

HOSPITAL PROFESSIONAL LIABILITY APPLICATION

In completing this application, all questions must be answered. If a question is not applicable, answer by stating "Not Applicable" or "N/A". If the answer to a question is none, state "None" or "O". If more space is needed to answer the question than is provided in the application, attach a separate sheet and identify the question to which you are responding.

I HOSPITAL * DATA

1A. Legal name and address of hospital: _____

1B. Is this hospital	YES	NO
licensed as a hospital by the state?	___	___
approved for Medicare?	___	___
accredited by the JCAH?	___	___
a member of the American Hospital Association	___	___

1C. If the answer to any item above is "no" or if accreditation, license, approval, or membership has ever been refused or canceled in the past 10 years, please explain:

1D. Date of most recent JCAH accreditation: _____

Please attach a copy of your most recent AHA survey and accreditation report for the JCAH. If the JCAH accreditation was awarded on a contingent basis which requires an interim on-site visit and/or interim written report, please provide copies of these reports and explain any/all corrective action taken.

*The term "hospital" as used in this application should be understood to include the hospital, its parent and subsidiaries.

II EXPOSURE SURVEY

2A. Inpatient Services

Please provide data for most recent annual period available.

Period involved: _____ This is to be used as a base period for exposure throughout this application.

Type of Beds	Number Licensed	Number Available	Number of	Average Daily	Number Patient	Average Length of
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	Beds	Beds(a)	Admissions	Census	Days	Stay
Adult/Critical Care						
Psychiatric Beds						
Pediatric						
Newborn Nursery						
Neonatal ICU						
Substance Abuse Unit						
Physical Rehabilitation						
Skilled Nursing						
Nursing Home						
Hospice						
Swing Beds(b)						
Other						
Total						

(a) # of "available" beds means the number of beds set up and staffed for use.

(b) Please state use of swing beds: _____

State percentage of time used as skilled nursing care: _____

State Length of Stay for skilled nursing care days: _____

2B. Are any additions to the number of available beds or change in use of the number of available beds planned in the next 12 months? If so, advise the number of beds and use.

2C. Number of Inpatient Surgical Cases (1) _____

2D. Number of Births:

Vaginal Deliveries _____

C-Sections _____

Stillborns _____

Total _____

2E. Outpatient Services

1. Emergency Room Visits
 - Treated/Discharged _____
 - Treated/Admitted _____
 - Total _____
2. Outpatient Surgical Cases (a) _____
3. Outpatient Clinic Visits involving Direct Physician-Patient Contact (b) _____
4. All Other Outpatient Visits (c) _____
5. All Home Health Visits _____
6. Other _____

(a) Surgical Cases includes all surgical procedures related to one clinical case.

(b) Outpatient Clinic Visits mean any outpatient visit on or off the hospital premises involving the examination or treatment of a patient by a physician. Count only "hands-on" physician/patient encounters, not indirect encounters where physician interprets an x-ray or laboratory result.

(c) Use visits rather than occasions of service. For example, a patient referred to the hospital by a physician for a laboratory test and an x-ray would be counted as one visit but two occasions of service. A visit is a threshold crossing which may involve multiple occasions of service from more than one clinical department.

2G. Miscellaneous Underwriting Data Yes No

1. Does the hospital purchase, repackage or sell pharmaceuticals to other health care providers? _____

If yes, please furnish full details including type of pharmaceuticals, sales for the most recent annual period available and estimated sales for the next twelve months.

2. Does the hospital provide management, personnel or patient care services to other health care providers? _____

If yes, please describe and give exposure basis for services rendered (number of visits, number of personnel by professional category, total payroll and total revenue). Please attach copy of contract(s).

3. Does the hospital own or manage a Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO)? _____

If yes, is this PPO or HMO separately insured? _____

Complete HMO/PPO questionnaire if coverage is to be included

4. Does the Hospital participate in any teaching program? _____

If yes, give type of program, if it is hospital sponsored and name of sponsoring institution.

