Physicians Insurance
A MUTUAL COMPANY

HOSPITAL PROFESSIONAL LIABILITY APPLICATION

I – GENERAL INFORMATION

Hospital name: ______________________________

D/B/A name: ______________________________

Mailing address: ______________________________

Additional locations: ______________________________

____

Web site address: ______________________________

Effective date: ______________ Tax ID #: ______________

Contact person:

Name: ______________ Title: ______________

Phone: ______________ E-mail: ______________

Coverage	Per Claim or Incident	Aggregate
Professional Liability	$	$
General Liability	$	$
Employee Benefits Liability	$	$
Excess Liability, If Applicable	$	$
Directors & Officers Liability, If Applicable	$	$
Employment Practices Liability, If Applicable	$	$

Deductible Options: Available upon Request

Requested retroactive dates

Professional Liability ______________

General Liability ______________

Employee Benefits Liability ______________

Excess Liability, If Applicable ______________

Directors & Officers Liability, If Applicable ______________

Employment Practices Liability, If Applicable ______________

II – PROFESSIONAL LIABILITY INFORMATION

Type of facility (check all that apply):

Acute care hospital
Rehabilitation hospital
Long-term care facility (Nursing home, extended care, assisted living)
Critical access hospital

Specialty hospital: ______________________________

Other (please specify): ______________________________

____

Ownership:

Individual
Partnership
Joint venture
Corporation
LLC

Category:

Government
For Profit
Not-for-Profit

Affiliations:

Does the hospital have any teaching affiliations?	Yes	No
Is the hospital a teaching and/or research center?	Yes	No
Does the hospital have any revenue affiliations (e.g., joint ventures, PPOs, HMOs)?	Yes	No

If *Yes*, percentage you own: ______________________________

With whom do you have the affiliation? ______________________________

Please check any and all of the following services that your facility provides:

Abortion
Ambulance
Blood bank
Burn unit
Cardiac catherization
CCU
Dialysis
Fertility clinic
Genetic testing
Home health care
Hospice
Hyperbaric treatment
ICU
NICU
Neurosurgery
Reference laboratory

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

If *Yes*, please provide details.

Will any services or locations be discontinued in the next 12 months? Yes No

If *Yes*, please provide details.

Have any services or locations been discontinued in the past 24 months? Yes No

If *Yes*, please provide details.

III – PROFESSIONAL LIABILITY EXPOSURES

Provide annual exposures for the upcoming policy year and for the past 10 years starting with the current policy year.

Inpatient Beds: (Average Occupied)	**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**
Acute Care:											
Cribs / Bassinets:											
Chemical Dependency:											
Health / Rehabilitation:											
Mental / Psychiatric:											

Extended Care: (Average Occupied)	**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**
Skilled:											
Intermediate:											
Residential:											
Independent / Assisted Living:											
Other:											

Outpatient visits:	**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**
Emergency Room:											
Home Health Care:											
Rehabilitation / Therapy:											
*Other Outpatient:											

** To include all other outpatient visits except 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).*

Procedures:	**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**
Total deliveries:											
Cesarean sections:											
Vaginal births after cesarean section (VBACs):											
Inpatient surgeries:											
Outpatient surgeries:											

Bariatric procedures											
Observation hours											

Employed Physicians, Contracted Physicians, and other Professional Employees:

*Employed physicians:											
*Contracted physicians:											

**Employed Physicians or Residents: Please attach a roster that lists each employed physician or resident, including medical specialty, whether the physician performs deliveries (if so, number of vaginal deliveries, cesarean sections, VBACs), major or minor surgery, and their retroactive date.*

**Contracted Physicians or Residents: Please attach a roster that lists each contracted physician or resident with whom the hospital has agreed to provide coverage, including medical specialty, whether the physician performs deliveries (if so, number of vaginal deliveries, cesarean sections, VBACs), major or minor surgery, and their retroactive date.*

	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**
Dentists:											
CRNAs:											
Nurse Midwives:											
Nurse Practitioners:											
Physician Assistants:											
Podiatrists:											
Pharmacists:											
Paramedics/EMTs:											
Registered Nurses:											
LPNs:											
X-Ray Technicians:											
Lab Technicians:											
Other professional employees:											
All other employees:											

Are employed physicians to:

Share in the hospital policy's PL limits of liability? Yes No

Have their own individual PL limits of (liability through a separate policy)? Yes No

IV – ANESTHESIA N/A

Is anesthesia provided by (check all that apply):

