THE MEDICAL PROTECTIVE COMPANY
HOSPITAL APPLICATION GUIDE

Thank you for choosing The Medical Protective Company for your liability insurance needs. The purpose of this guide is to identify the applications necessary for the insurance coverage(s) that you are requesting a premium quote.

Please find below a list of liability coverages offered by The Medical Protective Company. You may select any of the additional coverage types listed based on your needs. For every coverage selected, please fill out the corresponding application requirement.

BASIC COVERAGE	**APPLICATION REQUIREMENTS**
Every submission must include the **Application for Hospital Professional and/or General Liability** and the **Completed Application Notices and Agreements** signature section.	
□ Corporate/Facility Professional Liability	Hospital Professional Liability Application
□ If Behavioral Health Hospital, please complete Behavioral Health Hospital Professional Liability Supplement	Behavioral Health Hospital Professional Liability Supplement
□ Employed or Contracted Healthcare Providers Professional Liability	Healthcare Providers Application
□ General Liability	General Liability Application
□ Employee Benefits Professional Liability	Optional Coverages Application
□ Employer's Liability	Optional Coverages Application
□ Self-Insured Retention/Captive/Trust/RRG	Self-Insured Retention (SIR) Application

In addition to the applications required for each coverage selected above, a copy of the following information, if applicable, must be submitted:

1. A copy of the applicant's certificate/accreditation including any recommendations made; and JCAHO Report.
2. Financial information. Last two (2) years audited financial statements, and annual reports (if one is published) including auditor's opinion.
3. American Hospital Association annual survey.
4. Medical staff bylaws, and rules and regulations.
5. Loss information for all applicable coverages being requested. Recently valued loss runs from insurance carriers covering the last ten (10) full years, including indemnity payments or full indemnity reserves of $50,000 or more including expenses. All claims must be first dollar/ ground up, and if possible, sent electronically.
6. Copy of your current professional liability insurance policy with endorsements.
7. Declarations page of current general liability, helipad, aircraft, watercraft, auto and employer's liability.
8. Organizational chart, including the names of all entities and a brief description of operations.
9. Catalog or list of durable medical equipment that is manufactured, leased, rented or sold to others.

*Additional information may be required at the underwriters discretion for physicians with prevalent claims history.

Should you have any questions regarding coverage types or the application instructions, please contact your independent agent or a Customer Service Representative at 800-4MEDPRO.

THE MEDICAL PROTECTIVE COMPANY

APPLICATION FOR HOSPITAL PROFESSIONAL AND/OR GENERAL LIABILITY

INFORMATION

(If multiple facilities/locations exist, please complete a separate application for each.)

1. Please print legibly. Policy is based on readability of your brokerage firm/agency name.
2. Please answer all questions. If a question is not applicable, print, "n/a". 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 with a reference to the question or an additional form.

GENERAL INFORMATION

A. Applicant Information

_____

Applicant Name. Where ever "Applicant" or "Named Insured" is used in this application, the term means the entity listed above.

_____ _____

Mailing Address County

_____

Street Address (if different)

_____ _____

Primary Contact Person Name (Officer or Authorized Representative of Applicant) Title

_____-_____-_____ _____-_____-_____ _____

Phone Fax E-mail

_____

Website Address

Person responsible for risk management:

_____ _____

Name Title

_____-_____-_____ _____

Phone Email

Requested effective date: _____ /_____ /_____ 12:01 AM

B. Brokerage Firm/Agency Information

_____

Brokerage Firm/Agency Name

_____

City, State and Zip Code

_____ _____

Broker/Agent Name Broker/Agent License Number and Type

_____-_____-_____ _____-_____-_____ _____

Phone Fax E-mail

C. Are there any plans to build or expand operations during the next 12 months? □ Yes □ No

If Yes, please explain and include the timeframe and estimated cost: _____

_____

D. Is there a full-time risk manager? □ Yes □ No

If No, what are his/her other responsibilities and how much time is devoted to risk management? _____

_____

E. Is there a formal written risk management program? □ Yes □ No

If Yes, has the program been communicated to administrative and medical staff? □ Yes □ No

F. Is there a written incident reporting procedure? □ Yes □ No

1. If Yes, does this procedure require review and appropriate corrective action be taken? □ Yes □ No
2. Is follow-up made to assure compliance? □ Yes □ No

G. Have all known claims, as well as incidents which may give rise to future claims, been reported to past or current insurers? □ Yes □ No

H. Has there been a recent review of such incidents and other potential claims? □ Yes □ No

If Yes, was this review provided to the applicant's current insurer? □ Yes □ No

If Yes, when: _____ By whom? _____

I. Has any company ever cancelled or refused to offer the applicant insurance coverage?

Note: Do **not** answer in the states of Missouri and California. □ Yes □ No

If Yes, please explain: _____

J. Please furnish the following information for all owned or leased property operated or occupied by the applicant.
A separate summary of locations/exposures is acceptable, providing the information outlined below is furnished.

