MID-CONTINENT GENERAL AGENCY
3131 Eastside, Suite 600, Houston, Texas 77098
P. 713.639.6200 F. 713.639.6330

HEALTHCARE PROFESSIONAL LIABILITY AND GENERAL LIABILITY APPLICATION FOR HOSPITALS

The following additional information is required to be submitted along with the attached application:

1. Loss Information: Current loss runs for the last ten (10) years.*(if ten 10 years is unavailable, please provide as many years as possible – no less than five(5) years minimum)*. Losses must be valued no older than three (3) months from the policy expiration or renewal date. Please include paid and reserved losses and claim details. Loss runs from prior carriers are preferred.

2. Copies Of Latest JCAHO Report – If not available, or not applicable, please provide a copy of the most recent state licensure survey.

3. Current Audited Financial Information – If an audited financial statement is not available, please provide the most current financial information available.

4. Copy of The Medical Staff By Laws – Please include all amendments that may have been made to the By Laws.

5. Copy of Organizational Chart – Please show legal entities only; not personnel.

6. Copy of Contracts – Please provide copies of management agreements, hold harmless agreements, etc.

7. Changes in Operations or Ownership – If the operations or ownership have changed in the past or if the operations or ownership will be changing in the future, please provide an explanation of the changes.

Please report all known incidents that could lead to a claim to your existing insurance carrier. It will be excluded under the insurance policy to which you are applying for coverage.

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HEALTHCARE PROFESSIONAL LIABILITY AND GENERAL LIABILITY APPLICATION FOR HOSPITALS

Effective Date Desired: _____

I. APPLICANT INFORMATION

1. Name of Applicant *(First Named Insured)*: _____

_____

2. Street Address: _____

_____
City State Zip

3. Mailing Address: _____

_____
City State Zip

4. Person to Contact for Survey: _____

Title _____

Telephone Number: _____ e-mail:_____

5. Additional **Named Insured(s)** *(Please provide retroactive dates, addresses and relationship to First Named Insured. Please list exactly as it should appear on the policy. Use separate page if necessary)*: _____

_____

_____

_____

II. PROFESSIONAL LIABILITY INFORMATION

1. Type of facility *(Please check all that apply)*: ____ For Profit _____ Not For Profit
____ Governmental _____ Critical Access Center
2. Entity is: _____Individual _____ Partnership _____ Corporation _____ Joint Venture

3. Brief Description of Operations (specialty): _____

_____

4. Years in business? _____ Employer Fed ID #: _____

5. Retroactive Date: _____ Limits Requested: _____
6. Deductible on current insurance: _____ Deductible requested: _____

7. Prior Insurance History *(please provide five (5) years of PL & excess/umbrella information)*:

Policy Period	Carrier	Limits	Coverage	Deductible	Premium

8. Has there been any change in management, ownership or change in operations during the past 5 years? _____ No _____ Yes; if yes, please describe the change:

_____

_____

9. Are any management services provided for others? ____Yes ____No

If yes, please describe: _____

_____

_____

10. Is your facility managed by a management company? ____ Yes ____ No

If yes, please describe: _____

_____

(Please provide a copy of the management contract).)

11. Do you provide telemedicine services? _____Yes ____ No If yes, please describe:

_____

III. FACILITIES AND SERVICES

1. Services provided by your facility *(Please check all that apply)*:

_____ abortion clinic	_____ ambulance	_____ blood bank
_____ burn unit	_____ cancer therapy	_____ CCU
_____ day care	_____ dialysis	_____ dietary
_____ emergency	_____ gift shop	_____ hyperbaric chamber
_____ ICU	_____ inhalation therapy	_____ long-term care
_____ morgue	_____ NICU	_____ nursery
_____ obstetrical	_____ operating rooms	_____ pathology
_____ pharmacy	_____ physical therapy	_____ psychiatric therapy
_____ radiology	_____ restaurant	_____ self-care/rehabilitation
_____ teaching facility	_____ trauma center	_____ wellness center