5. Does the Hospital own a hotel/motel or otherwise engage in providing lodging accommodations for transients, whether or not patients? _____

6. Is the hospital currently or expect to be involved in any research or development programs? _____

If yes, include a full description of the program

7. Blood Bank

A. 1. Does the hospital have a blood bank? _____

“Blood bank” as used herein, does not mean the blood administration program wherein blood obtained from an independent source (e.g. American Red Cross, local blood bank, etc.) is stored by the hospital and the hospital is only doing the secondary typing and testing.

Yes No

“Blood bank”, as used herein, means that the hospital utilizes donors to obtain part or all of the hospital’s blood supply.

2. Does the hospital obtain all its blood from an independent source? _____

3. Is blood obtained from independent sources secondarily typed and tested? _____

4. Does the hospital offer autologous transfusions _____
If yes, number of autologous transfusions: _____
Is the blood tested? _____
If not, please explain. _____

If not used by the donor, is the blood administered to others? _____

THIS SECTION B. IS APPLICABLE IF THE HOSPITAL OBTAINS BLOOD FROM DONORS.

B. 5. a. Are the donors volunteers? _____
b. Are the donors paid? _____
c. Are the donors only relatives of the patient? _____
d. Are the donors employees? _____
If no to c. and d., describe how donors are obtained: _____

6. Total number of donors: _____

7. What percent of the donors are for directed donations? _____

If the blood is not used by the intended recipient, is it administered to others? _____

8. Does the hospital test all blood donors? Yes No
If not, under what circumstances is the blood not tested? _____

Do you perform your own testing of donors _____

If no, please explain: _____

9. Average number of donors rejected annually. _____

10. Do you pre-screen donors by interview? _____

11. Who pre-screens donors? RN's____, LPN's____,
Nurses Aides____, Laboratory Techs____ or others?
If others, please explain: _____

12. Are risk factors for HIV transmission discussed
verbally by the screener? _____

13. Are risk factors for HIV transmission addressed
on the donor card? _____

THIS SECTION C IS APPLICABLE TO BOTH ITEMS A. AND B. ABOVE.

C. 14. Are blood and blood products stored? _____

If yes, how long is blood stored:

Whole Blood (a) CPDA-1 _____ Days

(b) Adsol _____ Days

Packed Red Blood Cells (a) CPDA-1 _____ Days

(a) Adsol _____ Days

Platelets _____ Days

Fresh Frozen Plasma _____ Days

Cryoprecipitates _____ Days

Please attach a copy of your donor screening card and
information pamphlet.

15. Do you have written policies and procedures
pertaining to all aspects of the blood administration program? _____

16. Date of most recent AABB survey. _____
Please attach copies of last 12 months surveys

17. Date of last FDA survey. _____
Please attach a copy of most recent survey.

18. What is your ALT cut-off? Explain the protocol. _____

III NAMED INSURED - ADDITIONAL INSUREDS

3A. Please describe current corporate structure including parent, subsidiary, and related corporations. Explain the purpose and status (i.e. for profit/not-for-profit and taxable/nontaxable) of each entity. Specify the acquisition date or formation date of each entity.

Please attach a diagram depicting all corporate entities, partnerships and joint ventures reflecting their relationship to each other.

3B. Please state below the Named Insured exactly as it should appear on the policy.

3C. Please list below or attach a list of entities to be included as additional insureds and their interest:

3D. Please list any mortgage, lease holder, landlord, trustee, vendor, underwriter, issuing municipality, or other financial or bonding entity with which Hospital has agreements under which the Hospital must name said entity as an additional insured under its hospital professional or comprehensive general liability coverage:

3E. Please list any contracts or agreements in which the hospital indemnifies or holds harmless another party or otherwise assumes liability for the negligence of others in the delivery or administering of professional healthcare services. Do not include rental agreements, leasehold agreements, side track agreements, etc. If none, so state. _____

IV EMERGENCY SERVICES

4A. Please indicate how your Emergency Department is classified according to the JCAH standards:

____ Level I (Tertiary) ____ Level III (Basic) ____ Other
____ Level II (Comprehensive) ____ (Standby)

4B. Please account below for Emergency Department coverage 24 hours a day, 7 days a week. Specify if physicians are working under contract, staff on rotation, staff on call, etc.

4C. If Emergency Department is staffed by an independent physician contract group, please specify name of group, Professional Liability carrier, limits of liability and whether written on a claims-made or occurrence form.

