

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

1. Introductory Information

Legal Entity Name: _____

Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Contact Name: _____

Contact Email: _____

Number of Years in Operation: _____

Telephone Number: _____ Fax Number: _____

Hospital Fiscal Year Begins: _____

Tax ID Number: _____ NPI Number: _____

Website Address: _____

2. Facility/Corporate Organization

Type of Entity: Government Non-Profit Profit Other _____
 Individual Partnership Corporation Joint Venture

Type of Facility: _____

Do you have a Physician Medical Director? Yes No

Does the Medical Director provide any patient care as part of the Medical Director duties? Yes No

Please attach the following:

- A. Carrier Loss History:
 - i. **Ten years** of historical professional liability (PL) and general liability (GL) losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.
 - ii. Date of loss valuation must be within the past 90 days.
 - iii. Loss run must include carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL) and narrative of claim.
 - iv. Full details of allegations on all losses paid or outstanding in excess of \$100,000 even if greater than 10 years old.
- B. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or, if accrediting agency reports are unavailable, please submit the state licensure report with recommendations and the institution's response to any contingencies.
- C. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.
- D. Identity of each employed physician including name, specialty, date of hire, retro date, primary PL carrier, is primary coverage occurrence or claims-made and PL limits (if applicable).
- E. Identity related entities or subsidiaries to be considered for coverage on the policy including a brief explanation of their relationship to the applicant, scope of operations and their retro date on Schedule A (if historically written on claims-made basis).
- F. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.
- G. Copy of state license.
- H. List of all stockholders and their percent of ownership and identify any medical designations held by any stockholder.
- I. Copy of your facility accreditation.

3. Current Insurance/Claim Information

Type	Carrier or Self-Insured	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible	Premium
Primary Prof. Liability							
Primary General Liability							
Excess PL							
Umbrella GL							
Auto Liability							
Employers' Liability							
Helipad/Aviation							
Other:							

*Please specify by layer if more than one Retro Date applies.

- A. Do you participate in a Patient Compensation Fund or similar type program in the state in which you operate? Yes No
 If yes, what limit do you carry? _____
- B. Have any claims ever been made or suits brought against you or any of your employees in the last five years because of any alleged malpractice, error or mistake, or from any premise accident arising in any manner out of your operations? Yes No
 If yes, attach a separate sheet listing date of occurrence, circumstances of claim and amount paid or amount reserved.
- C. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future? Yes No
 If yes, please provide details: _____

4. Insurance Coverage Desired

Primary:	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible
Professional Liability (PL)					
General Liability (GL)					
#Limited Pollution Liability					
Excess/Umbrella:					
Excess PL					
Umbrella GL					

*Please specify by layer if more than one Retro Date applies.

#Separate Application Required – Refer to Company

Include the following as underlying coverage on the Excess/Umbrella (if applicable). Policy information must be indicated in the "Current Insurance" section above. Provide policy declaration pages for all applicable coverage.

- Auto Liability Employers' Liability Helipad/Aviation Other: _____

For each Excess/Umbrella underlying line of insurance above, describe any claims in excess of \$10,000.

5. General Exposure Data

- A. Do you maintain any beds for overnight occupancy? Yes No
 Surgery Center: _____ No. Operating Rooms Hours of Operation: _____
 _____ No. Occupied overnight/24-hour Beds
- B. Facility is licensed as: Ambulatory Surgical Center Surgical Hospital
- C. Select each type of surgical service that applies to the applicant and provide the number of annual procedures. (If new business start-up, please provide estimated number of annual procedures.)