Address of Property to be Insured	Use/Occupancy	Square Footage	Age	Type of Construction	Number of Stories	Fire Protection*
Patient Care Buildings:						
Other Buildings:						

*For each building, indicate if there is a: Sprinkler System—Full, Partial or No sprinkler system; Smoke Detector, Heat Detector; Fire Alarm—Central Station or Local Alarm

K. Do all facilities comply with the National Fire Protection Association (NFPA) 101 Life Safety Code 2000 Edition or newer? □ Yes □ No

If No, please explain: _____

L. Do any of the facilities have a Highly Protected Risk (HPR) designation? □ Yes □ No

If Yes, which ones? _____

M. Please list the entities related to the applicant on the Schedule of Related Entities below for all entities that the applicant is requesting coverage (subsidiaries, joint ventures, LLC's, partnerships, PPO's, HMO's, etc.). If extra space needed, please attach a separate piece of paper.

SCHEDULE OF RELATED ENTITIES

Name of Entity	Description of Operations	Date Acquired, Created or Merged	Indicate your ownership percentage in this entity	Coverage Desired?	Retroactive Date
				□ Yes □ No	
				□ Yes □ No	
				□ Yes □ No	
				□ Yes □ No	

N. Please complete the Schedule of Current Liability Policies and Coverages. For each policy below, please *provide a copy of the declarations page and the loss runs for the last ten years.*

SCHEDULE OF CURRENT LIABILITY POLICIES AND COVERAGES

COVERAGE	CARRIER	POLICY NUMBER	POLICY PERIOD	LIMITS OF LIABILITY (Per Claim or Medical Incident/ Aggregate)	EXPIRING PREMIUM
Professional Liability Facility				$ /$	$
General Liability				$ /$	$
Employer's Liability				$ /$	$
Employee Benefits Professional Liability				$ /$	$
Auto Liability Emergency Vehicle Liability				$ /$	$
Other, Please describe: _____				$ /$	$
Other, Please describe: _____				$ /$	$

HOSPITAL PROFESSIONAL LIABILITY

A. Type of facility: (Check all that apply.)

□ General Hospital	□ Skilled Nursing Facility	□ Governmental	□ For Profit
□ Children's Hospital	□ Substance Abuse Hospital	□ Corporation	□ Not for Profit
□ Critical Access Hospital	□ Surgical Hospital	□ Individual	
□ Senior Living/Long Term Care	□ University Hospital	□ Partnership	
□ Psychiatric Hospital	□ Women's Hospital	□ Joint Venture	
□ Rehabilitation Hospital	□ LTACH		

□ Other _____

B. Please provide the FEIN#(s) _____ **CMS (Medicare) Provider#:** _____

C. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage Coverage is provided on a limited duty and scope basis unless otherwise requested.	**Requested Per Event Limits**	**Requested Aggregate Limits**	**Policy Type**	**Shared Limits**	**Self-Insured Retention (SIR) Amount**
□ **Professional Liability Facility**	$	$	□ Claims-Made Retro-Date: ____	□ Shared Limits	Per Occurrence Indemnity and Defense □ $5,000 □ $10,000 □ $25,000 □ $50,000 □ $100,000 □ $250,000 □ $500,000 □ Other $ _____ Aggregate Indemnity and Defense □ No Aggregate □ 3X Per Occurrence □ 1X Per Occurrence □ 5X Per Occurrence □ 2X Per Occurrence □ Other _____

D. Please indicate the certifications/accreditations held by your facility:

□ JCAHO □ CARF □ NCQA □ HBIP □ Other _____

If JCAHO, is the accreditation: □ Conditional/Provisional* □ Full

**If Conditional/Provisional, attach a copy of the Type 1 Recommendations from the last visit.*

E. Medical School Affiliations:

1. Does the applicant have any formal relationships with a medical school for the purpose of training or educating residents, medical or nursing students, CRNAs or other allied health professionals? □ Yes □ No
   If Yes, please provide the name and location of the school and a description of each program: _____
2. Indicate by program type, how many students are involved:
   Type: _____ Number of Students: _____ Type: _____ Number of Students: _____
   Type: _____ Number of Students: _____ Type: _____ Number of Students: _____
3. Who supervises the students? _____
4. Is the applicant required to provide professional liability coverage for the residents or students as part of their residency or training program? □ Yes □ No

F. What is the applicant's total annual payroll? $_____ **Total annual receipts?** $_____

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

H. Does the applicant provide service to any prison/detention centers on or off hospital premises? □ Yes □ No
If Yes, please explain: _____

SCHEDULE OF PATIENT DATA

I. Schedule of Patient Data: Please complete the Schedule of Patient Data below for the last 5 years, or provide an attachment inclusive of all of the information requested. If none, indicate with a "0."