2. Professional Employees *(indicate total number of employees in each category)*:

Description	Full Time	Full Time Equivalents
Employed Physicians/Surgeons	_____	_____
Interns/Residents	_____	_____
Dentists/Oral Surgeons	_____	_____
Podiatrists	_____	_____
Optometrists	_____	_____
Physician Assistants/Nurse Practioners	_____	_____
Registered Nurses	_____	_____
LPNs	_____	_____
Student Nurses	_____	_____
Student CRNAs	_____	_____
X-Ray Technicians	_____	_____
Lab Technicians	_____	_____
Pharmacists	_____	_____
Profusionists	_____	_____
Paramedics	_____	_____
CRNAs	_____	_____
Midwives	_____	_____
Other Employees	_____	_____
Volunteers	_____	_____

EMPLOYED PHYSICIANS, SURGEONS AND RESIDENTS			
Name	**Specialty Practice at Facility**	**Board Certification**	**Retroactive Date**

(Please continue on separate page if more space is needed)

3. Professional Liability Exposures: (Five Years Historical Data)

EXPOSURE BASIS	(# Licensed Beds – for file only)	AVERAGE OCCUPIED Next 12 months	Expiring yr	Prior 2nd yr	Prior 3rd yr	Prior 4th yr	Prior 5th yr
ADULT/CRITICAL CARE							
PEDIATRIC							
BASSINETS/NEONATAL							
HOSPICE							
NURSING HOME							
PSYCHIATRIC BEDS							
REHABILITATION							
SUBSTANCE ABUSE							
OTHER:							
Total Beds:							
EMERGENCY ROOM VISITS	# Visits:						
HOME HEALTH/HOSPICE VISITS	# Visits:						
PSYCHIATRIC VISITS	# Visits:						
REHABILITATION VISITS	# Visits:						
INPATIENT SURGERIES	# Surgeries:						
OUTPATIENT SURGERIES	# Surgeries:						
ALL OTHER OUTPATIENT VISITS	# Visits:						
Total Visits:							

EXPOSURE BASIS		Next 12 months	Expiring yr	Prior 2nd yr	Prior 3rd yr	Prior 4th yr	Prior 5th yr
# BIRTHS	Total # for All Births – all types						
# CESCEREAN SECTION BIRTHS	# C-section only						
PHARMACY (not portion of sales to patients)	Receipts sold to Public						
# ATTENDEES IN DAYCARE							
OTHER EXPOSURES NOT LISTED ABOVE:							

Note: A visit is the number of times a patient comes to the hospital/clinic to have procedures done, not the number of procedures (for instance – a person may have several procedures done in one day, but it will only count as one visit for that day).

4. Additional Information:

A. Criteria for qualifications of employed Physicians:

1. Is history of previous employment verified? _____ Yes _____ No

2. Are references checked? _____ Yes _____ No

3. Has the license of any employed physician ever been revoked, restricted or suspended? _____ Yes _____ No
If yes, please explain: _____

4. Do the employed physicians carry their own insurance or do they share limits with the facility? _____
If they carry their own, what limits are required? _____

B. Staff Privileges of Private Practitioners:

1. Are credentials of doctors approved by the medical staff &/or hospital review board before privileges are granted? _____ Yes _____ No

2. Is there a probationary period of at least six months for all staff doctors? _____ Yes _____ No

3. Are all staff doctors' performances periodically reviewed by the medical staff &/or hospital review board? _____ Yes _____ No

4. Do hospital staff by-laws require staff doctors to carry Medical malpractice insurance? _____ Yes _____ No
If yes, what limits are required? _____per claim _____ aggregate

5. Are all privileges granted to staff doctors detailed in writing? _____ Yes _____ No

6. Has the license of any staff physician ever been restricted or suspended? _____ Yes _____ No
If yes, please explain: _____

C. Anesthesiology:

1. Anesthesiology department is staffed by:

____ Employed Physicians _____ Employed CRNAs ____ Staff Physicians

____ Contract Group If contract group, name:_____

Are certificates of insurance required? _____ Yes _____ No
If yes, what limits are required? _____ per claim _____ aggregate

