Physicians' Reciprocal Insurers

Nursing Home 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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PHYSICIANS' RECIPROCAL INSURERS
NURSING HOME FACILITY
PROFESSIONAL LIABILITY INSURANCE APPLICATION

PART I - APPLICANT

1. Name of Facility:
_____

2. D/B/A: _____

3. Main Location: _____
(Provide list of any additional locations, if applicable)

4. Number of years in business: _____ 5. Number of years under current management: _____

6. Facility Tax I.D. Number: _____

7. Are there plans to add on to the present location (increase in licensed bed) or add other locations within the next 3 years? If "Yes", please describe:
_____

8. Type of Ownership/Facility:

For Profit	Not For Profit	
Certified by Medicare	☐ Yes ☐ No	% of Residents: _____
Certified by Medicaid	☐ Yes ☐ No	% of Residents: _____
JCAHO Accredited	☐ Yes ☐ No	Accreditation Year: _____
Licensed by the State of New York	☐ Yes ☐ No	
A member of a State or National Association	☐ Yes ☐ No	

If yes, please identify: _____

9. Is the facility affiliated with a hospital or any other type of organization? ☐ Yes ☐ No
If yes, please identify :_____

10. 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?

11. Has the applicant been the subject of investigatory or disciplinary proceedings or the reprimands by an administrative of governmental agency or professional agency? ☐ Yes ☐ No If yes, please describe:

_____

12. Has any insurance company ever cancelled, non-renewed or declined to accept your professional or general liability insurance? ☐ Yes ☐ No If yes, please describe:

____

13. Has the Applicant's license ever been revoked/suspended/refused/cancelled/voluntarily surrendered or subject to enforcement action? ☐ Yes ☐ No If yes, please explain:

____

14. Have you ever filed for protection under Chapter 11 or Chapter 7 of Bankruptcy code? ☐ Yes ☐ No

15. Is your financial statements indicates going concern? ☐ Yes ☐ No

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

   Per Occurrence : __________________ Aggregate: __________________

4. REQUESTED DEDUCTIBLE (Check only one):

   No deductible.
   ☐ $10,000 ☐ $ 25,000 ☐ Other $__________________
   ☐ $50,000 ☐ $100,000

PART II A - INSURANCE PROFILE (FIVE YEARS)

1. Primary Professional Liability Coverage **Failure to complete will delay the process of the application**

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	$

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	$

PART III – FACILITY CLASSIFICATION AND BED CENSUS

Estimated Gross Revenue: $ ____________________

RESIDENT SERVICES PROVIDED	# of Licensed Beds	# of Occupied Beds
Skilled Care Services		
Professional nursing care – 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following : medical administration catheterizations ordered by physician tube feedings other procedures injections		
Intermediate Care Services		
Nursing care during the day shift, 7 days per week, by either RNs or LPNs. NO complex nursing care (IVs, tube feedings, etc.). Assistance with activities or daily living (i.e., walking, bathing, dressing, eating). Some assistance with medical administration		
Personal Care/Assisted Living services		
Some nursing and/or health-related care to residents who do not require the degree of care and treatment described as skilled or intermediate. Residents may require some minor nursin care or help in activities such as washing, eating, bathing, dressing, walking, taking of medication, and preparation of special diets.		
Residential Care Services		
Residents are provided with protective environments (meals and planned programs for social and/or spiritual needs). Residents responsible for their own medication.		
Independent Living Services		
Retirement communities where residents live in apartments. Nursing or personal care is provided an incidental or emergency basis only. More then 75% of the residents are over the age of 65.		

PART III A– NON RESIDENT SERVICES

Please indicate if the following services are offered:

Adult Day Care	☐ Yes ☐ No	# of average participants: __________
Child Day Care	☐ Yes ☐ No	# of average participants: __________
Hospice Care	☐ Yes ☐ No	# of annual visits: __________
Home Health Care	☐ Yes ☐ No	# of annual visits: __________
Respite Care	☐ Yes ☐ No	# of annual visits: __________
Rehabilitation Services	☐ Yes ☐ No	# of annual visits: __________

Other (please explain and include visits/# of participants/ gross receipts, as applicable):

Visits – Use a threshold count. For home care, count each patient each time you visit.

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.

PART IV - ADMINISTRATIVE/PROFESSIONAL STAFF

Title	Name	Employed or Contracted	License #	Years of Experience	Years at Facility
Administrator					
Director of Nursing (DON)					
Medical Director					

1. Please list Professional/Support Staff:

	1st Shift		2nd Shift		3rd Shift	
Title	Employees	Contracted	Employees	Contracted	Employees	Contracted
Physicians including Medical Director						
Director of Nursing						
Nursing Supervisor						
Administrative Personnel						
Registered Nurses						
Nurse Practitioners						
Licensed Practical Nurses						
Physical Therapists						
Respiratory Therapist						
Speech Therapists						
Occupational Therapists						
Rehabilitation Therapists						
Dieticians						
Social Workers						
Pharmacists						
Podiatrists						
Dentists						
Students (Nursing, Aids)						
Maintenance/Security Personnel						
Nursing Assistants						

3. Is coverage being requested for any employed physicians? ☐ Yes ☐ No

4. Is a Certificate of Insurance obtained on all physicians annually? ☐ Yes ☐ No

5. Is a Certificate of Insurance obtained from all independent contractors? ☐ Yes ☐ No

6. Does the Medical Director also act as the attending physician for any residents? ☐ Yes ☐ No
   If yes, please complete and list all physicians to be covered under the policy:

Name	Specialty	Full or Part time	Date of Hire

7. Volunteers:

a. Total number of volunteers: _____

b. Is there a formal screening and selection process? ☐ Yes ☐ No

c. Do volunteers receive formal orientation to the facility? ☐ Yes ☐ No

d. Are written instructions for duties and responsibilities furnished to each volunteer? ☐ Yes ☐ No

8. Has the Applicant entered into any indemnification agreements with third parties holding the applicant harmless? ☐ Yes ☐ No If yes, please list third parties and submit copies of contracts.

_____
_

PART V - PROFESSIONAL STAFF HIRING/SCREENING AND EMPLOYMENT PROCEDURES

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 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? ☐ 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		

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. Copy of the most recent Department of Health survey, including the Plan of Correction.
2. Complete copy of the most recent JCAHO report with recommendations.
3. Most recent audited annual financial statements.
4. Copy of current state license and registration.
5. Copy of Administrator's current license.
4. Copies of Certificates of Insurance for physicians covered under individual policies.
6. Copies of any contracts with independent physician groups.
8. Public relations materials, brochures, etc.
9. Copies of all 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: _____