4D. If Emergency Department is staffed by employed physicians, please indicate number of physicians and full-time equivalents (FTE's).

4E. Please be certain that the insurance information requested in 9B-9D, last 4 columns, is completed for all emergency service physicians.

Yes No

4F. Do any "moonlighting" residents provide services in the Emergency Room?

____ ____

If Yes, please indicate number of residents and full-time equivalents (FTE's)

4G. Do residents have separate insurance coverage?

____ ____

If so, state Professional Liability carrier, limits of liability and whether written on a claims-made or occurrence form.

Yes No

4H. Does the facility regularly handle street trauma?

____ ____

4I. Does the hospital have a contract with anyone to bring patients to the ER? (e.g. ambulance service contract)

____ ____

If Yes, please specify with whom _____

V ANESTHESIA SERVICES

- 5A. Are the hospital's anesthesia services provided by physicians? ___ ___
 If yes, by:
1. Employed ___ ___
 2. Individual staff physicians ___ ___
 3. Independent contract physician group ___ ___

5B. If the anesthesia services are provide by an independent physician contract group, please specify name of group, Professional Liability carrier, limits of liability, and whether on a claims-made or occurrence form.

Please be certain that the insurance information requested in 9A-9D, last 4 columns, is completed for all anesthesiologists.

5C. Do Certified Registered Nurse Anesthetists (CRNA's) provide anesthesia services? ___ ___

5D. Do CRNA's work under the direct supervision of an anesthesiologist? ___ ___
 If no, who is responsible for supervision of CRNA's? _____

VI OBSTETRICAL SERVICES

6A. Is the institution a regional referral center for newborns requiring intensive care? ___ ___

6B. Number of labor rooms: _____
 Number of delivery rooms: _____
 Is the delivery room suite separate from surgical suite? ___ ___
 Can Cesarean sections be performed within 30 minutes at all times? ___ ___
 Is anesthesiologist or CRNA available in-house 24 hours per day for obstetrical suite? ___ ___
 Is obstetrician available in-house 24 hours per day for obstetrical suite? ___ ___

6C. If institution has neonatal intensive care unit (NICU), state:

1. Total number of neonates admitted to NICU in past 12 months: _____
2. Number of neonates admitted to NICU who were delivered at more than 34 weeks gestation: _____
3. Number of neonates admitted to NICU who were transferred from other facilities: _____

	Yes	No
4. Is full-time attending neonatologist on site in NICU 24 hours per day?	___	___

6D. If institution does not have NICU, state:

1. Total number of neonates transferred from institution to other facilities in past 12 months: _____

2. Number of neonates transferred from institution who were delivered at less than 34 weeks gestation: _____

VII RADIOLOGY SERVICES

7A. Describe bio-medical policy and procedures for calibration of radiological equipment and testing for stray radiation.

7B. Has your hospital had any incidents involving the use of x-rays, radioactive medium, and/or radium? If yes, please attach explanation. _____

1. If Department of radiology is staffed by an independent physician contract group, please specify name of group, Professional Liability carrier, and limits of liability, and whether written on a claims-made or occurrence form.

2. If Department of Radiology is staffed by employed physicians, please indicate number of physicians and full-time equivalents (FTE's).

3. Please be sure that the insurance information requested in 9A-9D, last 4 columns, is completed for all Radiology Department physicians.

VIII PATHOLOGY SERVICES

8A. If Pathology Department is staffed by a physician contract group, please specify name of group, Professional Liability carrier, limits of liability, and whether written on a claims-made or occurrence form.

8B. If Pathology Department is staffed by employed physicians, please indicate number of physicians and full-time equivalents (FTE's).

8C. Please be sure that the insurance information requested in 9A-9D, last 4 columns, is completed for all Pathology Department physicians.