	Projected this Year	Expiring Year	Prior Year 1	Prior Year 2	Prior Year 3	Prior Year 4	Prior Year 5
Total Number of Births/Deliveries							
Primary C-Section (included in total above)							
VBAC's (included in total above)							
Annual Licensed Bed Totals							
Occupied Beds by Type							
Acute Care							
Bassinets & Cribs							
Neonatal Beds							
Maternity Beds							
Sub-Acute Care Beds							
Long Term Care/Skilled Beds							
Intermediate Care Beds							
Assisted Living Beds							
Residential/Independent Living Beds							
Rehab Beds							
Psychiatric Beds							
Chemical Dependency							
Long Term Acute Care Beds							
All Other Beds, please describe: _____							
Annual Visits Totals							
Hospice Visits							
Emergency Visits							
Clinic Visits (owned/operated by hospital; i.e. Urgi-care, Redi-care, Open to General Public)							
Home Health Visits							
Psychiatric Visits							
Wellness Visits							
Rehab Visits							
Blood Bank Visits							
All Other Outpatient Visits: List by patient encounters, not # of procedures.							
Outpatient Surgeries							
Inpatient Surgeries							
Bariatric Surgeries							

J. Ancillary services provided to <u>NON-patients</u> and <u>NON-owned</u> entities:

	ANNUAL REVENUES LAST 12 MONTHS	ANNUAL REVENUES NEXT 12 MONTHS
Blood Bank		
Durable Medical Equipment *Please provide a brochure, catalog or list of all items available.*		
Manufactured, produced, modified, serviced or assembled		
Leased or Rented to Others		
Sold to Others		
Medical or X-ray Lab		
Retail Pharmacy Services		
Resource Lab		
Wellness/Fitness Center		
Other (describe)		

K. Indicate if the applicant does, or will, conduct or provide any of the following services:

1. Research activities for pharmaceuticals, surgery, biomedical equipment or psychotherapy □ Yes □ No
   If Yes, complete a separate research supplemental questionnaire.
2. Full body scans to non-patients. □ Yes □ No
   If Yes, indicate the number of procedures anticipated for the next 12 months: _____
3. Alternative/complementary medicine. □ Yes □ No
   If Yes, indicate the type of alternative medicine provided: _____

L. Indicate if the applicant currently offers or plans to offer any of the following types of surgery during the next 12 months. For those planned to offer, please describe the types of surgery that will be performed under each category.

□ Abortions #1st Trimester _____ # Other _____
□ Bariatric Type: _____
□ Cardiac Type: _____
□ Cosmetic Type: _____
□ Liposuction Type: _____
□ Neurosurgery Type: _____
□ Opthalmology Type: _____
□ Lasik Type: _____
□ Organ Transplants Type: _____
□ Orthopedic Surgery—Spinal Type: _____
□ Other than spinal Type: _____
□ Sex Change Operations Type: _____
□ Vascular Type: _____
□ Non-FDA Approved Surgery Type: _____

M. Are any changes planned to the services offered by the applicant in the next 12 months? □ Yes □ No
If Yes, please describe. Please include additional services as well as services to be discontinued. _____

_____

N. Have any services been discontinued during the last 24 months? □ Yes □ No

If Yes, please describe. _____

O. 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. _____

P. Medical Staff—Physicians:

1. Indicate the total number of contracted medical staff: _____
2. Indicate the total number of employed staff physicians: _____
3. a. Are credentials for all new staff physicians checked and approved prior to granting privileges? □ Yes □ No
   b. Are privileges probationary for at least 6 months for all new staff physicians? □ Yes □ No
4. Are all staff physicians licensed and privileged without restrictions? □ Yes □ No

   If No, please provide details: _____
5. How often are privileges reviewed? _____
6. Does the applicant perform drug and alcohol testing for all physicians for credentialling and privileging purposes? □ Yes □ No
7. Are each of the physicians practicing at the applicant's facility board-certified? □ Yes □ No

   If No, how many are not board-certified? _____
8. Are all privileges granted to staff physicians in writing? □ Yes □ No
9. a. 1) Are staff physicans required to carry professional liability insurance? □ Yes □ No

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

   b. Are they insured with a carrier rated 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
11. Has the license of any staff physician been restricted, revoked or suspended during the last five years? □ Yes □ No

    If Yes, please explain: _____
12. Have you made reports to the National Practitioner Data Bank regarding any peer review action, suspension or professional liability payment involving any member of the medical/dental staff during the last five years? □ Yes □ No
13. Does the applicant supervise anyone other than its own employees? □ Yes □ No
    If Yes, please describe the responsibility of each individual, relationship to each individual and also indicate by type of medical professional, the number of individuals the applicant supervises:

    _____

Q. Hospitalists/Intensivists Services:

1. Is there a dedicated hospitalist/intensivist at your facility? □ Yes □ No
   If Yes, do they provide: □ House Coverage □ Critical Care Coverage □ Other: _____
2. Are they: □ Employed □ Staff Physicians □ Contracted
3. If Contracted, do they annually provide a certificate of insurance for professional liability? □ Yes □ No
4. What are the minimum professional liability limits that is required for the them to carry?

