



Physicians' Reciprocal Insurers

Hospital (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.

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PHYSICIANS' RECIPROCAL INSURERS
HOSPITAL (Renewal)
PROFESSIONAL LIABILITY INSURANCE RENEWAL 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. <input type="checkbox"/> General Hospital | <input type="checkbox"/> Children's Hospital |
| <input type="checkbox"/> Critical Access Hospital | <input type="checkbox"/> Teaching Hospital |
| <input type="checkbox"/> Psychiatric Hospital | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Specialty Hospital | |
| 2. <input type="checkbox"/> For Profit | <input type="checkbox"/> Government |
| <input type="checkbox"/> Not for Profit | <input type="checkbox"/> Other _____ |
| 3. <input type="checkbox"/> Accredited by JCAHO | <input type="checkbox"/> Accredited by AOA |
| <input type="checkbox"/> 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: _____



PART III – PROFESSIONAL LIABILITY EXPOSURES

1. Type(s) of Services offered:

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

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:			

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			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgeons			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospitalists			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Neonatology/Peds			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Podiatrists			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dentists			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Fellows			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Residents			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Certified Nurse Midwives			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
CRNAs			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Registered Nurses			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Physician Assistants			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacists			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> 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.



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

ANESTHESIOLOGY **Not Applicable**

1. Staffing is by:	# of Each	% Board Certified or Eligible
<input type="checkbox"/> Employed Physicians	_____	_____%
<input type="checkbox"/> Contracted Physicians	_____	_____%
<input type="checkbox"/> Employed Certified Registered Nurse Anesthetists (CRNAs)	_____	_____%
<input type="checkbox"/> Contracted Certified Registered Nurse Anesthetists (CRNAs)	_____	_____%
<input type="checkbox"/> 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
<input type="checkbox"/> Employed Physicians	_____	_____%
<input type="checkbox"/> Contracted Physicians	_____	_____%
<input type="checkbox"/> Residents	_____	_____%
<input type="checkbox"/> 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

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 |
|--|-----------|-------------------------------|
| <input type="checkbox"/> Employed Physicians | _____ | _____% |
| <input type="checkbox"/> Contracted Physicians | _____ | _____% |
| <input type="checkbox"/> Residents | _____ | _____% |
| <input type="checkbox"/> 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 |
|--|-----------|-------------------------------|
| <input type="checkbox"/> Employed Physicians | _____ | _____% |
| <input type="checkbox"/> Voluntary Physicians | _____ | _____% |
| <input type="checkbox"/> Contracted Physicians | _____ | _____% |
| <input type="checkbox"/> 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): _____

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:

- | | |
|--|----------------------|
| <input type="checkbox"/> Level I (Well Baby) | # of Bassinets _____ |
| <input type="checkbox"/> Level II (Intermediate care) | # of Bassinets _____ |
| <input type="checkbox"/> 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

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. Do you provide simulation training at your facility or offsite? (If YES please provide details on a separate sheet.)			<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Has Insured facility established Pressure Ulcer Program employing a Certified Wound Care Nurse?			<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Does Insured facility have a Wandering Prevention Program in place? (If applicable)			<input type="checkbox"/> Yes <input type="checkbox"/> No
k. 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 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: _____