Type of Procedure	Annual No. Procedures for Last Fiscal Year	Type of Procedure	Annual No. Procedures for Last Fiscal Year
*Bariatric		Gastroenterology	
Obstetrics		Vascular	
Urology		Cardiac Catheterization	
Hand		Otolaryngology (ENT)	
Orthopedic		Thoracic	
Colon and Rectal		Plastic (reconstructive)	
Head and Neck		Endoscopy	
General		Pain Management	
Cosmetic		Gynecology	
Podiatry		Oral and Maxillofacial	
Neurology		Wound Care	
Ophthalmology (cataracts)		Other (describe):	
Ophthalmology (Lasik, PRK, TKP)			

**Separate Application Required – Refer to Company*

- D. Other services provided:
 Medical Lab _____ Annual Receipts X-ray/Imaging Center _____ Annual Receipts

6. Other General Information

- A. Are anesthesia services provided by:
 Employed physicians Contract group Employed CRNA's
- i. If under contract, name of group: _____
- ii. If contract group, are certificates of insurance required? Yes No
- iii. If *yes*, what minimum limits are required: _____ per claim _____ aggregate
- B. Do you have the following equipment at the center:
- i. Laboratory, with the following capabilities—CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine Yes No
- ii. X-ray with on-premises processing Yes No
- iii. EKG Yes No
- iv. Monitor/defibrillator Yes No
- v. Crash cart with full cardiac life support capabilities and necessary intravenous fluids Yes No
- vi. Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage Yes No

- vii. Oxygen Yes No
 - viii. Suction Yes No
 - ix. Pneumatic anti-shock trousers Yes No
 - x. Dedicated telephone lines to the closest appropriate hospital emergency department and/or two-way communication with EMS Yes No
- C. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? Yes No
 If *yes*, please attach detailed explanation of this activity.
- D. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? Yes No
 If *yes*, please attach a copy of *all* of the advertisements.
- E. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? Yes No
 If *yes*, please attach detailed explanation and a copy of *all* of the advertisements.
- F. Do you maintain adequate medical records for each patient? Yes No
- i. How often and by whom are the medical records reviewed? _____

 - ii. What arrangements are made for transmitting medical records to other requesting physicians?

- G. Is there an established procedure and agreement with a hospital to accept emergency cases? Yes No
- i. Has time and distance from the center to the nearest appropriate hospital been determined and evaluated? Yes No
 - ii. Have procedures for Physician direction and supervision of personnel, facilities, and equipment for the provision of medical services under emergency conditions been evaluated? Yes No
 - iii. Is there an established procedure to secure sufficient blood supplies in emergency situations? Yes No
- H. Does the facility have a procedure to screen for inappropriate procedures or patients at risk for an ambulatory surgery procedure? Yes No
- I. Are any procedures performed on persons rendered unconscious through anesthesia? Yes No
 If *yes*, give detailed description on a separate sheet of how anesthesia is provided, including minimum patient age and number of overnight beds on premises or affiliated.

7. Personnel

A. Physicians providing health care services at this entity:

Name	Specialty	Board Certified	Limits	C=Contracted E=Employed O=Owner	Current Insurance Carrier

Please attach additional sheets if necessary.

- B. Do you require certification of Professional Liability Coverage? Yes No
 If *yes*, how much? _____

C. Non-Physician Personnel	No. Employed	No. Contracted
Anesthesiology Assistant		
*Dentists		
EEG or EKG Operators		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
*Nurse Anesthetists - Are they supervised by an anesthesiologist? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Nurse Practitioners/Clinical Nurse Specialists		
Occupational/Physical Therapists		
Paramedics or EMT's		
Pharmacists		
*Physician Assistants		
*Podiatrists		
RNs		
Scrub Nurses		
*Surgical Assistants (Certified or Licensed)		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe):		

**Separate Application Required – Refer to Company*

8. Premises and Operations

- A. Are there any construction plans for the next twelve months? Yes No
If *yes*, please provide cost of project: _____
- B. Total square footage of parking lots or decks: _____
- C. Total number of swimming pools: _____
- D. Total number of lakes: _____
- E. Total number of fountains: _____
- F. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. Yes No
- G. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. Yes No

Fraud 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

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____

Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):

Agent: _____

Phone: _____

Agency: _____

Fax: _____

Address: _____

Email: _____

License No.: _____

Signature: _____

**Insured Entities and D/B/A's
Schedule A**

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Entity Name:	_____		
Address:	_____		

Tax ID No.:	_____	Retroactive Date:	_____
Ownership and relationship to the policyholder:	_____		

Description of all operations and activities:	_____		

Please attach additional sheets if necessary.