   $_____ Per Medical Incident / $_____ Annual Aggregate

R. Blood Bank Services:

1. Does the applicant own/operate a blood bank? □ Yes □ No
   If No, skip to Question 7 below.
2. Are services provided only for the hospital's patients? □ Yes □ No
3. Indicate the number of pints acquired annually through: Donations: _____ Purchases: _____
4. Describe the screening procedures for volunteer and paid donors: _____

   _____
5. Do you sell blood/blood products for use in manufacturing vaccines or other products? □ Yes □ No

   If Yes, please describe and provide the estimated annual revenue: _____
6. Do you engage in the manufacturing of any products from blood collected? □ Yes □ No

   If Yes, please describe and provide the estimated annual revenue: _____
7. Does the hospital perform any plasmapheris procedures? □ Yes □ No

   If Yes, please indicate the number of procedures annually: _____
8. If the hospital does not own or operate a blood bank, from what source(s) does it obtain blood or blood products?

   _____

   _____

S. 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. Is there a trauma center? □ Yes □ No
3. Does the emergency department have 24-hour in-house physician coverage? □ 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. If a patient is admitted, who signs the admission papers? □ Emergency Room Physician □ Attending Physician
5. Is the emergency department staffed by a contract group or employees? □ Contract Group □ Employees
   If Employees, skip to Question 10.

   If contract group, what is the name of the Group? _____
   Name of group's insurance carrier: _____
6. Does the group provide a hold harmless agreement in favor of the hospital? □ Yes □ No
7. Do they annually provide the applicant with a certificate of insurance for professional liability? □ Yes □ No
8. What are the minimum professional liability limits that is required for the group to carry?

   $_____ Per Medical Incident / $_____ Annual Aggregate
9. Do the limits apply on an individual or shared limits basis? □ Individual Limits □ Shared Limits
10. Are all emergency department physicians board certified in emergency medicine? □ Yes □ No

    If No, please explain: _____

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

T. Ambulance Services

1. Do you have an ambulance service? □ Yes □ No
   If Yes, what is the number of runs annually? Emergency: _____ Non-Emergency: _____
2. Number of EMT/Paramedics: _____
3. Is the ambulance service provided by a contract group or employees? □ Contract Group □ Employees
   If Employees, skip to next section.

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

   Name of group's insurance carrier: _____
6. Does the group provide a hold harmless agreement in favor of the hospital? □ Yes □ No
7. Do they annually provide the applicant with a certificate of insurance for professional liability? □ Yes □ No
8. What are the minimum professional liability limits that is required for the group to carry?

   $_____ Per Medical Incident / $_____ Annual Aggregate
9. Do the limits apply on an individual or shared limits basis? □ Individual Limits □ Shared Limits

U. 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 Employees, skip to next section.

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

   Name of group's insurance carrier: _____

   Does the group provide a hold harmless agreement in favor of the hospital? □ Yes □ No

   Do they annually provide the applicant with a certificate of insurance for professional liability? □ Yes □ No
   What are the minimum professional liability limits that is required for the Group to carry?

   $_____ Per Medical Incident / $_____ Annual Aggregate

   Do the limits apply on an individual or shared limits basis? □ Individual Limits □ Shared Limits
3. Does the pharmacy use a bar coding system for dispensing medicine? □ Yes □ No
4. Does the pharmacy use a unit-dose system of dispensing medicine? □ Yes □ No
5. Is the pharmacy staffed 24 hours a day? □ Yes □ No
   If No, how are medications obtained when the pharmacy is closed? Please explain: _____

V. Obstetrical Services:

1. Is the hospital 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 hospital is not qualified to treat? □ Yes □ No
2. Do you 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. Is there an obstetrician on site 24 hours a day? □ Yes □ No
   If No, is there an obstetrician on-call 24 hours a day? □ Yes □ No
   If Yes, what is the maximum amount of time for arrival of the on-call physician? _____
   If No, please explain: _____
5. What is the maximum amount of time it takes to perform an emergency cesarean section once it is determined that one is necessary? _____
6. Who provides anesthesia during labor and delivery? _____
7. Does a board certified obstetrician chair the OB department? □ Yes □ No
8. In addition to obstetricians, who else can perform deliveries?
   □ Family Practice Physician □ General Medicine Physician □ Other: _____
   □ Resident (year of residency: _____) □ Nurse Midwife
9. What is the total number of physicians that have OB priveleges? _____
   Of those, how many are board certified/eligible in OB? _____
10. Do nurse midwives practice in labor and delivery? □ Yes □ No
    If Yes, are written protocols for privileges/supervision followed? □ Yes □ No
    How many deliveries are performed by midwives annually? _____
    Do midwives perform high risk deliveries? □ Yes □ No
    How many are employed? _____ How many are contracted? _____
    If employed, do they have their own professional liability insurance? □ Yes □ No
    If contracted, do they provide a hold harmless agreement in favor of the hospital? □ Yes □ No
    What are the minimum professional liability limits that is required for them to carry?
    $_____ Per Medical Incident / $_____ Annual Aggregate
    Do the limits apply on an individual or shared limits basis? □ Individual Limits □ Shared Limits
    Do they annually furnish you a certificate of insurance for professional liabliity? □ Yes □ No
11. Does the applicant have a formal written procedure regarding oxytocins? □ Yes □ No
    Is an attending physician required to supervise the use of oxytocins? □ Yes □ No
12. Do you sponsor any off-site delivery programs? □ Yes □ No
    If Yes, please explain: _____
13. Is electronic fetal monitoring performed on all patients in active labor? □ Yes □ No
    If No, please explain: _____