2F. Other Health Care Activities - Does the hospital own, operate, manage or have an interest as a shareholder or otherwise engage in the following health care activities, not otherwise identified or disclosed in item 2A-D above? Please complete the following exposure survey:

Activity	Yes	No	*Interest	Exposure	Exposure Basis
Abortion Facilities					# of Procedure
Ambulance Service					# of Runs
Bio-Medical Equipment or Implant Mfg					# Gross Sales
Bio-Medical Equipment Sales, Service or Rental					# Gross Receipts
Birth Center					# of Births
Convalescent/Nursing Home					# of Beds
Dialysis Center					# of Treatments
Facility for the Mentally Impaired					# of Beds
Fertility Clinic					# of Visits
Halfway House					# of Beds
Home for the Aged					# of Beds
Home Health Care					#PR/Hrs of Serv
Hospice					# Visits/Beds
Medical Arts Schools & Colleges					# of Students
Medical Clinic					# of Visits
Medical Equipment or Appliance Manufacturing					Gross Sales
Medical Equipment Sales, Service or Rental					G/S/& Rental Rec
Medical or X-Ray Laboratory					Gross Receipts
Mental Health Clinic					# of Visits
Mental-Psychopathic Institution					# of Beds
Organ Donor Service					# of Donors
Pharmaceutical Manufacturing					Gross Sales
Pharmacy Sales-Retail					Receipts
Pharmacy Sales-Wholesale					Receipts
Rehabilitation Facility					# of Visits/Beds
Research & Development Facility					Receipts
Sheltered Workshop					# of Clients/GS
Social Service Agencies					# of Visits, etc.
Sperm Bank					# of Donors
Substance Abuse Clinic					# of Visits/Doses
Surgical Center					# of Procedures
Urgent Care/Minor Emergency					# of Visits

*INTEREST: Please state whether owned, managed, Joint Venture, or other (describe)

Are the number of visits shown above included with visits reported in 2F? Yes ___ No ___

IX-A MEDICAL STAFF

EMPLOYED PHYSICIANS

1. Group by specialty.
2. List by name or number each physician or surgeon employed by the hospital providing all the information requested.
3. Do not include residents or fellows, contract physicians or staff physicians.

Specialty	(1) FTE	Name	(2) Degree	Admi- ssions	Surg. cases	No of Deliveries	Insured Under Hosp. Program	If No, Limits of Liability Carried	(3) Policy Form	Ins. Organ.	Verified Yes/No

(1) Full-time equivalent
(2) Degree - MD, DO, DDS, DPM, etc.
(3) Policy Form - Type O for occurrence and CM for claims-made

IX-B MEDICAL STAFF

RESIDENT, INTERNS AND FELLOWS

- 1. Group by specialty.
- 2. List by name each resident, intern and fellow providing all of the information requested

(1) Specialty	(2) FTE	Name	(3) Year	(4) Outside	(5) Emergency	Insured Under Hosp. Program	If No, Limits of Liability Carried	(6) Policy Form	Ins. Organ.	Verified Yes/No

- (1) List for all residents and fellows (PGY1-6)
- (2) Full Time Equivalent
- (3) Year of study post-graduate (PGY) - (1) PGY-1 (3) PGY-3 (5) PGY-5
(2) PGY-2 (4) PGY-4 (6) PGY-6
- (4) Answer yes/no whether individual required as part of formal training program to provide services at other health care facilities. Attach additional sheet to explain
- (5) Answer yes/no whether individual required to provide service in the Emergency Department
- (6) Policy form - Type O for occurrence form and CM for claims-made

IX-C MEDICAL STAFF

CONTRACT PHYSICIANS

- 1. Group by specialty.
- 2. List by name or number each physician or surgeon under contract to hospital providing all the information requested
- 3. Do not include residents or fellows, contract physicians or staff physicians.

Specialty	Name	Board Cert.	(1) Degree	(2) Service	Admissions	Limits of Prof. Liability Carried	Ins. Organ.	(3) Policy Form	Verified Yes/No

(1) Degree - MD, DO, DDS, DPM
(2) Service Status - (1) Contract with remuneration
(2) contract without remuneration
(3) Policy Form - Type O for occurrence and CM for claims-made

IX-E OTHER

1. Please complete the following:

	Number	FTE's	Status	Insured Under Hosp. Program?	If No, Limits of Liability	Insuring Organization
CRNA		(1)				
Nurses Midwife		(2)				
Physician Assistant		(2)				
Other(describe)		(2)				

