



## HOSPITALS – RENEWAL APPLICATION

**Instructions:**

- A. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence. All application questions must be fully answered.
- B. This application must be completed, signed and dated by an authorized officer of the entity.
- C. Submit the most recent accreditation and survey reports including JCAHO, CARF, DHHS/Medicare, etc.
- D. Provide the name and email address for Risk Management contact.

**I. GENERAL INFORMATION:**

- A. Name of Applicant (legal name): \_\_\_\_\_
- B. Do you want to change the current insurance structure? No Yes  
 If **yes** please check off changes and attach an explanation:  
Deductible    Limits    Umbrella    Physician Coverage    Other
- C. Has the applicant had any changes to their business operations over the past 12 months? No Yes  
 If **yes** please check off changes and attach an explanation.  
Discontinued Operations    New Contracted Services  
Acquisition    New Construction    Other
- D. Are there any changes to the Self Insured Retention (SIR)/Captive/Risk Retention Group (RRG) limits? No Yes  
 If **yes** please check off changes and attach an explanation.  
Limits    TPA/Claims Handling    Forms    Other
- E. Are there any changes to your additional named insured's? No Yes  
 If **yes** please provide list

**II. PROFESSIONAL LIABILITY EXPOSURE INFORMATION**

A. Provide *annual occupancy/visit* exposures for projected and current year.

	Projected	Current Year
Year:		
Total beds set up & staffed		
<u>Occupied beds by type:</u>		
Acute		
Bassinets		
Swing		
Skilled Nursing*		
Intermediate Care*		
Assisted Living*		
Residential*		
Psychiatric		
Rehabilitation		
Chemical Dependency		
Other: _____		

	Projected	Current Year
<u>Annual Total:</u>		
Total Deliveries		
Primary Caesarean Sections		
Repeat Caesarian Sections		
VBACs		
Inpatient Surgeries		
Outpatient Surgeries (excl. endoscopies)		

	Projected	Current Year
<u>Retail Receipts:</u>		
Pharmacy		
Non-patient Cafeteria		
Gift Shop		
DME (rental)		
DME (sales)		
Non-patient Fitness Center		

	Projected	Current Year
<u>Total Annual Visits:</u>		
Emergency room visits		
Home Healthcare		
All other OPVs		
<u>Of all other OPVs: # that are:</u>		
Diagnostic Testing**		
Radiology (CT, MRI, etc)**		
Laboratory Tests**		

\* If located in a separate facility, please complete LTC application

\*\* List by patient encounters, not number of procedure

B. Employed Physicians, Contracted Physicians, and other Professional Employees\*

Provide Full Time Employees (FTEs) for each of the categories below.

	Projected	Current Year		Projected	Current Year
Year:			CRNAs		
Dentists			Nurse Midwives		
Residents			Podiatrists		
Physicians Assistants			Nurse Practitioners		
Oral Surgeons			Paramedics/EMTs		

NOTE: List each employed physician and contracted physicians with whom the applicant has agreed to provide coverage. Include the medical specialty, whether the physician performs deliveries, major or minor surgery and the retroactive date.

**III. GENERAL LIABILITY**

Attach a list of all locations indicating square footage, number of floors, construction materials and fire protection used.

- A. Have there been any changes to the applicants Helipad Landings or number of aircraft?  Yes  No  
If **yes** attach an explanation.

**IV. UMBRELLA LIABILITY**

- A. Underlying Insurance. Complete the Chart below.

Type	Carrier	Policy Number	Policy Period	Limits of Liability	CM or Occ	Premium
Automobile Liability				\$		\$
Employers Liability				\$		\$
Helipad Liability				\$		\$
Non-owned Aircraft Liability				\$		\$
Other: _____				\$		\$
Other: _____				\$		\$

***APPLICABLE IN FL, NH, LA AND VT: IF ANY AUTOMOBILE COVERAGE IS PRESENT, YOU MUST COMPLETE THE APPROPRIATE COVERAGE SELECTION FORM.***

**V. LOSS HISTORY**

- A. Provide an updated loss history dated within 60 days for the past 10 years (including the current year) on a report-year basis. Loss data must include the incident/occurrence date, report date/claim made date, expense payments, indemnity payments, expense reserves, indemnity reserves, description of allegation and close date. **All claims must be first dollar/ground up, and if possible, sent electronically and be applicable to all lines of coverage to which you are applying.**
- B. Provide full details for any claim with an indemnity payment or indemnity reserve of \$100,000 or greater.

**VI. QUALITY / PATIENT SAFETY INITIATIVES:**

Check all that apply :

- |  |   |
|--|---|
| <input type="checkbox"/> Five Million Lives Campaign                         | <input type="checkbox"/> State quality CIO Award                        |
| <input type="checkbox"/> Eisenberg Award                                     | <input type="checkbox"/> Surgical Care Improvement Project              |
| <input type="checkbox"/> HealthGrades Award for Excellence or Patient Safety | <input type="checkbox"/> Thomson 100 Top Hospitals (formerly Solucient) |
| <input type="checkbox"/> Leapfrog "Top Hospitals"                            | <input type="checkbox"/> US News and World Report Top 100               |
| <input type="checkbox"/> Magnet Recognition Program                          | <input type="checkbox"/> National Patient Safety Foundation Award       |
| <input type="checkbox"/> Malcolm Baldrige Quality Award                      | <input type="checkbox"/> Other: _____                                   |
| <input type="checkbox"/> Press Ganey Summit or Compass Award                 |   |

**AUTHORIZATION**

I hereby certify that I have read the above questions and that all statements are true, material and complete. I understand that (1) if the policy is issued this is done in reliance upon these representations; and (2) any policy obtained by fraud, material misrepresentation or omission is void. I agree that a copy of my signature may be relied upon as if it were the original. My signing of this application does not bind the Insurance Company to sell nor does it bind the applicant to purchase the insurance.

**FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE**

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 or incomplete 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 SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: 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.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

\_\_\_\_\_  
Signature in full

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Name - please print

**ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED.**

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation.