MedPro Group
a Berkshire Hathaway company

Issuing Company:
National Fire & Marine Insurance Company
Omaha, Nebraska

HOSPITAL LIABILITY INSURANCE APPLICATION

INSTRUCTIONS

1. Please answer all questions. If a question is not applicable, print, "n/a".
2. This application must be completed and signed by an authorized officer of the applicant.
3. If additional space is needed, please use the Supplemental Information section at the end of the application and refer to the question or an additional form.

I. PRODUCER INFORMATION

Firm Name _____ Individual Name _____

Mailing Address _____ Phone ____ - ____ - ____

City/State/Zip _____ E-Mail _____

II. APPLICANT INFORMATION

A. Applicant Information:

Applicant Name _____

Mailing Address _____ County _____

Street Address (if different) _____

Website Address _____

Federal Tax ID Number _____ CMS Provider Number _____

B. Type of Facility: (Check all that apply)

☐ Acute Care Hospital
☐ Critical Access Hospital
☐ Specialty Hospital: _____
☐ Nursing Home/Long Term Care
☐ Other (specify): _____

☐ Governmental
☐ Not For-Profit
☐ For-Profit

☐ Corporation
☐ Partnership
☐ LLC

1. If the applicant is managed by a third party, please identify: _____
2. If the applicant manages another facility(s), please identify: _____
3. Is coverage requested for the managed facilities? ☐ Yes ☐ No

III. COVERAGE

A. Type of coverage requested:
☐ Insurance - Primary ☐ Insurance - Excess ☐ Reinsurance

B. Current Primary Coverage:

Insurance	Carrier	Occurrence or Claims-Made	Retro Date (if applicable)	Limits Per Occ/ Agg	Deductible or Self-Insured Retention (SIR) Limit	Premium	Are defense costs within policy limits?	Are defense costs within the Deductible or SIR?
☐ **Professional Liability (PL)**		☐ Occurrence ☐ Claims-Made			☐ Ded _____ ☐ SIR _____	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ **General Liability (GL)**		☐ Occurrence ☐ Claims-Made			☐ Ded _____ ☐ SIR _____	$	☐ Yes ☐ No	☐ Yes ☐ No
☐ **Employee Benefits Liability (EBL)**		☐ Occurrence ☐ Claims-Made			☐ Ded _____ ☐ SIR _____	$	☐ Yes ☐ No	☐ Yes ☐ No

III. COVERAGE (continued)

C. Current Excess Coverage:

Insurance	Carrier	Occurrence or Claims-Made	Retro Date (if applicable)	Limits Per Occ/ Agg	Premium	If more than one Retroactive Date applies to the excess limits, please specify	Are defense costs within Excess policy limits?
☐ **Lead Excess**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Total Excess (including lead)**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
Underlying Insurance	**Carrier or SIR**	**Occurrence or Claims-Made**	**Retro Date (if applicable)**	**Limits Per Occ/ Agg**	**Premium**	**If more than one Retroactive Date applies to the excess limits, please specify**	**Are defense costs within Excess policy limits?**
☐ **Underlying PL**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Underlying GL**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Underlying Auto Liability**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Underlying Employer's Liability**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Underlying EBL**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Underlying Helipad Liability**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Underlying Aviation Liability**		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No
☐ **Other Underlying (Describe):** _____		☐ Occurrence ☐ Claims-Made			$		☐ Yes ☐ No

1. Are Underlying PL limits eroded by: ☐ Indemnity only ☐ Indemnity and Expense
2. Are ancillary providers included in the Excess PL Program? ☐ Yes ☐ No
3. Are physicians & surgeons included in the Excess PL Program? ☐ Yes ☐ No

D. Coverage History:

	Year 2 - 1st Prior	Year 3 - 2nd Prior	Year 4 - 3rd Prior	Year 5 - 4th Prior
Insurer(s)				
Premium	$	$	$	$