Contracted CRNAs Employed CRNAs Staff physicians

Contracted group physicians Employed physicians

If contracted CRNAs or group physicians:

What is the group's name? ______________________________

What are the minimum required PL limits? **Each Claim** **Aggregate**

____________________ ____________________

Are certificates of insurance required? Yes No

Are all anesthesiologists required to be Board Certified or Board Eligible in anesthesiology? Yes No

Are CRNAs supervised by a physician? Yes No

What is the ratio of CRNAs to anesthesiologists? ________________

Is an anesthesiologist or CRNA on-site 24 hours per day? Yes No

Does any of the anesthesia services staff routinely work more than a 12-hour shift? Yes No

If *Yes*, please explain:

____

Is a separate anesthesia consent form used? Yes No

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

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

V – EMERGENCY DEPARTMENT N/A

Trauma level as designated by the Department of Health:

Level I Level II Level III

Level IV Level V

Is the ED staffed by (check all that apply):

Contracted group physicians Employed physicians Staff physicians

Mid-Level providers, If used, please explain below:

____

If contracted group physicians:

What is the group's name? ____

What are the minimum required PL limits? **Each Claim** **Aggregate**

____________________ ____________________

Are certificates of insurance required? Yes No

Are all ED physicians required to be Board Certified or Board Eligible in emergency medicine? Yes No

If *No*, list required credentials (e.g., ACLS, PALS):

____

Question	Yes	No
Are all ED support personnel ACLS/PALS certified?	Yes	No
Is the ED staffed 24 hours per day?	Yes	No
Does any of the ED staff routinely work more than a 12-hour shift?	Yes	No

If *Yes*, please explain:

Question	Yes	No
Are all patients examined by a physician prior to discharge?	Yes	No

If *No*, please explain:

Is the emergency room equipped with the following:

Item	Yes	No
Emergency resuscitation care equipped with a defibrillator?	Yes	No
Electrocardiograph machine?	Yes	No
Dedicated triage area and staff?	Yes	No
Dedicated trauma room(s)?	Yes	No

VI – PHARMACY

N/A

Question	Yes	No
Do providers use computerized physician order entry (CPOE)?	Yes	No
Does the pharmacy utilize the unit dose system of dispensing medicine?	Yes	No

If *No*, please explain:

Question	Yes	No
Do all unit dose packaging have barcodes?	Yes	No

If *No*, please explain:

Question	Yes	No
Does the pharmacy system include flags, alerts, or warnings for allergies, drug interactions, and dosing parameters?	Yes	No

List current patient safety quality initiatives involving reduction of medication errors:

Question	Yes	No
Is the pharmacy for patient use only?	Yes	No

If *No*, annual receipts for non-patient medications are: ______________________

VII – OBSTETRICS N/A

Is your facility a regional referral center for high-risk pregnancies or newborns requiring intensive care? Yes No

If *No*, does a written procedure exist for transferring all high-risk mothers and/or babies which the hospital is not qualified to treat? Yes No

Is continuous electronic fetal monitoring (EFM) utilized on all patients in active labor? Yes No

If *No*, please explain:

Are L&D nurses and physicians required to successfully complete an approved course in EFM? Yes No

Is anesthesia available in-house 24 hours per day for the L&D area? Yes No

Who is privileged to perform deliveries (check all that apply):

Family Practitioners

Certified Nurse Midwives

Residents (indicate year of residency and area of practice). Year: ______________________

Area of Practice: ______________________

Other (please describe):

Is there an obstetrician and/or a family practice physician privileged to perform deliveries on call 24 hours per day? Yes No

If *No*, please explain:

Can all emergency cesarean sections be performed within 30 minutes? Yes No

Are any deliveries performed outside of the hospital? Yes No

If *Yes*, please explain:

Do you have the following nurseries?

Level I Basic (Well baby)

Level II Intermediate Care

Level III Neonatal Intensive Care

Do you have an infant abduction prevention program? Yes No

VIII – RADIOLOGY N/A

Is the radiology department staffed by (check all that apply):

Contracted group physicians   Staff physicians   Employed physicians

If contracted group physicians:

What is the group's name? ____________________

What are the minimum required PL limits? **Each Claim** ____________ **Aggregate** ____________

Are certificates of insurance required?	Yes	No
Are all Radiologists required to be Board Certified or Board Eligible in radiology or nuclear medicine?	Yes	No
Is there a system for radiological interpretation over-read for all radiographs performed outside of the department (e.g., the ED, owned-clinics/physician offices)?	Yes	No

If there is a discrepancy in radiological interpretation, what is the process for notifying the patient and attending physician?