W. 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? _____
   Name of the contract group's insurance carrier: _____
   Does the contract group furnish a hold harmless agreement in favor of the hospital? □ Yes □ No
   What are the minimum professional liability limits that is required for them to carry?
   $_____ Per Medical Incident / $_____ Annual Aggregate
   Do the limits apply on an individual or shared limits basis? □ Individual Limits □ Shared Limits
   Do they annually furnish you a certificate of insurance for professional liabliity? □ Yes □ No
2. Number of radiologists: _____
   How many are employed? _____ How many are contracted? _____
3. Do you require a radiologist to be on site 24 hours a day? □ Yes □ No
   If No, please explain: _____
2. Are all radiology examinations and reports rendered to and interpreted by a radiologist? □ Yes □ No
   If No, please explain: _____
3. Are all radiologists required to be board certified/eligible in radiology and/or nuclear medicine? □ Yes □ No

4. Do X-ray technicians administer contrast media? □ Yes □ No
   If Yes, are they required to be licensed? □ Yes □ No

X. Anesthesia Services:

1. Number of employed and contracted: Anesthesiologists: _____ CRNA's: _____
2. Are the anesthesiologists required to be board certified/eligible in anesthesiology? □ Yes □ No
3. Does the applicant require certificates of insurance by those performing anesthesia? □ Yes □ No
4. What is the ratio of CRNAs to anesthesiologists? _____
5. Are CRNAs supervised by a physician? □ Yes □ No
6. Is anesthesia administered without the direct supervision of an anesthesiologist? □ Yes □ No

   _____
7. Is an anesthesiologist or CRNA on site 24/7? □ 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? _____
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

Y. Home Health Services:

1. Are home health services provided? □ Yes □ No
2. What are the types and number of visits?
   - □ Skilled
   - □ Intravenous Therapy _____ visits
   - □ Personal _____ visits
   - □ Rehabilitation _____ visits
   - □ Respiratory _____ visits
   - □ All Other _____ visits
   - □ Durable Medical Equipment _____ 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

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

Z. Surgical Services:

1. Is informed consent documented in the medical records? □ Yes □ No
2. Does the informed consent indicate that the patient was advised of the surgical procedure(s) to be done, the possible risks of the procedure(s) and alternative modalities of treatment? □ Yes □ No
3. Are sponge and instrument counts performed and documented in the medical record? □ Yes □ No
4. Can residents perform surgery without an attending physician present? □ Yes □ No

AA. Bariatric Surgery Services:

1. Does the applicant provide bariatric surgery? □ Yes □ No
   If No, are these services planned to be offered this year? □ Yes □ No

If Yes to either of the above questions, please complete the Bariatrics Information.

BB. Please complete details of your medical staff for the forthcoming period of insurance.

Doctors	Employed	Non-Employed	Surgeons	Employed	Non-Employed
Allergy			Abdominal		
Anesthesiology			Cardiac		
Cardiovascular Disease			Colon and rectal		
Chiropractor			Emergency		
Colonoscopy			Gastroenterology		
Dermatology			General		
Diabetes			Gynecologic		
Emergency Medicine			Hand		
Endocrinology			Head and neck		
General Practice			Laryngology		
Gastroenterology			Maxillofacial		
Geriatrics			Neonatology		
Gynecology			Neurosurgical		
Hematology			Obstetrics		
Hospitalist			Orthopedic		
Infectious Disease			Otology		
Intensive Care Medicine			Perinatology		
Laryngology			Plastic		
Lymphangiography			Thoracic		
Neonatology			Transplant		
Nephrology			Traumatic		
Neurology			Urologic		
Nuclear Medicine			Vascular		
Occupational Medicine			**Other Medical Staff**		
Oncology			Acupuncture		
Ophthalmology			Dental		
Otology			Registered Nurses		
Otorhinolaryngology			Nurse Practitioners		
Pediatrics			Nurse Midwives		
Pathology			Pharmacists		
Perinatology			Lab technicians		
Podiatry			Paramedics		
Psychiatry			Complimentary		
Radiology			Physician assistant		
Rhinology			Physiotherapist		
Urology			Surgical assistants		
Unclassified			Other		

Please complete the above table using Full Time Equivalents (FTE).

BARIATRICS

A. When did, or when will, the bariatric program commence? (MM/DD/YYYY) _____

B. Is the applicant an ASBS Bariatric Surgery Center of Excellence? □ Yes □ No

If Yes:

1. Please indicate the date the applicant became accredited: _____
2. Please check the applicable status:
   - □ Approved—Provisional Status
   - □ Denied—Provisional Status
   - □ Monitoring Status
   - □ Pending Status

C. How many bariatric surgeries are being performed annually?

□ 0-20 □ 21-39 □ 40-60 □ Greater than 60

D. Please indicate the types of procedures being offered:

- □ Vertical Banded Gastroplasty (VBG) - Open Procedures Only
- □ Roux-en-Y (RNY) - Open Procedures Only
- □ Biliopancreatic Diversion (BPG) - Open Procedures Only
- □ Laparoscopic Bariatric Procedures
  - □ Laparoscopic Roux-en-Y
  - □ Lap Band (Gastric Banding)
  - □ Other Laporoscopic Bariatric Procedures, Please explain: _____

_____

_____

- □ Other Bariatric Procedures, Please explain: _____

_____

_____

E. List the number of surgeries that resulted in complications: _____

Include a brief summary of the complications and the type of procedure performed:

_____

_____

_____

F. Who is responsible for determining patient eligibility? □ Facility Staff □ Physician

G. Who is responsible for the follow-up program with the patient? □ Facility Staff □ Physician

Continue to Question L if you checked Yes to ASBS Center of Excellence and Approved Status above.

By separate attachment, please include a detailed description of your bariatric guidelines, the informed consent, policies and procedures including the documentation procedure, patient pre-screening selection process, and post-surgery follow-up. Also include a list of other medical professionals involved and their roles.

H. Please describe the training obtained by the facility staff members involved in the bariatric care:

_____

_____

_____

_____

_____

I. Check the performance criteria monitored:

1. **Adverse Outcomes** □ Yes □ No
2. **Complications** □ Yes □ No
3. **LOS** □ Yes □ No
4. **Benchmarking Data** □ Yes □ No

J. Is the equipment (toilets, OR table, wheelchairs, beds, lifts, etc.) rated for the bariatric patient? □ Yes □ No

K. Does the post operative monitoring includes continuous pulse oximetry with centralized monitoring or alarm to nurse's pager? □ Yes □ No

L. List the physicians who are performing the bariatric surgery as well as the carrier providing their liability coverage:

Physicians	Carrier	Bariatric procedures included on this policy?
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No

*Please answer all of the following questions for the **physicians** performing these procedures:*

1. Are the physicians members of the American Society of Bariatric Surgery? □ Yes □ No

2. Do the physicians have full hospital privileges for general and gastrointestinal surgery, including bariatric procedures? □ Yes □ No

If Yes, please list OTHER facilities where these physicians will be performing bariatric procedures: _____

_____

3. How many years (on average) have the physicians been performing bariatric surgery (on an individual basis)? Check one:
□ Less than 5 years □ 5-10 □ More than 10 years

4. During the previous five (5) years, what is the average number of bariatric surgeries these physicians have performed per year on an individual basis?
□ 0-20 □ 21-39 □ 40-60 □ Greater than 60

5. How many bariatric surgeries does each bariatric surgeon (per surgeon) plan to perform during the next 12 months?
□ 0-20 □ 21-39 □ 40-60 □ Greater than 60

HEALTHCARE PROVIDERS

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event Limits	Requested Aggregate Limits	Policy Type	Shared Limits
□ **Professional Liability Employed or Contracted Healthcare Providers** (CRNAs, Nurse Midwives, CRNPs, Physician Assistants and Surgical Assistants)	$	$	□ Claims-Made Retro-Date: ____	□ Shared Limits

B. When hiring allied professionals, are credentials checked and verified? □ Yes □ No

If No, please explain: _____

C. Medical Staff Mid-Level Providers

1. a. Are credentials for all new staff providers verified and approved prior to granting privileges? □ Yes □ No
   b. Are privileges probationary for at least 6 months for all new staff providers? □ Yes □ No
   c. Does an identical credentialing and privileging process apply to:
      1) mid-level providers (i.e. CRNA's, Certified Nurse Midwives, Physician Assistants, etc.)? □ Yes □ No
      2) physicans' employees on premises (private scrubs, first assistants, nurse practitioners, etc.)? □ Yes □ No
   d. Are physicans' employees working on the premises required to meet the identical standards of employed staff (i.e. education, training, licensure, certification, etc.)? □ Yes □ No
2. Are all staff members licensed and privileged without restrictions? □ Yes □ No

   If No, please provide details: _____
3. How often are privileges reviewed? _____
4. Are all privileges granted to mid-level providers in writing? □ Yes □ No
5. Are mid-level providers required to carry professional liability insurance? □ Yes □ No
   a. If Yes, what are the liability limits? $_____ Per Event / $_____ Annual Aggregate
   b. Are they insured with a carrier rated less than A– by AM Best? □ Yes □ No
      If Yes, please explain: _____

D. Schedule of Medical Professionals—CRNAs, CRNPs, Nurse Midwives, Physician Assistants and Surgical Assistants

Please provide the information below for each CRNA's, CRNPs, Nurse Midwives, Physician Assistants and Surgical Assistants 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. Coverage is designed to provide retroactive dates equal to the start date with the applicant unless otherwise requested.

Employee Status: (C)ontract; (E)mployed
Full Time Equivalency (FTE): Calculate (FTE) by dividing the total number of hours of professional service per week by 40 hours.
Limits: (SH) Shared limits with the facility, restricted to the named insured's operations.