E. Have the applicant's limits of liability changed in the last 5 years? ☐ Yes ☐ No

If Yes, please explain: _____

F. Has the applicant's deductible or SIR changed in the last 5 years? ☐ Yes ☐ No

If Yes, please explain: _____

G. Self-Insured Retention (SIR):

1. Does SIR coverage include coverage other than PL and GL? ☐ Yes ☐ No

If Yes, please explain: _____

2. Describe method of SIR funding: ☐ Dedicated Trust ☐ Balance Sheet Accrual ☐ Operating Capital ☐ Captive
3. Has an independent actuarial funding study been completed? ☐ Yes ☐ No
   If Yes, provide a copy.

III. COVERAGE (continued)

4. Provide current SIR funding balance: $_____ As of date: _____
5. Who handles claims within the SIR? _____
6. If TPA, provide contact information below:

_____
Third Party Administrator

_____
Mailing Address

_____ _____
Primary Contact Person Name Title

_____ - _____ - _____ _____
Phone E-Mail

7. Is the applicant interested in utilizing the Company for claims handling? ☐ Yes ☐ No
8. What law firm(s) are utilized for claims? _____

IV. EXPOSURES

HOSPITALS

A. Please complete the data below for the upcoming year and the last 5 years, or provide an attachment inclusive of all the information requested.

Total Number of Licensed Beds: _____

	Projected this Year	Prior Year 1 (Expiring Year)	Prior Year 2	Prior Year 3	Prior Year 4	Prior Year 5
Occupied Beds by Type						
Acute Care						
Bassinets & Cribs						
Neonatal						
Chemical Dependency						
Long Term Acute Care (LTAC)						
Psychiatric						
Rehabilitation						
Skilled Nursing/Hospice						
Sub-Acute Care Beds						
Intermediate Care Beds						
Assisted Living Beds						
Residential/Independent Living Beds						
All Other, please describe: _____						
Procedures						
Births						
Outpatient Surgeries						
Inpatient Surgeries						
Outpatient Visits (Provide number of patient visits, not number of procedures)						
Emergency						
Home Health						
Physician Office Practice						
Psychiatric						
All Other, please describe: _____						
Ancillary Services (if a revenue generating business for other than the applicant's patients)						
Med & X-Ray Labs Receipts						
Pharmacies Receipts						

IV. EXPOSURES (continued)

ALLIED PROFESSIONALS

B. <u>If coverage is requested</u>, please provide the information below or attach a spreadsheet with the same information:

	Active Number of FTE's				
Class	**Current Year**	**Prior Year**	**Retro Date if other than applicant's**	**Limits Shared (SH) or Separate (SE)**	**Employed (E) or Contracted (C)?**
Certified Registered Nurse Anesthetist (CRNA)				☐ SH ☐ SE	☐ E ☐ C
Nurse Midwife				☐ SH ☐ SE	☐ E ☐ C
Nurse Practitioner				☐ SH ☐ SE	☐ E ☐ C
Physician's Assistant				☐ SH ☐ SE	☐ E ☐ C
Podiatrist				☐ SH ☐ SE	☐ E ☐ C
Other:				☐ SH ☐ SE	☐ E ☐ C

If separate limits are indicated above, or separate limits are required for State Fund/PCF compliance, please complete the Ancillary Healthcare Professional Liability Application or if the applicant prefer providers to be specifically named on the policy schedule, please complete the following or attach a spreadsheet with the same information.

Name of Medical Professional Last Name, First Name, Middle Name	Employed (E) or Contracted (C)?	State	Class	Retro Date	License Number
	☐ E ☐ C				
	☐ E ☐ C				
	☐ E ☐ C				
	☐ E ☐ C				
	☐ E ☐ C				

If the applicant has continuing risk in connection with departed providers, please provide a roster with such providers' names, specialties, hire dates, termination dates, number of hours worked, and license numbers.