Do the physicians provide interventional radiology?	Yes	No

If *Yes*, please explain:

Do you use teleradiology services?	Yes	No

If *Yes*, please explain:

For interventional radiology procedures, does an informed consent discussion take place between the patient and radiologist that includes procedure, benefits, risks, alternatives, and complications?	Yes	No
If mammograms are performed, is the program ACR certified?	Yes	No
If *No*, do you follow ACR Practice Guidelines for the performance of screening mammography?	Yes	No
Is digital equipment used?	Yes	No

IX – SURGERY N/A

Are any of the following procedures performed at the hospital? (check all that apply)

Bariatric surgery   Pediatric surgery

Experimental surgery   Transplants

Does an informed consent discussion take place between the patient and surgeon that includes procedure, benefits, risks, alternatives, and complications?	Yes	No
Is the informed consent discussion documented in the medical record?	Yes	No
Is there a written policy/procedure for surgical site identification?	Yes	No
Is a time-out called in the OR prior to the beginning of the procedure?	Yes	No
Are sponge, needle, and instrument counts performed in the course of a surgical procedure?	Yes	No

If *Yes*, at what intervals of the operation?

Are patients called following discharge from surgery?	Yes	No

If *Yes*, how is it documented?

Is your hospital reporting as part of the SCOAP initiative? (See www.scoap.org)	Yes	No

X – MEDICAL STAFF

Are credentials for all new staff physicians verified and approved by the medical staff and/or the hospital boards before privileges are granted?	Yes	No

If *No*, please explain:

Is there a probationary period of at least six months for all staff physicians?	Yes	No

If *No*, please explain:

Is history of previous employment verified?	Yes	No
Are references checked?	Yes	No
Do you perform criminal background checks for all new staff physicians?	Yes	No
Are all privileges granted to staff physicians detailed in writing?	Yes	No
Do mid-level providers (i.e. CRNAs, CNMs, NPs, PAs) undergo the same credentialing and privileging process as the staff physicians?	Yes	No
Is the performance of staff physicians periodically reviewed by the medical staff and/or the hospital board?	Yes	No

If *No*, please explain:

If *Yes*, how frequently?

Are all foreign medical school graduates required to be certified by the Education Council for Foreign Medical School Graduates (ECFMG)? Yes No

In the past five years, has the license of any medical staff member ever been:

Denied
Suspended
Restricted
Revoked

If *Yes*, please explain:

Do hospital medical staff bylaws require staff physicians to maintain professional liability insurance? Yes No

For all hospital employees, does pre-employment screening include criminal background checks, drug screens, and reference verifications? Yes No

XI – RISK MANAGEMENT / QUALITY IMPROVEMENT

Who coordinates your risk management / quality improvement program?

Name: ______

Title: ______

Phone: ______

E-mail: ______

Years of experience: ______

Reports to: ______

Does your risk manager report results of quality improvement activities to the hospital board? Yes No

Have your board members received training in their role in continuous quality improvement? Yes No

Does the risk manager have access to legal counsel for legal advice not directly related to claim activities? Yes No

Is there a risk management plan that has been approved by the governing board? Yes No

Please attach a current summary or update involving progress towards quality initiatives that was last presented to the hospital board.

Does the risk management program include and/or does the risk manager participate in the following:

Claims review
Contract evaluation
Disclosure
Emergency management plan
Incident reporting
Infection control
Patient safety program
Patient satisfaction results
Policy & procedure development

Do all contracts for clinical services include mutual hold harmless / indemnification agreements? Yes No

If *No*, please describe the contracted services where these provisions do not exist:

Do all contracts for clinical services contain minimum professional liability insurance requirements for the other party? Yes No

If *Yes*, what are the minimum required PL limits? **Each Claim** **Aggregate**

If *No*, describe the contracted services where the provision does not exist.

XII – GENERAL LIABILITY

Provide the following information for each location you own, occupy, or lease: (Attach additional pages if needed)

*Fire Protection Key: **AS** = Approved sprinkler; **S** = Smoke detector; **H** = Heat detector; **A** = Automatic alarm

	Address	Own or Lease	Use (Patient Care or Other)	Year Built	Number of Floors	Square Footage	Construction Type (Brick / Fire Resistive)	*Fire Protection (See "Key" above)
1.								
2.								
3.								
4.								
5.								