2. Are all anesthesiologists required to be board certified or eligible in anesthesiology? _____ Yes _____ No

3. Is the anesthesiology care performed by CRNAs supervised and reviewed by the anesthesiologist? _____ Yes _____ No
If no, please explain: _____

D. Radiology:

1. Radiology department is staffed by:

_____ Employed Physicians _____ Staff Physicians _____ Contract Group

If contract group, name: _____
Are certificates of insurance required? _____ Yes _____ No
If yes, what limits are required? _____ per claim _____ aggregate

3. Are all radiologists required to be board certified or eligible in radiology &/or nuclear medicine? _____ Yes _____ No

E. Emergency Department:

1. How is the emergency department classified? ____ Level I (tertiary) _____ Level II (comprehensive) _____ Level III (basic)

____ Other _____

2. Emergency Department is staffed by:
_____ Employed Physicians _____ Rotating Staff _____ Contract Group If contract group, name: _____

Are certificates of insurance required? _____ Yes _____ No
If yes, what limits are required? _____ per claim _____ aggregate
Are the physicians on site or is care provided via telemedicine? _____

_____

3. Are all physicians required to be board certified or eligible in emergency medicine?

If no, what are the specialties of the ER physicians *(Please list on separate page if necessary)*?

_____

_____

4. Does the facility provide ambulance service? _____ Yes _____ No
If yes, please explain ambulance use *(ex: transport only, first responder, second responder, 911 dispatch service)*: _____
Number of ambulances: _____ Number of runs per month: _____

F. Obstetrics:

1. Does the facility have a written procedure for transferring all high-risk mothers &/or babies which the hospital is not qualified to treat?

2. Do you have the following nurseries:
_____ Level I (Well baby) _____ Level II (Intermediate Care)
_____ Level III (Neonatal Intensive Care)

3. Does the facility allow vaginal birth after C-section (VBAC)? ____Yes ___ No
If so, how many in the previous 12 months? _____

4. Is continuous electronic fetal monitoring performed on all patients in active labor?
If no, please explain: _____

5. Do nurse midwives practice at the facility? _____ Yes _____ No
If so, are they properly certified? _____ Yes _____ No
Do they deliver babies? _____ Yes _____ No
If so, where (patient's home or at facility or other)?_____
_____
Are the nurse midwives under supervision of an OB/GYN?____Yes ____ No

6. Do Family Practitioners (FP) deliver babies? _____Yes _____ No
If so, how many Family Practitioners are delivering babies? _____

7. Are ACOG standards incorporated into hospital protocols & procedures?

G. Surgery:

1. 1. Are any of the following procedures performed at your facility? Neurosurgery (including back surgery) _____ Yes _____ No

Experimental Surgery _____ Yes _____ No
Weight Reduction Surgery (bariatric) _____ Yes _____ No
Laser Assisted Surgery _____ Yes _____ No
Cardiac Surgery _____ Yes _____ No

If yes to any of the above, how many of each:
a. Were done in the past 12 months? _____
b. How many do you anticipate for the next 12 months? _____

2. If bariatric surgeries are performed, what changes in the facility and equipment have been made to accommodate the morbidly obese?
_____
_____
How many physicians perform bariatric surgery at the facility? _____
What are their qualifications?_____

3. Are sponge, needle and instrument counts performed during the course of a surgical procedure? _____ Yes _____ No
If yes, at what intervals? _____

H. Pharmacy:

1. Does the facility utilize a unit dose system of dispensing medicine? _____Yes _____ No

2. Is the pharmacy for patients use only?

3. Does a contract group staff the pharmacy? _____ Yes _____ No
If contract group, name: _____

I. Risk Management:

1. Who coordinates your risk management program?

Name: _____ Title: _____

Telephone: _____ e-mail: _____

2. Is there a formal risk management program in place? _____ Yes _____ No

If so, does the risk management program include the following?