PHYSICIAN/SURGEON

C. Please provide the information below for each physician, surgeon, resident, intern, fellow, dentist and oral surgeon for whom coverage is to be provided under this policy. If additional space is needed, please use an additional piece of paper and include all information requested in the Schedule of Medical Professionals, below.

Coverage is provided on a limited duty and scope basis unless otherwise requested. If coverage for separate limits is required for State Fund/PCF compliance or outside activities is being requested please complete the Physician Application. Coverage is designed to provide retroactive dates equal to the hire date of the applicant unless otherwise requested.

Employee Status: (C)ontract; (E)mployed; (F)aculty; (R)esident
Limits: (SH) Shares limits with the facility, restricted to the named insured's operations.
(SE) Separate limits, restricted to the named insured's operations.

If the applicant has continued exposure from departed physicians, please include in the table below.

SCHEDULE OF MEDICAL PROFESSIONALS—PHYSICIANS, SURGEONS, DENTISTS AND ORAL SURGEONS

Name of Medical Professional Last Name, First Name, Middle Name	Status (C) (E) (F) (R)	State	County	Specialty ISO-Code-List all that apply. (Please see ISO Code Reference)	Retro Date	Hire Date	Termination Date (if applicable)	Number of hours per week if less than 40	License #	Limits (SH) (SE)

IV. EXPOSURES (continued)

TOTAL EMPLOYEES

D. Provide the total number of employees: _____

E. Provide the total number of full time equivalents (FTE's): _____

V. SERVICES

Check any/all services the applicant provides:

- ☐ Behavioral Health - If checked, complete Behavioral Health Supplemental Application
- ☐ Research/Clinical Trials - If checked, complete Research Activities Supplemental Application
- ☐ Prison Health
- ☐ Alternative Work Programs (i.e. work release, court mandated community service, etc.)
- ☐ Home Health
- ☐ Tissue/Organ Banks
- ☐ Genetic Testing/Counseling
- ☐ Reference Lab
- ☐ Hyperbaric Chamber
- ☐ Burn Unit
- ☐ Teaching Programs

A. Does the applicant practice or provide alternative/naturopathic medicine? ☐ Yes ☐ No

If Yes, indicate the type of alternative medicine provided: _____

B. Describe any newly planned services or discontinued services: _____

_____

C. Does the applicant engage in telemedicine? (i.e. radiology, cardiology, ophthalmology, remote monitoring for home patients, dermatology, etc.) ☐ Yes ☐ No

If Yes, is applicant the recipient or provider? ☐ Recipient ☐ Provider

If Yes, please describe and list all states involving telemedicine: _____

D. Medical Staff—Physicians:

1. Are all of the physicians practicing at the applicant's facility board-certified? ☐ Yes ☐ No

   If No, how many are not board-certified? _____

2. a. Are staff physicans required to carry PL insurance? ☐ Yes ☐ No

   If Yes, what are the minimum limits required? $ _____ Per Event / $ _____ Annual Aggregate

   b. Are any insured with a carrier rated less than A– by AM Best? ☐ Yes ☐ No

E. Hospitalists/Intensivists Services:

1. Is there a dedicated hospitalist/intensivist at the applicant's facility? ☐ Yes ☐ No

   If Yes, do they provide: ☐ House Coverage ☐ Critical Care Coverage ☐ Other: _____

2. Are they: ☐ Employed ☐ Staff Physicians ☐ Contracted

3. If applicable, what limit of liability does the contract group carry? $_____ Per Medical Incident / $_____ Annual Aggregate

F. Blood Bank Services:

1. Does the applicant own/operate a blood bank other than receiving blood from an outside vendor or autologous transfers? ☐ Yes ☐ No

   If Yes, please provide details of services: _____

2. List any outside vendors that supply applicant with blood or blood products: _____

   _____

G. Emergency Services:

1. What is the American College of Surgeons designation of the emergency department?

   ☐ Level I (tertiary) ☐ Level II (comprehensive) ☐ Level III (basic) ☐ Other: _____

2. Does the emergency department have a physician on-site 24-hours a day? ☐ Yes ☐ No

   If No, please explain: _____

3. Is it required that all emergency department patients be seen by a physician? ☐ Yes ☐ No

   If No, please explain: _____

4. Is the emergency department staffed by a contract group or employees? ☐ Contract Group ☐ Employees

   If contract group, what is the name of the group? _____

5. If applicable, what limit of liability does the contract group carry? $_____ Per Medical Incident / $_____ Annual Aggregate

6. Are all emergency department physicians board certified in emergency medicine? ☐ Yes ☐ No

   If No, please explain: _____

   Total number of ER Physicians: _____ Total number **not** board certified in emergency medicine: _____

V. SERVICES (continued)

7. Are all emergency department support personnel ACLS/PALS certified? ☐ Yes ☐ No

8. Are physician evidence-based protocols in place for: ☐ Chest Pain ☐ Abdominal Pain ☐ Fever in Children ☐ Headache

H. Ambulances:

1. Does the applicant operate any ambulances? ☐ Yes ☐ No

   If Yes, what is the number of runs annually? Scene Response Emergency: _____ Emergency: _____ Non-Emergency: _____

2. Are they operated by a contract group or employees? ☐ Contract Group ☐ Employees

   If contract group, what is the name of the group? _____

3. If applicable, what limit of liability does the contract group carry? $_____ Per Medical Incident / $_____ Annual Aggregate

I. Pharmaceutical Services:

1. Does a full-time registered pharmacist direct the pharmacy? ☐ Yes ☐ No

   If No, please explain: _____

2. Is the pharmacy staffed in whole or in part by a contract group? ☐ Yes ☐ No

   If contract group, what is the name of the group? _____

3. If applicable, what limit of liability does the contract group carry? $_____ Per Medical Incident / $_____ Annual Aggregate

4. Does the pharmacy use a bar coding system for dispensing medicine? ☐ Yes ☐ No

5. Does the pharmacy use a unit-dose system of dispensing medicine? ☐ Yes ☐ No

6. Is the pharmacy staffed 24-hours a day? ☐ Yes ☐ No

   If No, how are medications obtained when the pharmacy is closed? Please explain: _____

   _____

J. Obstetrical Services:

1. Is the applicant a regional referral center for high-risk pregnancies or newborns? ☐ Yes ☐ No

   If No, is there a written procedure for transferring all high-risk mothers and/or babies the applicant is not qualified to treat? ☐ Yes ☐ No

2. Does the applicant provide ongoing treatment for high risk pregnancies or newborns? ☐ Yes ☐ No

3. Indicate the level of nursery care the applicant provides and the corresponding number of bassinets:

	Number of Bassinets
☐ Level I: Well Baby	_____
☐ Level II: Intermediate Care	_____
☐ Level III: Neonatal Intensive Care	_____

   Is a neonatologist on-site 24-hours a day? ☐ Yes ☐ No

4. a. How many births are Primary C-Section? _____

   b. How many births are VBAC? _____

   Are VBAC's scheduled? ☐ Yes ☐ No

   If Yes, is staff immediately available to perform a C-section? ☐ Yes ☐ No

5. In addition to obstetricians, who else can perform deliveries?

   ☐ Family Practice/General Medicine Physician ☐ Other: _____

   ☐ Resident (year of residency: ____) ☐ Nurse Midwife

6. a. What is the total number of physicians that have OB privileges? _____

   Of those, how many are board certified/eligible in OB? _____

   b. How many Family Practice physicians have C-section privileges? _____

7. a. If nurse midwives practice in labor and delivery, are written protocols for privileges/supervision in place and followed? ☐ Yes ☐ No

   b. How many deliveries are performed by midwives annually? _____

   c. Do midwives perform high risk deliveries? ☐ Yes ☐ No

   d. How many are employed? _____ How many are contracted? _____

   If employed, do they have their own PL insurance? ☐ Yes ☐ No

   e. What limits are they required to carry? $_____ Per Medical Incident / $_____ Annual Aggregate

