HOSPITAL APPLICATION FOR PROFESSIONAL LIABILITY (Claims Made), GENERAL LIABILITY, AND UMBRELLA COVERAGE

☐ New ☐ Renewal Effective Date: ____/____/____

Some of the coverage being applied for are Claims Made.
If there are questions concerning this coverage, please contact your insurance agent.

Instructions:

A. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.

B. All application questions must be fully answered. If a question does not apply, please write "N/A".

C. If more space is needed, continue on a separate sheet of the applicant's letterhead and indicate the question number.

D. **You may be required to complete a supplemental application in addition to this Common Application in order to secure coverage**.

E. To this application, please attach copies of:

1. Marketing or Advertising brochures or descriptive materials provided to clients.
2. Latest annual audited financial statement.
3. A copy of the organizational chart (per hospital, if applicable)
4. Bond and/or Debt rating: _____ Rating Company (i.e. Moody's, S&P, etc.): _____
5. Other attachments as required in response to application questions. .

F. This application must be completed, signed and dated by an authorized officer of the entity.

I. GENERAL INFORMATION:

A. Name of Applicant (legal name): _____

d/b/a name (if applicable): _____

Mailing Address of Facility: _____

City: _____ State: _____ Zip Code: _____ County: _____

Does the facility have any additional locations? ☐ Yes ☐ No

If "Yes" list all separate locations on a separate letterhead and attach to this application.

Website Address of Facility (if applicable): _____

CMS (Medicare) Provider #: _____

B. Requested Effective Date: ____/____/____

C. Requested Limits:

Coverage	**HPL** – Each Claim or Medical Incident **GL** – Per Occurrence **Umbrella** – Each Occurrence/Claim/Medical Incident	Aggregate
HPL	$	$
GL	$	$
Umbrella	$	$

D. Requested Deductible: ☐ Deductible; or
☐ Self Insured Retention/Captive/RRG (complete Section IV on page 13)

Coverage	**HPL** – Each Claim or Medical Incident **GL** – Per Occurrence	Aggregate	Are ALAE included in the deductible?
HPL	$	$	☐Yes ☐No
GL	$	$	☐Yes ☐No

E. Requested Retroactive Date: _____/_____/_____ ☐ HPL _____/_____/_____ ☐ GL or N/A for GL ☐
_____/_____/_____ Umbrella (if different from primary)
If multiple retroactive dates apply please attach a list.

II. PROFESSIONAL LIABILITY INFORMATION:

A. Type of Facility:

1. ☐ Hospital Acute Care
☐ Long Term Care Facility (Nursing Home, Assisted Living, CCRC. Must complete Long Term Care Application and provide supplemental information).
☐ Integrated Health System (submit separate application for each entity).
☐ Critical Access Hospital
☐ Specialty Hospital Type: _____
☐ Other (specify): _____
Please list separately all of the entities that are requested to be covered by this policy.

2. ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ LLC

3. ☐ Government ☐ For-Profit ☐ Not-for-Profit

B. Does this facility have any teaching affiliations? ☐ Yes ☐ No
Is the facility a teaching and/or research facility? ☐ Yes ☐ No
Does the facility have any ownership or partnership interests (i.e. joint ventures, PPOs, HMOs, etc.)? ☐ Yes ☐ No
If "yes" to any of the above provide full details: _____
_____
_____

C. Check any and all of the following services that your facility provides.

☐ Burn Unit ☐ Reference Laboratory ☐ Tissue/Organ/Bone/Eye Bank
☐ Dialysis ☐ Research Center ☐ Genetic Testing/Counseling
☐ Fertility Clinic