SCHEDULE OF MEDICAL PROFESSIONALS—CRNAs, CRNPs, NURSE MIDWIVES, PHYSICIAN ASSISTANTS & SURGICAL ASSISTANTS

Name of Medical Professional	Status: (C) (E)	State	County	Indicate: CRNA, CRNP, Nurse Midwife, Physician Assistant, Surgical Assistant	If a CRNP or a Physician Assistant, does the individual prescribe medication?	Retro date*	Hire Date	FTE's	License Number
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				
					☐ Yes ☐ No				

SCHEDULE OF TERMINATED-INACTIVE HEALTHCARE PROVIDERS

E. If coverage is sought for inactive healthcare providers who are sharing limits or who have been previously provided ongoing incurred but not reported coverage, please complete the Schedule of Terminated-Inactive Healthcare Providers below. If coverage for inactive healthcare providers is not being requested, skip to the next question. Coverage is provided on a shared limit basis unless otherwise requested. If additional space is needed, use an additional piece of paper.

Name of Medical Professional Last Name, First Name, Middle Name	State	County	License Number	Retro Date	Hire Date	Termination Date

GENERAL LIABILITY

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event / Medical Incident or Per Occurrence Limits	Requested Aggregate Limits	Policy Type	Shared Limits	Self-Insured Retention (SIR) Amount
□ **General Liability****	$	$	□ Occurrence □ Claims-Made Retro-Date: _____	□ Shared Limits	Per Occurrence Indemnity and Defense □ $5,000 □ $10,000 □ $25,000 □ $50,000 □ $100,000 □ $250,000 □ $500,000 □ Other $ _____ Aggregate Indemnity and Defense □ No Aggregate □ 3X Per Occurrence □ 1X Per Occurrence □ 5X Per Occurrence □ 2X Per Occurrence □ Other _____

** Fire and water damage liability is automatically provided at a $50,000 limit. If higher limits are desired, please contact your agent.

B. Please indicate below which of the following apply and specify the corresponding projected number or amount of receipts for the next 12 months.

1. □ Child Daycare Center □ Adult Daycare Center □ None

a) Number of Children/Adults per week: _____ Children _____ Adults

b) Are references checked prior to hiring on all employees and on all volunteers? □ Yes □ No

c) Are these services offered to: □ Employees Only □ Open to the Public

d) What is the staff to participant ratio? _____ Staff _____ Children/Adults Participants

2. Habitational Risk: □ Apartment □ Dwelling □ Hotel □ None □ Other, please describe: _____

a) Number of Units: _____ Units Year Built: _____

b) Are there at least two exits located remotely from each other? □ Yes □ No

c) For apartment buildings and hotels, are there lighted emergency exit signs? □ Yes □ No

3. Restaurant: □ Yes □ No Receipts/Year: $_____

a) Is the restaurant staff contracted or employed? □ Contracted □ Employed

b) If contracted, do you require them to carry a general liability (GL) insurance policy with a limit of $1,000,000 per occurrence? □ Yes □ No

c) Are certificates of insurance obtained annually to verify coverage is in place? □ Yes □ No

d) Is the hospital added as an additional insured on their GL policy? □ Yes □ No

e) Does the restaurant comply with all state and local codes and regulations? □ Yes □ No

If No, please explain: _____

f) 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.

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

Describe planned events for the upcoming year and indicate if alcohol will be served: _____

_____

5. Swimming Pool: □ Yes □ No How deep is the pool? _____

a) Is it open to the public? □ Yes □ No If Yes, Receipts/Year: $_____

b) Is there a diving board? □ Yes □ No If Yes, is there a lifeguard on duty at all times? □ Yes □ No

C. Is there a heliport/helipad on the premises? □ Yes □ No

1. If Yes, is it FAA approved? □ Yes □ No
2. What is the estimated number of landings per year? □ 0-365 □ 366-1000 □ 1001—Up
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
   Please provide a copy of the Declarations and Loss Runs.

D. 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
   Please provide a copy of the Certificate of Insurance.

E. Do you lease space to others? □ Yes □ No

1. If Yes, indicate the address, square footage and the occupancy/use of the space. _____

   _____
2. Does the lease require the tenant to carry a general liability (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

F. Is there an employee or contract security service? □ Yes □ No

If Yes, do they carry guns? □ Yes □ No

G. Are the management services of your facility provided by a management company? □ Yes □ No

1. If Yes, please provide the name and address of the hospital management company and indicate the operational positions provided:

   _____

   _____
2. If contracted, do you require them to carry a general liability (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

H. Environmental Exposures:

1. Is there a hazardous waste management/environmental safety program? □ Yes □ No
2. Is there a program in place for monitoring the facility's environmental exposures on an ongoing basis? □ Yes □ No
   Submit the following items:
   A) Copies of any governmental sanctions or citations.
   B) Documentation of any voluntary cleanup from releases or spills (over $50,000) whether or not reported to your insurance carrier.
3. Do you have written spill prevention and spill control programs in place? □ Yes □ No