8. Does the applicant sponsor any off-site delivery programs? ☐ Yes ☐ No

9. Is continuing education for NICHD fetal heart tracing education required? ☐ Yes ☐ No

K. Radiology Services:

1. Is the radiology department staffed in whole or in part by a contract group? ☐ Yes ☐ No

   If Yes, what is the name of the contract group? _____

V. SERVICES (continued)

2. If applicable, what limit of liability does the contract group carry? $_____ Per Medical Incident / $_____ Annual Aggregate
3. Is a radiologist on-site 24-hours a day? ☐ Yes ☐ No

   If No, please explain: _____
4. Is there a protocol for radiological interpretation over-read for all radiology exams and reports performed outside the department? ☐ Yes ☐ No

   If No, please explain: _____
5. Are all radiologists required to be board certified/eligible in radiology and/or nuclear medicine? ☐ Yes ☐ No

L. Anesthesia Services:

1. Is the anesthesia department staffed in whole or in part by a contract group? ☐ Yes ☐ No

   If Yes, what is the name of the contract group? _____
2. If applicable, what limit of liability does the contract group carry? $ _____ Per Medical Incident / $ _____ Annual Aggregate
3. Are the anesthesiologists required to be board certified/eligible in anesthesiology? ☐ Yes ☐ No
4. What is the ratio of CRNAs to anesthesiologists? _____
5. If anesthesia is administered by CRNAs, does a physician or surgeon supervise? ☐ Yes ☐ No
6. Is an anesthesiologist or CRNA on-site 24-hours a day? ☐ Yes ☐ No

   If No, is an anesthesiologist or CRNA on-call when one is not on-site? ☐ Yes ☐ No

   If Yes, what is the maximum amount of time for arrival for the on-call physician? _____

M. Home Health Services:

1. If home health services are provided, describe the scope of service (i.e. ventilators, dialysis, IV therapy, chemotherapy, DME, home care, pharmacy, etc):

   _____
2. Does the applicant require certification of home health aides by NAHC or other accrediting organizations? ☐ Yes ☐ No

N. Surgical Services:

Indicate if the applicant does, or will, provide any of the following surgical procedures:

☐ Bariatric — Complete Bariatric Supplemental Application
☐ Cosmetic — Type: _____
☐ Liposuction — Type: _____
☐ Organ Transplants — Type: _____
☐ Sex Change Operations — Type: _____
☐ Non-FDA Approved Surgery — Type: _____

VI. GENERAL LIABILITY

Please indicate below which of the following apply.

A. Daycare Center: ☐ Child Daycare Center ☐ Adult Daycare Center ☐ None

1. Number of Children/Adults per week: _____ Children _____ Adults
2. Are references checked prior to hiring on all employees and on all volunteers? ☐ Yes ☐ No
3. Are these services offered to: ☐ Employees Only ☐ Open to the Public
4. What is the staff to participant ratio? _____ Staff _____ Children/Adults Participants

B. Habitational Risk: ☐ Apartment ☐ Dwelling ☐ Hotel ☐ None ☐ Other, please describe: _____

1. Number of Units: _____ Units Year Built: _____ Number of Stories: _____
2. Are there at least two exits located remotely from each other? ☐ Yes ☐ No
3. For apartment buildings and hotels, are there lighted emergency exit signs? ☐ Yes ☐ No

C. Restaurant: ☐ Yes ☐ No Receipts/Year: $ _____

1. Is the restaurant operated by? ☐ Contract ☐ Employees
2. If contracted, does the applicant require them to carry a GL insurance policy with a limit of $1,000,000 per occurrence? ☐ Yes ☐ No
3. Are certificates of insurance obtained annually to verify coverage is in place? ☐ Yes ☐ No
4. Is the hospital added as an additional insured on their GL policy? ☐ Yes ☐ No
5. Does the restaurant comply with all state and local codes and regulations? ☐ Yes ☐ No

   If No, please explain: _____
6. Did any inspector who visited the restaurant during the last 12 months indicate any violations or make any recommendations for change? ☐ Yes ☐ No

   If Yes, please provide a copy of the violation/recommendation and indicate the corrective action(s) taken.

VI. GENERAL LIABILITY (continued)

D. Special Athletic or Fund Raising Events: Receipts/Year: $ _____

Describe planned events for the upcoming year: _____

_____

If alcohol is served, is it from a licensed vendor? ☐ Yes ☐ No

E. Swimming Pool: ☐ Yes ☐ No If Yes, how deep is the pool? _____

1. Is it open to the public? ☐ Yes ☐ No If Yes, Receipts/Year: $ _____
2. Is there a diving board? ☐ Yes ☐ No If Yes, is there a lifeguard on duty at all times? ☐ Yes ☐ No

F. Fitness Center:

1. Does the hospital operate a fitness center that is open to the public? ☐ Yes ☐ No
2. Total number of members during the past 12 months: _____
3. Types of programs provided: _____

G. Is there a heliport/helipad on the premises? ☐ Yes ☐ No

1. If Yes, is it FAA approved? ☐ Yes ☐ No
2. Estimated number of landings per year: _____
3. Is there a separate insurance policy in place covering this heliport/helipad exposure? ☐ Yes ☐ No
4. If Yes, what are the limits? $ _____ Per Event / $ _____ Annual Aggregate

H. Provide the number and type of owned, non-owned, leased or chartered watercraft:

1. Give a brief explanation of watercraft use: _____
2. Are any of the watercraft over 26 feet? ☐ Yes ☐ No

   If Yes, provide a description of the craft and its length: _____

   _____
3. Is there a separate insurance policy in place covering this watercraft exposure? ☐ Yes ☐ No
4. If Yes, what are the limits? $ _____ Per Event / $ _____ Annual Aggregate

I. Is the applicant's security service: ☐ Employed ☐ Contracted ☐ Not Applicable

1. Describe type of weapons utilized: _____
2. Describe training, supervision: _____
3. Does applicant operate its own police department? ☐ Yes ☐ No
4. Is there a separate insurance policy in place covering this exposure? ☐ Yes ☐ No

   If Yes, what are the limits? $ _____ Per Event / $ _____ Annual Aggregate

J. Environmental Exposures:

1. Is there a hazardous waste management/environmental safety program? ☐ Yes ☐ No
2. Is there a separate insurance policy in place covering this environmental exposure? ☐ Yes ☐ No

   If Yes, what are the limits? $ _____ Per Event / $ _____ Annual Aggregate

VII. OPTIONAL COVERAGES

A. Damage to Premises Rented to an Insured Business: ☐ Coverage Requested ☐ Coverage Not Requested

A $50,000 limit is automatically provided. If higher limits are desired, please indicate below.

If requested, please identify the Per Occurrence Limit:

☐ $100,000 Per Occurrence Limit
☐ $250,000 Per Occurrence Limit

B. Medical Payments: ☐ Coverage Requested ☐ Coverage Not Requested

A $1,000 limit is automatically provided. If higher limit is requested, please identify the Per Person Limit:

☐ $2,500 Per Person Limit ☐ $5,000 Per Person Limit ☐ $10,000 Per Person Limit

C. Patients' Property Liability: ☐ Coverage Requested ☐ Coverage Not Requested

If requested, please identify the Per Patient Limit and Deductible:

☐ $1,000 Per Patient Limit ☐ $250 Deductible ☐ $500 Deductible

☐ $2,000 Per Patient Limit ☐ $250 Deductible ☐ $500 Deductible

☐ $5,000 Per Patient Limit ☐ $250 Deductible ☐ $500 Deductible

VII. OPTIONAL COVERAGES (continued)

D. Hired and Non-Owned Auto Liability Coverage (Not available if applicant maintains a commercial auto policy.)
☐ Coverage Requested ☐ Coverage Not Requested