D. Exposures

1. Provide *annual occupancy/visit* exposures for the past 10 years starting with this policy period.

	Projected	Current Year	Year minus 1	Year minus 2	Year minus 3	Year minus 4	Year minus 5	Year minus 6	Year minus 7	Year minus 8	Year minus 9
Year:											
Total Beds Set Up & Staffed											
Occupied beds by type:											
Acute											
Bassinets											
Swing											
Skilled Nursing*											
Intermediate Care*											
Assisted Living*											
Residential*											
Psychiatric											
Rehabilitation											
Chemical Dependency											
Other: _____											
Annual Total											
Total Deliveries											
Primary Caesarean sections											
Repeat Caesarean sections											
VBACs											
Inpatient Surgeries											
Outpatient Surgeries (excl. endoscopies)											
Endoscopies											
Total Annual Visits											
Emergency Room Visits											
Home Healthcare											
All other OPVs											
Of "All Other OPVs" how many are:											
Diagnostic Testing?**											
Radiology (CT,MRI,etc)?**											
Laboratory Tests?**											
Retail Receipts											
Pharmacy											
Non-patient Cafeteria											
Gift Shop											
DME (rental)											
DME (sales)											
Non-patient Fitness Center											

* If located in a separate facility, please complete LTC application.
** List by patient encounters, not number of procedures

2. Will any new services or construction projects be implemented within the next 12 months? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper.

3. Have any services been discontinued within the last 12 months? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper.

4. Has the applicant acquired any facilities with the past 12 months? ☐ Yes ☐ No
   If "Yes" have the exposures and losses been included within the attached data? ☐ Yes ☐ No
   If "No" please explain on a separate sheet of paper.

5. Are there any plans to acquire other facilities within the next 12 months? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper.

6. Does the applicant provide service to any prison/detention centers on or off hospital premises? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper.

7. Has the applicant developed software programs or other materials/programs/services that are sold or contracted? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper and provide sample contract.

8. Does the applicant provide management services to other healthcare entities? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper and provide sample contract.

9. Is the applicant managed by a contracted entity? ☐ Yes ☐ No
   If "Yes" provide name and address on a separate sheet of paper and provide sample contract.

10. Does the applicant engage in telemedicine (i.e. radiology, cardiology, ophthalmology, remote monitoring for home patients, dermatology, etc.)? ☐ Yes ☐ No
    If "Yes" provide details on a separate sheet of paper.

11. Does the applicant operate a telephone nurse triage program? ☐ Yes ☐ No
    If "Yes" provide details on a separate sheet of paper.

12. Does the applicant provide any internet services? ☐ Yes ☐ No
    If "Yes" provide details on a separate sheet of paper.

13. Have any enhancements been made to the technology at the applicant's facility(ies) over the last five years? ☐ Yes ☐ No
    If "Yes" provide details on a separate sheet of paper.

14. Does the applicant have a business continuity plan in the event of a computer system failure, virus or malfunction? ☐ Yes ☐ No
    If "Yes" provide a copy of the plan.

15. What is the applicant's technology budget? current fiscal year: $_____
    upcoming fiscal year: $_____

E. Employed Physicians, Contracted Physicians, and other Professional Employees

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

	Projected	Current	Year minus 1	Year minus 2	Year minus 3	Year minus 4	Year minus 5	Year minus 6	Year minus 7	Year minus 8	Year minus 9
Year:											
Employed Physicians*											
Contracted Physicians**											
Dentists											
Residents											
Physicians Assistants											
Oral Surgeons											
CRNAs											
Nurse Midwives											
Podiatrists											
Nurse Practitioners											
Paramedics/EMTs											

* List each employed physician including the medical specialty, whether the physician performs deliveries, major or minor surgery and the retroactive date on a separate sheet of paper.

** Provide a list of all contracted physicians with whom the applicant has agreed to provide coverage. The list should include the medical specialty, whether the physician performs deliveries, major or minor surgery, and retroactive date.

2. Do the employed physicians:
   - ☐ share in the hospital PL limits of liability? or
   - ☐ have individual PL limits of liability through the hospital's policy? or
   - ☐ have their own separate PL coverage?

3. Do the contracted physicians:
   - ☐ share in the hospital PL limits of liability? or
   - ☐ have individual PL limits of liability through the hospital's policy? or
   - ☐ have their own separate PL coverage?

