Physicians Insurance
A MUTUAL COMPANY

COMMUNITY HEALTH CENTERS (CHC) APPLICATION FOR PROFESSIONAL & GENERAL LIABILITY INSURANCE CLAIMS - MADE

Broker Name: _____

PART I – GENERAL APPLICANT INFORMATION

Name of Center: _____

D/B/A name: _____

Mailing address: _____

Business address: _____

Billing address (if different): _____

Tax ID #: _____ Phone: _____ Fax number: _____

Website: _____

Contact person (name and title): _____

Phone: _____ E-mail address: _____

PART II – COVERAGE INFORMATION

Requested effective date: _____ Expiration date: _____ Retroactive date: _____

Coverages		**Limits of Liability**		
Professional Liability:	_____	Each Medical Incident:	_____	Annual Aggregate
General Liability:	_____	Each Incident:	_____	Annual Aggregate
Employee Benefits Liability:	_____	Each Claim:	_____	Annual Aggregate
Excess Limits desired:	_____	Each Claim:	_____	Annual Aggregate
Directors & Officers Liability:	_____	Each Claim:	_____	Annual Aggregate
Employment Practices Liability:	_____	Each Claim:	_____	Annual Aggregate

Deductible options are available; refer to Company.

PART III – FEDERAL TORT CLAIMS ACT DEEMED FACILITY

When did the CHC first obtain deemed status? _____

Have there been any changes in the CHC's FTCA deemed status since first becoming deemed facility? ☐ Yes ☐ No

If *Yes,* please explain: _____

What is the percentage of the CHC's overall expenses covered by Federal grants? _____

Are there specific criteria patients need to meet in order to qualify for services at the CHC? ☐ Yes ☐ No

If *Yes,* please explain: _____

PART IV – PROFESSIONAL LIABILITY INFORMATION

Will any new services or locations be added in the next 12 months? ☐ Yes ☐ No

If *Yes*, please list: _____

Does the CHC have any teaching affiliations? Or is it a teaching center? ☐ Yes ☐ No

Professional Liability Exposures: (Anticipated number for the next 12 months)

Primary Care visits: _____ Dental visits: _____

Mid-Level visits: _____ Nurse (WIC, geriatric, diet): _____

Normal Deliveries: _____ Mental Health visits: _____

C-Section Deliveries: _____ Home Health Care visits: _____

Substance Abuse Treatment: _____ Methadone Treatment: _____ Number of doses: _____

*Other Outpatient: _____

*To include all other outpatient visits other than emergency room, home health, rehabilitation / therapy (e.g., medical clinics, urgent care, psychiatric, blood bank, etc.)

*For Diagnostic Testing, Radiology (CT, MRI, etc.), and Laboratory tests, list by patient encounters, not number of procedures (to avoid double-counting).

Does you facility have Acute Care beds? ☐ Yes ☐ No If Yes, indicate the number of beds: _____

Does your facility have Extended Care beds? ☐ Yes ☐ No If *Yes*, indicate the number of beds: _____

Type of care provided: Skilled Care: # of Occupied Beds: _____ Intermediate Care: # of Occupied Beds: _____

Residential Care: # of Occupied Beds: _____ Assisted Living: # of Occupied Beds: _____

Does your facility perform bariatric procedures? ☐ Yes ☐ No If *Yes,* number of procedures: _____

Please provide copies of the complete program, including Patient Selection, Pre-Op/Post-Op Care and Consent forms used.

Dental Services:

Please indicate what types of anesthesia/analgesia are used in the treatment of your patients:

	Administered by your staff		Administered by others	
	Use	Do Not Use	Use	Do Not Use
Local anesthesia or none:	☐	☐	☐	☐
Inhalation analgesia (N2O):	☐	☐	☐	☐
Intravenous/Intramuscular conscious sedation:	☐	☐	☐	☐
General anesthesia:	☐	☐	☐	☐

Where do you administer general anesthesia? ☐ Health Center ☐ Hospital

If in a health center, is there someone with an ACLS and/or PALS Certification present? ☐ Yes ☐ No

Emergency Room:

Do any of your physicians provide regular coverage at a hospital Emergency Room? ☐ Yes ☐ No

If *Yes,* does the hospital provide the professional liability coverage for your physicians when they work in the Emergency Room? ☐ Yes ☐ No

Explain: _____

If *No*, please attach a list of providers indicating the Emergency Room location and the hours they work.

PART V – GENERAL LIABILITY INFORMATION

Is the CHC currently undergoing construction or renovation? ☐ Yes ☐ No

If *Yes*, please list: _____

Is the CHC planning construction or renovation? ☐ Yes ☐ No

If *Yes*, please list: _____

Facility Building Schedule: List all buildings you own, control, or occupy (use separate sheet if necessary).

Facility name: _____ Use: _____

Address: _____ Total square feet: _____

Is there a fire alarm? ☐ Yes ☐ No Are buildings sprinkled? ☐ Yes ☐ No Are there smoke detectors? ☐ Yes ☐ No

Facility name: _____ Use: _____

Address: _____ Total square feet: _____

Is there a fire alarm? ☐ Yes ☐ No Are buildings sprinkled? ☐ Yes ☐ No Are there smoke detectors? ☐ Yes ☐ No

Facility name: _____ Use: _____

Address: _____ Total square feet: _____

Is there a fire alarm? ☐ Yes ☐ No Are buildings sprinkled? ☐ Yes ☐ No Are there smoke detectors? ☐ Yes ☐ No

Are there any underground storage tanks on the premises? ☐ Yes ☐ No

If *Yes*, please provide the name of the insurance carrier: _____

Non-owned automobiles: (Vehicles owned by employees who regularly drive to perform their job.)