If Coverage is requested,

1. What evidence of auto insurance does the facility require from employees and volunteers who are using their own autos for the applicant's business?
   ☐ None ☐ Certificate of Insurance ☐ Copy of Auto ID Card ☐ Copy of Auto Policy
   ☐ Other, please explain: _____
2. What minimum personal auto liability limits does the applicant require of employees and volunteers using their personal autos for the applicant's business?
   ☐ Not Required ☐ Statutory ☐ Other, please explain: _____
3. Does the applicant check Motor Vehicle Records on the employees and volunteers? ☐ Yes ☐ No
4. How many active employees and volunteers work for the applicant's business?
   ☐ 0-150 ☐ 151-1,000 ☐ 1,001-2,500 ☐ 2,501+
5. Does the applicant use hired and non-owned autos to transport patients? ☐ Yes ☐ No
6. Do the applicant's home health employees and volunteers rent or use their own autos? ☐ N/A ☐ Yes ☐ No
   If Yes, how many employees and volunteers rent or use their own autos? _____
7. Has the applicant made any hired or non-owned auto claims? ☐ Yes ☐ No

E. Employee Benefits Liability: ☐ Coverage Requested ☐ Coverage Not Requested

1. Is liability for the applicant's employee benefits program self-insured? ☐ Yes ☐ No
   If Yes, please describe: _____
2. Is the applicant's employee benefits program self-administered?
   If Yes, please describe: _____
3. Total number of employees:
   ☐ 0-499 ☐ 500-699 ☐ 701-999 ☐ 1,000-1,499 ☐ 1,500-2,999 ☐ 3,000+

F. Employer's Liability/Stop Gap Liability: ☐ Coverage Requested ☐ Coverage Not Requested

1. Does the applicant do business in a monopolistic state and require primary employer's liability coverage? ☐ Yes ☐ No
2. Is excess employer's liability coverage requested? ☐ Yes ☐ No
3. Is the applicant subject to: ☐ Jones Act ☐ FELA ☐ USLHW ☐ Other: _____

G. Limited Pollution Short Term Event Liability: ☐ Coverage Requested ☐ Coverage Not Requested

Pollution Liability: Coverage is excluded from our standard coverage with exception for a very limited grant for bodily injury and property damage. A limited endorsement of coverage is available, including an option for underground storage tanks.
If an endorsement is requested, complete the Limited Pollution Short Term Event Liability Supplemental Application.

VIII. EXCESS LIABILITY

If Excess coverage is requested, please complete this section, otherwise skip to Part IX.

For each underlying policy listed in subsection C. of Section III. COVERAGES, please provide a copy of the declarations page and loss runs for each.

A. If the excess limits of liability have been increased within the last 5 years, indicate the prior limit and when it was increased:

_____

B. Indicate the number and type of autos owned or leased by the hospital: *Please provide a copy of the Schedule of Vehicles from each of the current primary auto policies.*

Type	Number	Passenger Capacity of Each
☐ Ambulance—Emergency Use	_____	
☐ Ambulance—Non-Emergency Use	_____	
☐ Public Service Auto/Bus	_____	_____
☐ Private Passenger	_____	_____
☐ Trucks/Truck Tractors	_____	_____

C. Does the applicant confirm driver's licensure of employees and agents? ☐ Yes ☐ No

D. Does the applicant check motor vehicle records (MVRs) annually on each individual driving on behalf of the applicant? ☐ Yes ☐ No

E. What minimum personal auto liability limits does the applicant require of employees and volunteers using their personal autos for applicant's business? ☐ Not Required ☐ Statutory ☐ Other, please explain: _____

F. Provide the number and type of owned, non-owned, leased or chartered aircraft: _____

_____

VIII. EXCESS LIABILITY (continued)

G. Give a brief explanation of the use of each aircraft and indicate the passenger capacity: _____

_____

IX. RISK MANAGEMENT

A. Indicate the certifications/accreditations held by the applicant:

☐ CMS Certificate of Compliance with Conditions of Participation

☐ TJC ☐ CARF ☐ NCQA ☐ HBIP ☐ DNV ☐ HFAP ☐ Other: _____

B. When was the last accreditation/survey conducted by an outside entity?

Date/facility: _____ Name (DOH, TJC, etc.): _____

Total number of deficiencies: _____ Date Corrective Action Plan accepted: _____

If multiple surveys, attach a summary or copies of the survey documents.

C. Risk Management representative contact information for a telephonic or on-site review of the applicant's facility:

Name/Title: _____

Telephone Number: _____ E-mail Address: _____

D. Is there formal interface between performance improvement, patient safety, quality and risk management? ☐ Yes ☐ No

E. Is the applicant participating in Meaningful Use (for Electronic Medical Record)? ☐ Yes ☐ No

F. Has the applicant had its Medicare or Medicaid certification limited, suspended or revoked? ☐ Yes ☐ No

If Yes, please explain: _____

G. What is the RN annual turnover rate (% of full/part time RNs who terminated/total full/part time RN positions)? _____

H. Is agency staffing used? ☐ Yes ☐ No

If Yes, what is the annual % of agency staff utilized? _____

I. How many DOH patient/family complaints/grievances were investigated in the past 3 years? _____

J. List the quality and risk initiatives implemented as a result of large losses or claims trends:

_____

_____

_____

X. CLAIMS AND LOSS HISTORY

A. Who is responsible for reporting claims to insurers?

_____ _____ _____ - _____ - _____ _____

Name Title Phone E-mail

B. Have all circumstances and incidents that are reasonably likely to give rise to a claim been reported to current insurer(s)? ☐ Yes ☐ No

C. Specify preferred defense counsel: _____

D. Provide 10 years loss history: (Excel format preferred)

1. Currently valued
2. Detailing each loss, status (open/closed) and line of coverage (PL/GL)
3. Paid and Reserve amount
4. Insurer loss runs supporting other formats

E. Are the losses submitted ground-up and unlimited? ☐ Yes ☐ No

F. If excess coverage is requested, provide recently valued loss run(s) for underlying coverages i.e. Auto, Helipad, Aviation, etc.

XI. ATTACHMENT CHECKLIST

Please include the following:

- ☐ Audited Financial Statements
- ☐ Organizational Structure Chart
- ☐ List of all Subsidiaries and Affilitates, etc., for which coverage is requested
- ☐ Latest Accreditation Survey(s)
- ☐ Current policy(ies)
- ☐ Copy of unique policy language/endorsement
- ☐ Medical Provider's roster
- ☐ Supplemental Applications for Allied Providers and/or Physicians & Surgeons (if applicable per Section IV.)
- ☐ Schedule of Owned Vehicles
- ☐ Supplemental Applications for Behavioral, Research Activity, Bariatric and/or Limited Short Term Pollution
- ☐ Loss Runs

For SIR and/or Reinsurance:

- ☐ Actuarial Funding Study
- ☐ Funding Balance
- ☐ Captive Policy Language

XII. IMPORTANT NOTICE

This insurance may contain claims-made and reported coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date which are reported to the Company during the policy period or any applicable extended reporting period. Please read and review the policy carefully.

XIII. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DECEIVE, OR DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.

_____
INITIAL HERE

XIV. STATE SPECIFIC NOTICES

If Delaware: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 and Delaware Bulletin No. 46 including the following: Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

If Illinois: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under Illinois Bulletin 2011-06 And The Religious Freedom Protection and Civil Union Act which states: "The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married" or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

If Rhode Island: **THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.**

XV. PLEASE READ AND SIGN

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on their or the facility/entity's behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

XV. PLEASE READ AND SIGN (continued)

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that neither I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

Signature of Officer or Authorized Representative	Title	Date

XVI. SUPPLEMENTAL INFORMATION