAL STAFF

Attach a schedule of all physicians to be covered under this policy. Please include name, specialty, date of hire, full or part time status. Use separate sheets if necessary

	Employed		Include in Coverage	Contracted		Include in Coverage
	Full Time	**Part Time**		**Full Time**	**Part Time**	
Physicians			☐ Yes ☐ No			☐ Yes ☐ No
Surgeons			☐ Yes ☐ No			☐ Yes ☐ No
Hospitalists			☐ Yes ☐ No			☐ Yes ☐ No
Neonatology/Peds			☐ Yes ☐ No			☐ Yes ☐ No
Podiatrists			☐ Yes ☐ No			☐ Yes ☐ No
Dentists			☐ Yes ☐ No			☐ Yes ☐ No
Fellows			☐ Yes ☐ No			☐ Yes ☐ No
Residents			☐ Yes ☐ No			☐ Yes ☐ No
Certified Nurse Midwives			☐ Yes ☐ No			☐ Yes ☐ No
CRNAs			☐ Yes ☐ No			☐ Yes ☐ No
Registered Nurses			☐ Yes ☐ No			☐ Yes ☐ No
Physician Assistants			☐ Yes ☐ No			☐ Yes ☐ No
Pharmacists			☐ Yes ☐ No			☐ Yes ☐ No
Other:			☐ Yes ☐ No			☐ Yes ☐ No
Other:			☐ Yes ☐ No			☐ Yes ☐ No
Total number:						

Training services offered by the hospital/facility (please include any contractual agreements):

1. If the facility is an Academic or Teaching Hospital, list programs below:

   _____

   _____

   _____

2. Do any of the programs listed above include resident rotations? ☐ Yes ☐ No
   Please include any contractual agreements.
3. Do the training program(s) include rotations to outside teaching hospitals? ☐ Yes ☐ No

   If "yes", list participating Departments and indicate whether the parent or receiving facility is responsible for professional liability coverage.

   _____

   _____

   _____

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Part V – MEDICAL SERVICE DEPARTMENTS: (if applicable, please submit contract(s))

ANESTHESIOLOGY **Not Applicable ☐**

1. Staffing is by:

	# of Each	% Board Certified or Eligible
☐ Employed Physicians	_____	_____%
☐ Contracted Physicians	_____	_____%
☐ Employed Certified Registered Nurse Anesthetists (CRNAs)	_____	_____%
☐ Contracted Certified Registered Nurse Anesthetists (CRNAs)	_____	_____%
☐ Contracted Group	_____	_____%

Do CRNA's work under direct supervision of an anesthesiologist? ☐ Yes ☐ No

If not, please explain:_____

2. If contracted group, please indicate:

Name of Group: _____

Limits required: $_____per claim $_____ aggregate

Is a Certificate of Insurance required? ☐ Yes ☐ No

Does the applicant obtain Certificates of Insurance from the companies providing professional liability insurance for contracting physicians? ☐ Yes ☐ No

RADIOLOGY **Not Applicable ☐**

1. Staffing is by:

	# of Each	% Board Certified or Eligible
☐ Employed Physicians	_____	_____%
☐ Contracted Physicians	_____	_____%
☐ Residents	_____	_____%
☐ Contracted Group	_____	_____%

2. If contracted group, please indicate:

Name of Group: _____

Limits required: $_____per claim $_____ aggregate

Is a Certificate of Insurance required? ☐ Yes ☐ No

Does the applicant obtain Certificates of Insurance from the companies providing professional liability insurance for contracting physicians? ☐ Yes ☐ No

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EMERGENCY DEPARTMENT **Not Applicable ☐**

1. Level of Service: ☐ Level I ☐ Level II ☐ Level III ☐ Other
   If other, please indicate:_____

2. Staffing is by:

	# of Each	% Board Certified or Eligible
☐ Employed Physicians	_____	_____%
☐ Contracted Physicians	_____	_____%
☐ Residents	_____	_____%
☐ Contracted Group	_____	_____%

3. If contracted group, please indicate:

   Name of Group: _____

   Limits required: $_____per claim $_____ aggregate

   Is a Certificate of Insurance required? ☐ Yes ☐ No

   Does the applicant obtain Certificates of Insurance from the companies providing professional liability insurance for contracting physicians? ☐ Yes ☐ No

OBSTETRICS **Not applicable ☐**

1. Staffing is by:

	# of Each	% Board Certified or Eligible
☐ Employed Physicians	_____	_____%
☐ Voluntary Physicians	_____	_____%
☐ Contracted Physicians	_____	_____%
☐ Contracted Group	_____	_____%

2. If contracted group, please indicate:

   Name of Group: _____

   Limits required: $_____per claim $_____ aggregate

   Is a Certificate of Insurance required? ☐ Yes ☐ No

   Does the applicant obtain Certificates of Insurance from the companies providing professional liability insurance for contracting physicians? ☐ Yes ☐ No

3. Besides obstetricians, please indicate providers with privileges to perform deliveries:

   ☐ Family Practitioner ☐ Certified Nurse Midwife ☐ Family/General Practitioner
   ☐ Physician Assistant ☐ Residents
   ☐ Other (explain):_____

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If applicable, can a resident perform deliveries (vaginal or C-Section) without direct supervision of an attending physician? ☐ Yes ☐ No

4. Level of Neonatal Services:

☐ Level I (Well Baby)	# of Bassinets_____
☐ Level II (Intermediate care)	# of Bassinets_____
☐ Level III (Neonatal Intensive care)	# of Bassinets _____

5. Is there an obstetrician available in-house 24 hours per day? ☐ Yes ☐ No
Is there an obstetrician on call 24 hours per day? ☐ Yes ☐ No
Is there an anesthesiologist or CRNA available in house 24 hours per day for the obstetrical suite? ☐ Yes ☐ No

BARIATRICS (If applicable, please complete separate bariatric addendum) **Not applicable** ☐

OTHER CONTRACTED SERVICES:

☐ Laboratory ☐ Pathology ☐ Home Health Care ☐ Physical/Occupational Therapy
☐ Social Work ☐ Other (specify):_____

Is a Certificate of Insurance required? ☐ Yes ☐ No
Does the applicant obtain Certificates of Insurance from the companies providing professional liability insurance or contracting physicians? ☐ 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? c. Is there a formal written performance improvement/QA plan? d. Are the national patient safety goals addressed in the RM or QA plans? If no provide details on separate sheet. e. Is there a formal, documented peer review and credentialing process in place?			☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ 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. Do you provide simulation training at your facility or offsite? (If YES please provide details on a separate sheet.)			☐ Yes ☐ No
i. Has Insured facility established Pressure Ulcer Program employing a Certified Wound Care Nurse?			☐ Yes ☐ No

. j. Does Insured facility have a Wandering Prevention Program in place? (If applicable)			☐ Yes ☐ No
k. 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 VII – CONTACT INFORMATION

Please provide 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. Most recent State Health Department Survey and Plan of Correction.
2. Most recent JCAHO report with recommendations and status of recommendations.
3. Copy of current State license.
4. Current annual and audited financial reports.
5. Actuarial review of the SIR (if applicable).
6. Trust agreement for the SIR (if applicable).
7. Copies of all contracts with independent physicians' groups.
8 Copies of all agreements between hospital and any clinical training programs.
9. Copy, in electronic form, of the most recently valued loss run for the last 10 years
10. Copy of the Resume of individual responsible for Risk Management
11. Copy of the Risk Management Plan

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.

Signature: _____

Name (please print): _____

Title: _____

Date: _____