F. Medical Staff

1. Indicate the total number of staff physicians? _____

2. a. Are credentials for all new staff members checked and approved prior to granting privileges? ☐ Yes ☐ No

   b. Does an identical credentialing and privileging process apply to:

   1) mid-level providers (i.e. CRNAs, Certified Nurse Midwives, Physician Asst's, etc)? ☐ Yes ☐ No

   2) physicians' employees on premises (i.e. private scrubs, first assts, nurse practitioners, etc) ☐ Yes ☐ No

   c. Are physicians' employees working on the premises required to meet the identical standards of employed staff (i.e. education, training, licensure, certification, etc) ☐ Yes ☐ No

3. Are all staff members licensed and privileged without restrictions? ☐ Yes ☐ No
   If "no", provide details on a separate sheet of paper.

4. How often are privileges reviewed? _____

5. Does the applicant require all foreign medical school graduates to be certified by the Education Council for Foreign Medical School Graduates? ☐ Yes ☐ No

6. Does the applicant perform drug and alcohol testing for all physicians for credentialing and privileging purposes? ☐ Yes ☐ No

7. Does the applicant perform criminal background checks for all physicians for whom privileges have been granted? ☐ Yes ☐ No

8. Are all privileges granted to staff physicians and mid-level providers detailed in writing? ☐ Yes ☐ No

9. a. 1) Are staff physicians required to carry professional liability insurance? ☐ Yes ☐ No
   2) Are Mid-level providers required to carry professional liability insurance? ☐ Yes ☐ No

   Required minimum limits of insurance: $_____

   b. Are they insured with a carrier rated no less than A- by AM Best? ☐ Yes ☐ No

10. Does the applicant collect certificates of insurance from all staff physicians as evidence of compliance? ☐ Yes ☐ No

G. Anesthesia

1. Is anesthesia provided by:
   ☐ Hospital employed physicians ☐ Staff Physicians ☐ Hospital employed CRNAs
   ☐ Contract Group Physicians ☐ Contract Group CRNAs

   If a Contract Group Physicians or CRNAs provide name of group and sample contract. _____

   If a contract group or staff is used, what are the minimum required limits of insurance?

   $_____ per claim $_____ aggregate

2. Are certificates of insurance required? ☐ Yes ☐ No

3. Are all anesthesiologists Board certified? ☐ Yes ☐ No
   If "No" is the medical director Board certified? ☐ Yes ☐ No

4. What is the ratio of CRNAs to anesthesiologists? _____

5. Are CRNAs supervised by a physician? ☐ Yes ☐ No

6. Are ASA standards for monitoring required in all areas where anesthesia is administered (i.e. OR, OB, GI Lab, Cardiac Cath Lab, etc)? ☐ Yes ☐ No

7. Is an anesthesiologist or CRNA on site 24/7? ☐ Yes ☐ No

8. Does an informed consent discussion take place between the patient and the anesthesiologist or CRNA that includes anesthesia contemplated, possible risks and alternatives? ☐ Yes ☐ No

9. Is the informed consent discussion documented in the medical record? ☐ Yes ☐ No

H. Surgery

1. Is there any surgical involvement with interns/residents? ☐ Yes ☐ No
   If "Yes", to what extent? _____

2. Can a resident perform surgery without direct supervision of an attending physician? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper.

3. Are any of the following procedures performed at your facility?
   ☐ Experimental Surgery ☐ Pediatric Surgery ☐ Bariatric Surgery ☐ Transplants

   If any of these are performed at your facility, provide full details as to the specific procedure(s) performed and the number performed on an annual basis.

4. Does an informed consent discussion take place between the patient and surgeon that includes possible risks and alternatives? ☐ Yes ☐ No

5. Is the informed consent discussion documented in the medical record? ☐ Yes ☐ No

6. Is a written policy/procedure present for surgical site identification? ☐ Yes ☐ No

7. Is a time-out called in the OR prior to the beginning of the procedure? ☐ Yes ☐ No

8. Are patients called following discharge from ambulatory surgery? ☐ Yes ☐ No
   If "Yes" how is it documented? _____

9. Is primary Percutaneous Coronary Intervention (PCI) performed at the hospital? ☐ Yes ☐ No
   a. If "Yes" how many procedures are performed annually? _____
   b. If "Yes" is on-site cardiac surgery immediately available? ☐ Yes ☐ No
   c. If "No" to 9.b., does the hospital meet the requirements of the ACC/AHA/SCLAI Practice Guidelines for "Criteria for the Performance of Primary PCI at Hospitals Without On-Site Cardiac Surgery"? ☐ Yes ☐ No
   d. If "No" to 9.c., please explain in detail on a separate sheet of paper.

10. Is elective PCI performed at the hospital? ☐ Yes ☐ No
    a. If "Yes" how many procedures are performed annually? _____
    b. If "No" to 9.b., does the hospital meet the requirements of the ACC/AHA/SCLAI Practice Guidelines for quality assurance "Institutional and Operator Competency" ☐ Yes ☐ No
    c. If "No" to 10.b., please explain in detail on a separate sheet of paper.

I. Emergency Department (ED)

1. What level of service is the ED?
   ☐ I (Tertiary) ☐ II (Comprehensive) ☐ III (Basic)
   ☐ Trauma Center ☐ Stand-by Services Only
   ☐ Other (Describe): _____

2. Is the ED staffed by:
   ☐ Hospital Employed Physicians
   ☐ Contract Group (provide name of the group and a sample contract): _____
   ☐ Staff
   ☐ Residents
   ☐ Mid-level Providers (if used, please provide explanation on separate sheet of paper)

   if a contract group or staff is used, what are the minimum required limits of insurance?

   $_____ per claim $_____ aggregate

3. Are all ED physicians Board certified in ED medicine? ☐ Yes ☐ No
   If "No" is the Medical Director Board certified in ED medicine? ☐ Yes ☐ No

4. If physicians are not Board certified in ED medicine, list required credentials (i.e. ACLS, PALS, etc): _____

5. Are certificates of insurance required? ☐ Yes ☐ No

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

7. Do ED physicians respond to in-house codes? ☐ Yes ☐ No

8. Do ED physicians write admitting orders? ☐ Yes ☐ No

9. Are all patients examined by a physician prior to discharge? ☐ Yes ☐ No
   If "No", provide details on a separate sheet of paper.

10. Is a patient triage system present? ☐ Yes ☐ No

11. Who performs triage? _____

12. Is the level of urgency documented? ☐ Yes ☐ No

13. Are clinical pathways present for conditions such as chest pain, CHF, women with abdominal pain, children with fever, etc.? ☐ Yes ☐ No

14. Has the hospital ever been cited for violating EMTALA? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper.

15. Are all ED support personnel ACLS/PALS certified? ☐ Yes ☐ No

16. a. Does the ED own or operate an ambulance service? ☐ Yes ☐ No
   If "Yes" provide the following:
   1) Number of emergency runs annually: _____
   2) Number of non-emergency runs annually: _____

   b. Are all ambulance patients taken to your facility? ☐ Yes ☐ No
   If "No" provide the following:
   1) Total number of runs to other facilities annually: _____
   2) Total number of runs to your facility annually: _____

17. Are paramedics/EMTs in radio contact with an ED physician for orders? ☐ Yes ☐ No

18. Do paramedics/EMTs execute treatment according to standard and approved protocols? ☐ Yes ☐ No

19. Does the hospital have a transport team (ground or air)? ☐ Yes ☐ No

J. Radiology

1. Is the radiology department staffed by:
   ☐ Hospital Employed Physicians
   ☐ Contract Group (provide name of the group and a sample contract): _____
   ☐ Staff
   ☐ Residents
   if a contract group or staff is used, what are the minimum required limits of insurance?
   $_____ per claim $_____ aggregate

2. Are certificates of insurance required? ☐ Yes ☐ No

3. Are all radiologists Board certified? ☐ Yes ☐ No
   If "No" is the Medical Director Board certified in radiology? ☐ Yes ☐ No

4. Is there a system for radiological interpretation over-read for all radiographs performed outside of the department (i.e. the ED, owned clinics/physicians offices, etc.)? ☐ Yes ☐ No
   Describe on a separate sheet of paper the process for notifying the patient and attending physician, if there is a discrepancy in radiological interpretation.

5. Have there been any accidents at your facility(ies) involving the use of radiological or nuclear medicine materials? ☐ Yes ☐ No
   If "Yes" provide details on a separate sheet of paper.

6. If mammograms are performed,
   a. is the program ACR certified? ☐ Yes ☐ No
      If "No" do you follow ACR Practice Guidelines for the performance of screening mammography? ☐ Yes ☐ No
   b. is digital equipment used? ☐ Yes ☐ No

K. Obstetrics (OB)

1. Is the facility a regional referral center for newborns requiring intensive care or high risk pregnancies? ☐ Yes ☐ No
   If "No" does the hospital have a written procedure governing the transferring of all high risk mothers and/or babies the hospital is not qualified to treat? ☐ Yes ☐ No

2. Is electronic fetal monitoring (EFM) utilized on all patients in active labor? ☐ Yes ☐ No
   If "No", provide details on a separate sheet of paper.

3. Are L&D nurses required to successfully complete an approved course in EFM? ☐ Yes ☐ No

4. Is there an obstetrician on site 24 hours per day? ☐ Yes ☐ No
   If "No", is there an obstetrician on call 24 hours per day? ☐ Yes ☐ No
   If "No", provide details on a separate sheet of paper.

5. What is the maximum amount of time it takes to perform an emergency Caesarean Section once it has been determined that one is necessary? _____

6. Does a board certified obstetrician chair the OB Department? ☐ Yes ☐ No

7. Who provides anesthesia during labor and delivery? _____

8. Is an anesthesiologist or CRNA dedicated to labor and delivery? ☐ Yes ☐ No

9. In addition to obstetricians, who else is privileged to perform deliveries?
   ☐ Family practitioner
   ☐ Certified nurse mid-wife
   ☐ Resident – indicate year of residency and area of practice: _____
   ☐ Other: _____

10. In addition to obstetricians, who else is privileged to perform Caesarean sections?
    - ☐ Family practitioner
    - ☐ Certified nurse mid-wife
    - ☐ Resident – indicate year of residency and area of practice: _____
    - ☐ Other: _____

11. In addition to obstetricians, who else is privileged to perform VBACs?
    - ☐ Family practitioner
    - ☐ Certified nurse mid-wife
    - ☐ Resident – indicate year of residency and area of practice: _____
    - ☐ Other: _____

    Provide the policies and procedures that apply for on-site availability of the provider who performs the delivery and administers anesthesia during VBACs. If Certified Nurse Midwives practice at the hospital, provide the policy/procedure for physician backup.

12. What is the induction rate? _____

13. Are oxytocins utilized to induce or augment labor for VBAC patients? ☐ Yes ☐ No
    Explain: _____

14. During labor, how often do physicians/midwives review FHT? _____

15. Do physicians/midwives have the capability to review FHT in their office and home? ☐ Yes ☐ No

16. Can a resident perform deliveries (vaginal or Caesarean section) without direct supervision of an attending physician? ☐ Yes ☐ No

17. Are deliveries performed outside of the hospital? ☐ Yes ☐ No
    If "Yes", explain: _____

18. a. What level of service is the nursery?
    ☐ Level I Basic – well newborns ☐ Level II Intermediate ☐ Level III Intensive Care

    b. Total number of neonates admitted to the NICU within the past 12 months: _____

    c. Total number of neonates transferred from other hospitals: _____

    d. Is a full-time neonatologist on duty 24 hours a day? ☐ Yes ☐ No

    e. If the hospital does not have a NICU, how many neonates were transferred to other hospitals? _____

19. Is the medical director of the nursery board-certified in pediatrics or neonatology? ☐ Yes ☐ No

20. Does a pediatrician attend emergency Caesarean sections? ☐ Yes ☐ No
    If "No", is another physician or other qualified person skilled in neonatal resuscitation available and dedicated to the neonate? ☐ Yes ☐ No

21. Are abduction drills conducted? ☐ Yes ☐ No

22. Have you ever had an infant abduction? ☐ Yes ☐ No
    If "Yes", describe changes made to prevent future abductions on a separate sheet of paper.

23. Is advice given to patients over the telephone? ☐ Yes ☐ No
    If "Yes" describe how it is documented on a separate sheet of paper.

L. Home Health Services

1. Are home health services provided? ☐ Yes ☐ No

2. What are the types and number of visits?

☐ Skilled	_____ visits
☐ Intravenous Therapy	_____ visits
☐ Personal	_____ visits
☐ Rehabilitation	_____ visits
☐ Respiratory	_____ visits
☐ All Other	_____ visits
☐ Durable Medical Equipment (Receipts)	_____ receipts

3. Describe the scope of service (i.e. ventilators, dialysis, IV therapy, chemotherapy, DME, home care, pharmacy, etc.): _____

4. Is certification required for home health aides by NAHC or other? ☐ Yes ☐ No

Provide the policy/procedure for on-site scheduled and unscheduled supervisory visits.

M. Behavioral Health Services

1. Are inpatient behavioral health services provided? ☐ Yes ☐ No
If "Yes" provide the following percentage of patients:

Geriatric:	_____%	
Adult:	_____%	
Adolescent:	_____%	
Pediatric:	_____%	
Other :	_____%	Specify: _____

2. Are patients separated based on age, sex or other criteria? ☐ Yes ☐ No
Explain on a separate sheet of paper.

3. Are patients admitted with a primary diagnosis of chemical dependency? ☐ Yes ☐ No

4. Are policies and procedures present to address patient security? ☐ Yes ☐ No

5. Are elopement drills conducted? ☐ Yes ☐ No

6. Is the medical director board certified in psychiatry? ☐ Yes ☐ No

7. Is there a policy/procedure for management of medically ill patients? ☐ Yes ☐ No

8. a. Is electroconvulsive therapy (ECT) performed? ☐ Yes ☐ No
b. If "Yes" are policies/procedures present to address informed consent, sedation, post procedure monitoring, etc.? ☐ Yes ☐ No

9. Are outpatient behavioral health services provided? ☐ Yes ☐ No
If "Yes" provide detail on a separate sheet of paper.

10. Is service to clients provided in group homes or other residential settings? ☐ Yes ☐ No
If "Yes" provide detail on a separate sheet of paper.

N. Outpatient Clinics/Physicians Office

1. Does the clinic/physician office participate in the hospital risk, safety and quality management programs? ☐ Yes ☐ No

2. Are policies/procedures present for:
   - ☐ Follow-up on missed appointment
   - ☐ Follow-up on test results and notification of patients
   - ☐ Distribution of sample medications
   - ☐ Documentation of telephone advice including after hour calls

O. Blood Bank

1. Does your hospital own or operate a blood bank? ☐ Yes ☐ No
2. If "No" from where is the blood or blood product obtained? _____
3. If "Yes" is the blood bank:
   a. accredited by the American Association of Blood Banks? ☐ Yes ☐ No
   b. a blood / blood products provider for facilities other than the applicant(s)? ☐ Yes ☐ No

P. Risk / Quality / Safety Management

Please provide a copy of:
- Risk / quality / safety plan(s)
- Most recent accreditation or survey reports including JCAHO, CARF, DHHS/Medicare, etc.
- Incident/occurrence report form

1. Who is responsible for administrating your risk / quality / safety management plan?
   Name: _____ Title: _____
   Phone: _____ e-mail address: _____
2. Does this person have any other responsibilities? ☐ Yes ☐ No
   If "Yes", describe the other responsibilities: _____
3. To whom does this person report: Name: _____ Title: _____
4. Is there formal interface between performance improvement and risk management? ☐ Yes ☐ No
5. Are the national patient safety goals addressed in the risk / quality / safety plan? ☐ Yes ☐ No
   If "No", provide detail on a separate sheet of paper.
6. Is information on patient safety, risk and quality management reported to the governing board on a regular basis? ☐ Yes ☐ No
7. Does the hospital measure patient satisfaction? ☐ Yes ☐ No
8. Does the hospital have complaint resolution policies and procedures? ☐ Yes ☐ No
9. Are incident reports tracked, trended and reported to a governing board on a regular basis? ☐ Yes ☐ No
10. Check the responsibilities that apply to the function of the risk / quality / safety department:
    - ☐ Health information management
    - ☐ Emergency preparedness
    - ☐ Infection control
    - ☐ Claims management
    - ☐ Contract review
    - ☐ Patient relations
    - ☐ Corporate compliance
    - ☐ Quality/performance improvement
    - ☐ Safety
    - ☐ Other: _____

12. List all accreditations/surveys (i.e. JCAHO, CARF, DHHS/Medicare, etc): _____

_____

III. HUMAN RESOURCES:

A. Does pre-employment screening include a criminal background investigation, drug screen and reference verification? ☐ Yes ☐ No

If "No" please explain: _____

B. Are job descriptions, orientation programs and performance appraisals job specific and competency based? ☐ Yes ☐ No

If "No" please explain: _____

C. Are agency personnel used? ☐ Yes ☐ No

If "Yes" is orientation provided and documented? ☐ Yes ☐ No

D. Do you participate in any alternative work programs (i.e. work release, court mandated community service, etc.)? ☐ Yes ☐ No

E. What is the total number of employees? _____

IV. SELF INSUREND RETENTION (SIR)/CAPTIVE/RISK RETENTION GROUP (RRG):

Please provide a copy of the following documents (if applicable):

- Most recent actuarial funding study
- Trust agreement for the self-insured retention or policy form(s) for captive or RRG
- Claims handling policy and procedure manual
- Trust fund or Captive/RRG financials

A. What are the limits of liability for the SIR/Captive/RRG?

$_____ per claim $_____ aggregate

B. What coverages are contemplated? Specify the claims basis for each line of business:

_____

_____

C. Is there a dedicated trust? ☐ Yes ☐ No

D. Has an independent actuarial funding study been completed? ☐ Yes ☐ No

E. Does ALAE erode the limits of the SIR/Captive/RRG? ☐ Yes ☐ No

F. Who handles the claims within the SIR/Captive/RRG? _____

G. Does the applicant have written policies and procedures regarding incident reporting, claims handling and reserve philosophy? ☐ Yes ☐ No

Provide authority levels for setting reserves and determining whether cases are tried or settled:

_____

_____

H. Is there a specific law firm used to defend claims? ☐ Yes ☐ No

If "Yes" provide name and address of law firm: _____

V. GENERAL LIABILITY:

On a separate sheet of paper, list all locations indicating square footage, number of floors, construction materials and fire protection used.

A. Helipad

1. Does the applicant own an aircraft? ☐ Yes ☐ No
   If "Yes" provide detail on a separate sheet of paper.
2. Does the applicant lease any aircraft? ☐ Yes ☐ No
   If "Yes" provide detail on a separate sheet of paper.
3. Does the applicant have a helipad or heliport? ☐ Yes ☐ No
   If "Yes" provide responses to the following:
   a. Are there re-fueling capabilities? ☐ Yes ☐ No
   b. How many landings are there per year? _____
   c. Does the hospital contract with an air flight service? ☐ Yes ☐ No

B. Fitness Center

1. Does the hospital operate a fitness center that is open to the public? ☐ Yes ☐ No

C. Day Care

1. Does the hospital have a day care facility (child or adult)? ☐ Yes ☐ No
2. Is it open to the public? ☐ Yes ☐ No
3. What is the ratio of child/adult to day care staff? _____
4. Is the day care facility located within the hospital? ☐ Yes ☐ No
5. Are the day care staff? ☐ employees of the hospital; or ☐ Independent contractors
   If independent contractors, does the hospital require that they carry insurance for the operation of a day care facility? ☐ Yes ☐ No
   If "Yes", what limits of liability are required?
   $_____ per claim $_____ aggregate

6. Does pre-employment screening include a criminal background investigation, drug screen and references verification? ☐ Yes ☐ No
   If "Yes" how often are the above conducted? _____
   If "No" please explain on a separate sheet of paper.

D. Swimming Pool

1. Does the hospital have a swimming pool? ☐ Yes ☐ No
2. Are there supervising staff? ☐ Yes ☐ No
   If "Yes" are they CPR certified? ☐ Yes ☐ No

D. Watercraft

1. Does the applicant? ☐ own or ☐ lease any watercraft?
   If "Yes" provide detail on a separate sheet including description of watercraft and of use.

E. Special Events – list any special events planned for the year: _____

_____

VI. CURRENT LIABILITY COVERAGE

A. Complete the following chart:

	HPL	GL	Umbrella	Other: Specify:_____	Other: Specify:_____
Carrier					
Policy Period					
Limits of Liability	$	$	$	$	$
Are ALAE included in the Limits of Liability?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Deductible/SIR	$	$	$	$	$
Claims-Made or Occurrence	☐CM ☐Occ	☐CM ☐Occ	☐CM ☐Occ	☐CM ☐Occ	☐CM ☐Occ
Expiring Premium	$	$	$	$	$

B Has any insurance carrier cancelled, refused or non-renewed your previous liability insurance? ☐ Yes ☐ No
If "Yes" provide full details on a separate sheet of paper.
(This question is not applicable in Missouri.)

VII. LOSS HISTORY

A. Provide loss history 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.**

B. Provide full details for any claim with an indemnity payment or indemnity reserve of $100,000 or greater.

VIII. UMBRELLA LIABILITY

A. Underlying Insurance. Complete the Chart below.

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

B. Automobiles

1. Please complete the following:

Type of Auto	Number Owned	Number Leased
Private Passenger		
Light Trucks/Service Vans		
Heavy Trucks		
Tractors		
Semi-Trailers (incl. customized)		

Type of Auto	Number Owned	Number Leased
Passenger Vans		
Buses		
Emergency Vehicles		
Patient Transport Vehicles		
Emergency Transport Vehicles		

2. For passenger vans and buses, indicate the capacity and use of each: _____

3. Are any units operated beyond a 50-mile radius of their usual garage location? ☐ Yes ☐ No
   If "Yes" describe including the number of such units: _____

4. Are explosives, caustics, flammables or other dangerous cargo hauled? ☐ Yes ☐ No
   If "Yes" explain: _____

5. Are passengers carried for a fee? ☐ Yes ☐ No
   If "Yes" explain: _____

6. Are any units not insured by underlying policies? ☐ Yes ☐ No
   If "Yes" explain: _____

7. Are any vehicles leased or rented to others? ☐ Yes ☐ No
   If "Yes" explain: _____

8. Is Hired and Non-owned Auto coverage provided? ☐ Yes ☐ No
   If "Yes" explain: _____

APPLICABLE IN FL, NH, LA AND VT:

IF ANY AUTOMOBILE COVERAGE IS PRESENT, YOU MUST COMPLETE THE APPROPRIATE COVERAGE SELECTION FORM.

C. Employers Liability

1. Is applicant self-insured in any state? ☐ Yes ☐ No
   If "Yes" explain: _____

2. Is applicant subject to: ☐ Jones Act ☐ Fela ☐ Stop Gap ☐ Other: _____

D. Loss History

1. Does the loss information include umbrella losses (paid and reserved)? ☐ Yes ☐ No
   If "No", please provide information in the same format described in Section VII. Loss History.

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.