- a.
 - 1. Employed by Hospital
 - 2. Employed by Anesthesiologist
 - 3. Employed by Surgeon
 - 4. Contract (independent)

- b.
 - 1. Employed
 - 2. Contact

	Yes	No
Does Anesthesiology Department credential CRNA's?	___	___
Does Obstetrics Department approve nurse midwives?	___	___

2. Please list below those employed physicians, residents, interns, fellows, CRNA's, nurse midwives, or physician assistants you are requesting to be added as Additional Insureds:

Specialty	#	FTE's

These professional will not be additional insureds unless specifically acknowledge prior to binding

	Yes	No
9F. Does the hospital employ medical school graduates who are not licensed physicians?	___	___
If yes, please explain: _____		
If yes, are these medical school graduates separately insured for malpractice?	___	___
9G. Does the hospital contemplate employing or contracting with any additional physicians during the next 12 months?	___	___
If yes, please explain: _____		
9H. 1. Does the hospital require all members of the medical staff to carry professional liability insurance?	___	___
If yes, what are the limits requirements? _____		
2. Do the limits vary by specialty or physician?	___	___
If yes, provide breakdown: _____		
3. Is proof of professional liability insurance required of all medical staff members?	___	___
What form of proof is required? _____		
Is the hospital administration aware of any member of the medical staff who is uninsured?	___	___
If yes, please provide names, specialty and details: _____		
9I. Is the hospital administration aware of any member of the medical staff insured for less than \$200,000/\$600,000?	___	___
If so, please provide names, specialty and details: _____		
If yes, please be certain the information is entered in items 9A-9D.		
9J. 1. Are there any member(s) of the medical staff with restricted licenses?	___	___
If yes, please explain: _____		
2. Are there any member(s) of the medical staff with restricted privileges?	___	___
If yes, please explain: _____		

X-FINANCIAL DATA

10A. Please complete the following financial summary for the past 5 years.

Fiscal Year (Ending Date)	Revenue from Operations	Profit (Loss) from Operations	Sum of Fund Balances	Medicare	Medicaid	Blue Cross	Other

10B. Please submit copies of hospital's most recent audit financial statements

10C. Total mortgage or bonded indebtedness: \$_____

XI-COVERAGE DATA

11A. Expiring liability insurance coverage: Expiration date:_____ Retro date if claims made:_____

Liability Coverage	Carrier	Limits	Premium	Deductible or Self-Insured Retention	Form
Hospital Professional					() Occurrence () Claims-Made
Comprehensive General					() Occurrence () Claims-Made
Excess/Umbrella					() Occurrence () Claims-Made

11B. Insurer's rating basis for expiring coverage mentioned in item 11A:
 Average census (beds + bassinets)_____ Outpatient visits_____
 (This information can be obtained from expiring carrier.)

11C. What limits of hospital professional and general liability coverage do you seek?_____

11D. Renewal quotations and/or indications received

Liability Coverage	Carrier	Limits	Premium	Self-Insured Retention	Form
Hospital Professional					() Occurrence () Claims-Made
Comprehensive General					() Occurrence () Claims-Made
Excess/Umbrella					() Occurrence () Claims-Made

11E. Insurer's rating basis for renewal coverage mentioned in 11D:
 Average census (beds + bassinets) _____ Outpatients visits _____
 (This information can be obtained from expiring carrier.)

Yes No

11F. Has any insurance company or Lloyd's ever canceled, declined, refused to renew or accepted only on special terms your professional liability or general liability insurance? _____

If yes give details: _____

XII-GENERAL LIABILITY COVERAGE

12A. Please list all premises owned, occupied, or leased by the hospital, any subsidiary thereof, or any other organization controlled by the hospital.

Location	Use	# Sq. Feet	Classification Code *	# Stories	Date Built	Date Improved/ Any Addition	Construction	Sprinkler Total	Partial	None

*What is the purpose of this building, e.g., hospital, nursing wing, private resident, etc. Yes No

12B. Does the applicant store any equipment or supplies in premises owned by others? _____
 Have waivers of subrogation been secured from the lessor and the property insurers thereof? _____
 Describe equipment or supplies that are stored: _____

12C. Is any new construction contemplated? _____

Describe purpose of project, including number of additional beds, if any and projected completion date. _____

Will professional contractor be utilized? _____

XIII-LOSS HISTORY

13A. Please complete summary of losses as indicated below by policy term for the last 10 years. Loss runs from previous carriers showing individual claims showing occurrence date and report date must be submitted with this application.