Is the hospital currently undergoing construction or renovation? Yes No

If *Yes*, please explain:

Is the hospital planning construction or renovation for this year? Yes No

If *Yes*, please explain:

Does the hospital have a heliport or helipad: Yes No

How many landings are there per year?

What is the distance between the heliport / helipad and the closest hospital building? ______

Does the hospital require the heliport / helipad to maintain liability coverage? Yes No

If *Yes*, what limits are required? ______

Does the hospital own, lease, or operate any aircraft? Yes No

If *Yes*, list how many of each and describe purpose:

______

Does the hospital own, lease, or operate any watercraft? Yes No

If *Yes*, list how many of each and describe purpose:

______

Does the hospital owns or operates a day care center: Yes No

Is it open to the public? Yes No

What is the ratio of child to day care staff? ______

What is the child age range? ______

Is the center located within the hospital? Yes No

Has the center been tested for lead levels? Yes No

Does pre-employment screening include criminal background investigations, drug screens, and reference verifications? Yes No

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

If "Yes," provide the following information:

Address: ______

Capacity: ______

Age of tank: ______

Are the tanks in use? Yes No

Special Events – List and describe any special events planned for the upcoming policy year.

______

______

______

______

______

XIII – EMPLOYEE BENEFITS LIABILITY

What is the total number of employees covered by employee benefit plans? ____________________

Are employee benefits self-administered? Yes No

If *No*, what is the name of the vendor? ____________________

What is the total payroll of the hospital? $ ____________________

XIV DIRECTORS AND OFFICERS, IF APPLICABLE

Total Number of Directors, Officers, & Trustees of primary facility, including the hospital administrator: ____________________

Total Assets $ ____________________

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

XV EMPLOYMENT PRACTICES LIABILITY, IF APPLICABLE

Total Number of Full-Time Employees: ____________________

Total Number of Part-Time Employees: ____________________

How many employees have been terminated in the past 12 months?

Voluntary: ____________________ Involuntary: ____________________ Laid off: ____________________

Is any reduction of employees or change of status anticipated or being contemplated in the next year?

Voluntary: ____________________ Involuntary: ____________________ Laid off: ____________________

Options:

Deductible option? Yes No

Wages & Hours Coverage (Defense only)? Yes No

Are limits to be shared with Directors and Officers Liability? Yes No

XVI – SEXUAL MISCONDUCT

Do you have written Sexual Harassment/Misconduct prevention policies, procedures, and protocols? Yes No

If *Yes*, please attach.

Is there a chaperone present in the room at all times for sensitive patient exams? Yes No

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

How often do you conduct training for all employees ____________________ For volunteers? ____________________

Do you require a 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 insured or its employees? Yes No

If *Yes*, please attach details.

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

If *Yes*, please attach details.

XVII – CLAIMS HISTORY

Please provide claims history for the past 10 years (including the current year). Claim data should include:

Allegation	Close date
Incident/occurrence date	Report/claims-made date
Indemnity payments	Expense payments
Indemnity reserves	Expense reserves

Provide full details for any claim with an indemnity payment or indemnity reserve of $100,000 or more:

Question		
Are you aware of any incidents, circumstances, or potential claims which have occurred after the proposed retroactive date, and which are likely to result in a claim?	Yes	No

If *Yes*, please provide details:

Question		
Have all such incidents, circumstances, or potential claims been reported to your current or previous carrier(s)?	Yes	No
Are you aware of any threatened or pending civil or criminal actions or litigation?	Yes	No

If *Yes*, please provide details:

Question		
Has any insurance carrier ever canceled, refused, or non-renewed your previous liability insurance?	Yes	No

If *Yes*, please provide details:

FRAUD WARNING, DECLARATION & CERTIFICATION, AND SIGNATURE

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 subject to prosecution for insurance fraud.

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 claim containing false, incomplete, or misleading information may be prosecuted under state law.

APPLICANT'S REPRESENTATION (PLEASE READ CAREFULLY)

I hereby represent that the information contained in this application and any supplementary 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 policy of insurance requested and that I will notify Physicians Insurance of any changes contained herein.

Signature of Applicant (required) ____________________ Date ____________

Print full name ____________________

Title ____________________

Signature of Broker ____________________ Date ____________

Print full name ____________________ License # ____________

I UNDERSTAND THAT SIGNATURE OF THIS APPLICATION DOES NOT BIND THE COMPANY TO COMPLETE THIS INSURANCE