Total number of non-owned automobiles: _____

Do you verify that employees/independent contractors/volunteers who use their own vehicles on behalf of your business have personal auto liability policy? ☐ Yes ☐ No

If *Yes*, what are the minimum limits required? $ _____

PART VI – EMPLOYEE BENEFITS LIABILITY

Total number of employees covered by employee benefit plans: _____

PART VII – DIRECTORS AND OFFICERS, IF APPLICABLE

Total number of board members of the primary facility: _____

Total Assets: $ _____

Are limits to be shared with Employment Practices Liability? ☐ Yes ☐ No

PART VIII – EMPLOYMENT PRACTICES LIABILITY, IF APPLICABLE

Total number of full-time employees (excluding partners of a partnership): _____ Total number of part-time employees: _____

Percentage of employees that are union: _____ How many employees have been terminated in the past 12 months? _____

Voluntary: _____ Involuntary: _____ Laid off: _____

Total number of volunteers: _____ Do you conduct background checks on volunteers? ☐ Yes ☐ No

PART IX – STAFF INFORMATION
(PLEASE SCHEDULE ALL PHYSICIANS, MID-LEVEL PROVIDERS, AND DENTISTS BELOW.)

Community Health Center Employees by Specialty:

	Full-Time	Part-Time	FTE (Full-Time Equivalency= Billable Hours ÷ 40 hours per week)
Nurses (RN & LPN):			
Dentists:			
LICSW/LMHC:			
EFDA:			
Nurse Practitioners:			
Physician Assistants:			
Midwives (CNM):			
Other:			

Please provide a list of all Employed, Contract, and Resident Physicians, Mid-Level Providers (ARNP, PA-C, CNM, Perfusionists) and Dentists for whom the Named Insured is responsible for providing professional liability insurance.

*Surgery Definitions: NS = No Surgery (minor procedures common in Family Practice such as suturing of skin).
MS = Minor Surgery (minimally invasive surgery, or assists in major surgery on their own patients).
MA = Major Surgery (invasive operations in or upon any body cavity, or assists in surgery on other's patients).

PART X – SEXUAL MISCONDUCT

Do you have a written Sexual Harassment/Misconduct policy? ☐ Yes ☐ No

If *Yes*, please attach.

Do you have a formal orientation program that is required for all new employees/volunteers? ☐ Yes ☐ No

Is a copy of the Sexual Harassment policy provided to all current and new employees/volunteers? ☐ Yes ☐ No

Do you require criminal background checks on all new employees/volunteers? ☐ Yes ☐ No

Do you have written policies and procedures for handling allegations of sexual misconduct? ☐ Yes ☐ No

Have any Sexual Misconduct claims been made against the facility or its employees? ☐ Yes ☐ No

Are you aware of any circumstances that might reasonably lead to a claim or suit being brought against the facility or any employees even if you believe the claim or suit would be without merit? ☐ Yes ☐ No

If *Yes*, please list:

Do you have Sexual Harassment/Misconduct prevention policies, procedures and protocols in place? (e.g. Is there a chaperone present in the room at all times for sensitive patient exams?) ☐ Yes ☐ No

PART XI – CLAIMS HISTORY

Are there any circumstances known to your organization which may give rise to a claim or lawsuit? ☐ Yes ☐ No

(Include Professional Liability, Management Liability, Employment Practices Liability, etc.)

If *Yes*, give details:

Date of Loss	Date Reported	Amount Paid	Status	Claimant name and/or Incident description (Attach separate sheet, if necessary.)

Please note that your POLICY will not cover, nor will the COMPANY be liable for, CLAIMS based upon, arising from, or in consequence of any EVENT, if written notice of, or constructive notice of, such EVENT has previously been given to another insurer that covers CLAIMS under any coverage section of which this AGREEMENT is a replacement, or if the INSURED has constructive notice of such an EVENT and fails to disclose the EVENT to the COMPANY.

PART XII - REMARKS

THE FOLLOWING DOCUMENTS ARE REQUIRED TO BE SUBMITTED WITH THIS RENEWAL APPLICATION:

1. FTCA Deeming Letter
2. Current Declarations Page
3. Loss History with a valuation date within the past ninety days, with details of losses
4. Verified Schedule of Providers
5. Most recent audited Financial Report
6. Current list of Subsidiaries

APPLICANT'S REPRESENTATION (READ CAREFULLY)

I hereby represent that the information contained in this application and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance in considering this application have been omitted. I agree that this shall be the basis of the locum tenens coverage provided to me and that I will notify Physicians Insurance of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (READ CAREFULLY)

I acknowledge that as a condition precedent to acceptance of this application, an inquiry and investigation of my professional background, qualification and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, any prior insurance carriers, prior employers or professional associates and Physicians Insurance or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance, its duly authorized representatives and the members or consultant of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives.

Signature of Applicant (Administrator or Clinical Director) **Date**

Print Full Name

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Oregon State law requires us to inform you of the following: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Idaho State law requires us to inform you of the following: Any person who knowingly, with the intent to defraud or deceive an insurer, presents a false or fraudulent claim for payment of a loss or benefit is guilty of a felony.

Wyoming State law requires us to inform you of the following: Any person who knowingly or willfully makes any false or fraudulent statement or representation in any application for insurance for the purpose of obtaining any money or benefit or presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Alaska State law requires us to inform you of the following: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

I understand that signature of this application does not bind the company to complete this insurance.
(A photocopy or facsimile of this Authorization shall be considered as effective and valid as the original.)

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