Policy Term	Total Indemnity	Total Expense	Paid Indemnity	Paid Expense	Reserve Indemnity	Reserve Expense

13B. Losses exceeding \$50,000 - Please copy the attached Serious Case Report and complete a separate form for each loss reserved at \$50,000 or more, or any loss incident involving infants, death, loss of limb, brain damage, paraplegia or quadriplegia. If information has been previously provided, please provide an update on status of claim and any change in reserve or payment.

XIV-INSURED PRIMARY COVERAGES

14A. Workers' Compensation/Employers Liability Coverage

Source of Coverage

___ Primary Commercial Insurance
Insurer: _____
Employers Liability Limits \$ _____ each accident
___ Hospital is a qualified self-insurer
Excess Insurer: _____ Aggregate Excess Limit \$ _____
___ Other (explain): _____

14B. Automobile Liability Coverage

1. Please list below the number of vehicles owned, leased or operated by the hospital. If none in a particular category, so state.

Private Passenger _____ Motor Homes _____ Vans _____
Buses _____ Emergency Ambulances _____ Transfer Ambulances _____
Commercial Trucks: Light _____ Medium _____ Heavy _____

2. Present automobile insurer: _____
Policy # _____ Policy Period _____
Limits of Liability _____ Annual Premium _____

	Yes	No
Primary automobile policy is on a comprehensive form?	___	___
Primary automobile policy includes non-ownership liability?	___	___
Primary automobile policy includes hired car liability?	___	___
Any vehicles leased that are not insured by primary policy?	___	___

3. Have any automobile losses been paid or are any currently reserved for an amount in excess of \$25,000? ___ ___
If yes, please describe loss or losses _____

14C. Aircraft/Helipad Data

Yes No

1. Does the hospital have a heliport or helipad?
If yes, where is the pad located (e. g. parking lot top of building,
etc.)? _____

How far from hospital? _____

Dimensions of pad: _____

Is pad lighted?

Is it FAA approved?

Average number of flights per month: _____

Is a separate helipad liability policy purchased?

2. Insured: _____ Limits: _____
Policy Period: _____
Explain who owns and/or operates helicopters which land at the
hospital helipad.

3. Does any beneficiary or insured own, lease or charter
any aircraft?
If yes, provide description including make, model. number of engines
and passenger capacity _____

4. Does any beneficiary or insured expect purchase, lease,
charter, rent or borrow any aircraft during the next 18 months?
If yes, explain _____

5. Does the hospital own, operate, lease, charter, maintain
or use any watercraft?
If yes, describe all watercraft: _____

XV-RISK MANAGEMENT

Yes No

15A. Does the hospital have a Risk Management Program and Quality Assurance Program in place? _____

If yes, please attach a synopsis of these programs. Please provide the name and telephone number of the person responsible for these programs.

Risk Management _____
Name Telephone

Quality Assurance _____
Name Telephone

15B. Does the hospital settle or coordinate the settlement of professional liability claims? _____

If yes please provide the name of the person responsible for claims handling.

Name Telephone

I hereby declare that the above statements and information provided are true and correct to the best of my ability and that all of said questions have been answered to the fullest extent possible. I understand that any retroactive coverage (prior acts) that may be provided by the Company will not apply to any liability for a claim or circumstances which may result in a claim which were known to the applicant or any insurer prior to the proposed effective date of the policy.

Name of Hospital: _____

By: _____

Title: _____ Date: _____

Attachments to be include with Application:

1. Most recent AHA survey
2. Most recent JCAH accreditation report and any interim reports, and response to contingencies.
3. Copies of management, personnel, or patient care service contracts to other healthcare providers, if applicable.
4. Most recent audited financial statement.
5. Serious case reports for each loss reserve excess of \$50,000 or more.
- 6 Copy of trust funding report and current balance confirmation, if applicable