OPTIONAL COVERAGES SUPPLEMENTAL APPLICATION

A. Please indicate the coverages, limits and deductibles desired on the chart below.

COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event Limits	Requested Aggregate Limits	Policy Type	Shared Limits	Self-Insured Retention (SIR) Amount
□ **Employer's Liability**	$	$	□ Occurrence ONLY	□ Shared Limits	Per Occurrence Indemnity and Defense □ $5,000 □ $10,000 □ $25,000 □ $50,000 □ $100,000 □ $250,000 □ $500,000 □ Other $ _____ Aggregate Indemnity and Defense □ No Aggregate □ 3X Per Occurrence □ 1X Per Occurrence □ 5X Per Occurrence □ 2X Per Occurrence □ Other _____

EMPLOYEE BENEFITS LIABILITY □ Coverage Requested □ Coverage Not Requested

A. Is liability for the applicant's employee benefits program self-insured? □ Yes □ No
If Yes, please describe: _____

B. Is the applicant's employee benefits program self-administered? □ Yes □ No
If Yes, please describe: _____

C. Total number of employees:
□ 0-499 □ 500-699 □ 701-999 □ 1,000-1,499 □ 1,500-2,999 □ 3,000+

EMPLOYER'S LIABILITY □ Coverage Requested □ Coverage Not Requested

A. Are any of the applicant's facilities in a monopolistic state and require primary employer's liability coverage? □ Yes □ No

B. Is the applicant subject to: □ Jones Act □ FELA □ Stop Gap □ Other: _____

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

MEDICAL PAYMENTS □ Coverage Requested □ Coverage Not Requested

If requested, please identify the Per Person Limit:
□ $1,000 Per Person Limit □ $5,000 Per Person Limit
□ $2,500 Per Person Limit □ $10,000 Per Person Limit

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

HIRED AND NON-OWNED AUTO LIABILITY COVERAGE □ Coverage Requested □ Coverage Not Requested

If provided, the limits and deductible will the same as, and this coverage will share the limits and deductible of, the Commercial General Liability, Coverage A.

A. Does the applicant maintain a commercial auto policy for owned autos? □ Yes □ No
If Yes, is hired and non-owned auto liability coverage available under that policy? □ Yes □ No

B. 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: _____

C. 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: _____

D. Does the applicant check Motor Vehicle Records on the employees and volunteers? □ Yes □ No

E. How many active employees and volunteers work for the applicant's business?
□ 0-150 □ 151-1,000 □ 1,001-2,500 □ 2,501+

F. Does the facility use hired and non-owned autos to transport patients? □ Yes □ No

G. 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? _____

H. Has the applicant had any hired or non-owned auto claims? □ Yes □ No
If Yes, please provide complete loss runs.

SELF-INSURED RETENTION (SIR) APPLICATION

Note: The SIR will be outside the Limits of Liability and it will apply to loss and claims expense.

A. Please indicate any applicable retention by checking the box(es) below:

□ Self-Insured Retention □ Captive

□ Trust □ Risk Retention Group (RRG)

B. Is there a dedicated trust? □ Yes □ No

C. Has an independent actuarial funding study been completed? □ Yes □ No

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

E. Is the applicant interested in utilizing The Medical Protective Company for handling claims within the retention? □ Yes □ No

F. What law firm is utilized for claims? _____

G. If a TPA is being utilized, please provide the contact information below:

_____
Third Party Administrator

_____
Mailing Address

_____ _____
Primary Contact Person Name Title

_____-_____-_____ _____-_____-_____ _____
Phone Fax E-mail

ATTACHMENTS

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

1. Most recent **actuarial funding study**.
2. **Trust agreement** for the Self-insured Retention or policy form(s) for Captive or RRG.
3. **Claims handling policy and procedure manual**.
4. **Trust fund or Captive/RRG financials**.

COMPLETED APPLICATION NOTICES AND AGREEMENTS

Please read the following information carefully and return fully executed with the completed application.

IMPORTANT NOTICE

THIS INSURANCE MAY CONTAIN CLAIMS-MADE 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. PLEASE READ AND REVIEW THE POLICY CAREFULLY.

FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:
ANY PERSON WHO KNOWINGLY AND WITH THE INTENTION OF DEFRAUDING PRESENTS FALSE INFORMATION IN AN INSURANCE APPLICATION, OR PRESENTS, HELPS, OR CAUSES THE PRESENTATION OF A FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS OR ANY OTHER BENEFIT, OR PRESENTS MORE THAN ONE CLAIM FOR THE SAME DAMAGE OR LOSS, SHALL INCUR A FELONY AND, UPON CONVICTION, SHALL BE SANCTIONED FOR EACH VIOLATION BY A FINE OF NOT LESS THAN FIVE THOUSAND DOLLARS ($5,000) AND NOT MORE THAN TEN THOUSAND DOLLARS ($10,000), OR A FIXED TERM OF IMPRISONMENT FOR THREE (3) YEARS, OR BOTH PENALTIES. SHOULD AGGRAVATING CIRCUMSTANCES [BE] PRESENT, THE PENALTY THUS ESTABLISHED MAY BE INCREASED TO A MAXIMUM OF FIVE (5) YEARS, IF EXTENUATING CIRCUMSTANCES ARE PRESENT, IT MAY BE REDUCED TO A MINIMUM OF TWO (2) YEARS.

Initial Here

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 his, her 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.

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 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 form 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 a 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

SUPPLEMENTAL INFORMATION