Occurrence reporting _____ Yes _____ No
Claim management _____ Yes _____ No
Safety program and Safety committee _____ Yes _____ No
Review and participation in medical staff committees _____ Yes _____ No
Contract review and evaluation _____ Yes _____ No
Sexual Harassment policy in place _____ Yes _____ No

3. Does the facility comply with all state and federal guidelines regarding the handling of blood borne pathogens? ____ Yes _____ No

J. Claims History:

1. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit? _____ Yes _____ No

2. 2. Do you have knowledge of any event(s) that could possibly lead to a claim, or suit? _____ Yes _____ No

If yes, have you reported it/them to your prior insurance carrier? _____ Yes _____ No

IV. GENERAL LIABILITY INFORMATION

A. Insurance Information:
1. Is current insurance coverage Claims Made? _____Yes _____ No
If yes, what is Retroactive Date? _____

2. What limits of liability are requested? _____

3. What deductible is requested: _____

4. Prior Insurance History *(please provide at least five (5) years of information)*:

Policy Period	Carrier	Limits	Coverage	Deductible	Premium

B. Incidental Exposures:
1. Has the facility planned any new construction, expansion, closure or change to the facility for this year? _____ Yes _____ No
If yes, please provide details: _____
_____

2. Are there any elevators or escalators on any premises owned, leased or occupied by the insured? _____ Yes _____ No
If yes, how many? _____
Who is responsible for the maintenance? _____

3. Does the facility have a helipad or heliport? _____ Yes _____ No

4. Does the facility own, lease or charter aircraft? _____ Yes _____ No
If yes, does the hospital have separate insurance coverage for the heliport, owned, leased or chartered aircraft? _____ Yes _____ No if yes, please provide details of coverage for each to include carrier, limits and policy periods *(Please use separate page)*.

5. Please list the number and type of owned or leased vehicles *(Please use separate page if necessary)*: _____

_____

6. Please list all owned, leased and non-owned watercraft *(Please use separate page if necessary)*:_____

_____

C. Hold harmless and Indemnification Agreements:
1. Has the facility agreed to hold harmless or indemnify others under contract?
_____ Yes _____ No if yes, please provide copies of all contracts.

2. Does the facility rent or lease equipment from others? ____ Yes _____ No
If yes, please explain (please list the type of equipment and who is responsible for the maintenance of it. *Please use a separate page if necessary*): _____

_____

_____

_____

D. Employee Benefits Administration Liability
1. Do you currently have &/or want to purchase Employee Benefits Administration Liability Coverage?

2. Number of Employees: _____

3. What is the current or requested retroactive date? _____

4. Are Employee Benefits Self Administered? _____ Yes _____ No

V. GENERAL LIABILITY EXPOSURE INFORMATION

A. Please list all properties on the chart on page 13 *(Please use more than one page if necessary)*:

VI. APPLICANT AUTHORIZATION

NOTICE TO ARKANSAS APPLICANTS: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

NOTICE TO COLORADO APPLICANTS: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award
payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Authorities."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

NOTICE TO FLORIDA APPLICANTS: "Any person who knowingly and with intent to injure, defraud, or deceive and insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree."

NOTICE TO KENTUCKY APPLICANTS: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

NOTICE TO LOUISIAN APPLICANTS: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

NOTICE TO MAINE APPLICANTS: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

NOTICE TO NEW JERSEY APPLICANTS: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

NOTICE TO NEW MEXICO APPLICANTS: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

NOTICE TO NEW YORK APPLICANTS: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

NOTICE TO OHIO APPLICANTS: "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

NOTICE TO OKLAHOMA APPLICANTS: "Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony" (365:15-1-10, 36 3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

NOTICE TO VIRGINIA APPLICANTS: "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."

The undersigned authorized officer of the organization declares that to the best of his/her knowledge, the statements set forth herein are true.

Signing of the applications does not bind the undersigned to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued.

_____ _____

Signature of Chief Executive Officer Date

_____

Title

SCHEDULE OF LOCATIONS

Fire Protection Key: AS = Approved Sprinkler S = Smoke Detectors H = Heat Detector A = Automatic Alarm

LOCATION	AREA	AGE	TYPE OF CONSTRUCTION	# OF FLOORS	TYPE OF FIRE PROTECTION	CITY	STATE	INSURANCE REQUESTED?
Patient Care Buildings:								
Other Buildings:								
Parking Lots:								
vacant Lots:								