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Agent Information	
Agency	_____
Address	_____
Producer	_____

APPLICATION FOR HEALTHCARE FACILITIES PROFESSIONAL LIABILITY INSURANCE

Please complete the entire application. Indicate not applicable (N/A) where appropriate. Incomplete applications cannot be processed.
Cancer Treatment Centers, Dialysis Centers, Imaging Centers, Laboratories, Rehabilitation Facilities, Surgery Centers and Urgent Care Facilities must complete the Specialized Services Supplemental Application.

PART I – APPLICANT INFORMATION

Legal Name of Applicant _____ Website _____ Tax ID Number _____

Address (Street, City, State, Zip Code) _____ County _____

Telephone Number _____ Fax Number _____ E-mail Address _____

Legal Structure (Check all that apply):

Sole Proprietorship Corporation Partnership Joint Venture For Profit Not for Profit Government

Other (Specify): _____

Accreditations/Certifications (check all that apply):

JCAHO Accredited CCAC Accredited CCRC Accredited AAAHC Medicare/Medicaid Certified

Other (Specify): _____

Description of services provided: _____

Who may our Risk Management representatives contact for a telephone or on-site review of your facility?

Name/Title: _____

Telephone Number: _____ Fax Number: _____ E-mail Address: _____

PART II – CURRENT COVERAGE

Professional Liability Carrier Information:

General Liability Carrier Information:

Limit of Coverage: _____ Limit of Coverage: _____

Deductible/Retention: _____ Deductible/Retention: _____

Policy Period: _____ Policy Period: _____

Policy Premium: _____ Policy Premium: _____

Coverage Type: Occurrence Claims-Made Coverage Type: Occurrence Claims-Made

If Claims-Made, retroactive date is: _____ If Claims-Made, retroactive date is: _____

Has any insurer cancelled or declined to issue any of the coverages being applied under this application? Yes No

If Yes, please explain: _____

PART III – COVERAGE REQUESTED

Limits of Liability (Limits are expressed as per claim/aggregate)

Professional Liability Limit: \$1,000,000/\$3,000,000 Other: _____

General Liability Limit: \$1,000,000/\$3,000,000 Other: _____

Employee Benefits Liability Limit: \$1,000,000/\$3,000,000 Other: _____

Deductibles – General Liability Only

No Deductible \$5,000/\$25,000 \$10,000/\$50,000 \$25,000/\$125,000 Other: _____

Form of Insurance

Is retroactive coverage being applied for? Yes No Retroactive Date: _____

PART- IV GENERAL INFORMATION

Indicate the number of years the Applicant has been:

Operating: _____ Owned by present owners: _____ Managed by present management: _____

Is the Applicant managed by a management company? Yes No

If yes, provide the name of the management company: _____

How many years in place with this management company? _____

Within the next 12 months does the Applicant plan to:

Obtain another operation/entity? Yes No

Add or reduce the number of employees? Yes No

Add or reduce the number of locations? Yes No

Add or reduce current services? Yes No

Operate in other states? Yes No

Explain all "yes" answers in the Comments section.

Within the past 5 years, has the Applicant acquired, sold or discontinued any operations? Yes No

If yes, use the Comments section to explain.

Total Annual Revenue

Provide total annual revenue for the year's indicated:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Total Annual Revenue					

Financial Interest

List the following details for each medical professional that has a financial interest in the Applicant's business. Use Comments section if more space is needed.

Name	Profession	Interest (Owner/director/etc)	Patient Care	
			For the Facility	Outside Practice
			%	%
			%	%
			%	%
			%	%
			%	%
			%	%
			%	%
			%	%
			%	%

Subsidiaries and Affiliates

List all subsidiaries and affiliates of the Applicant.

Name of Subsidiary/Affiliate	Description of Operations	Ownership Interest	Date Acquired	Current Insurance Carrier	Retroactive Date if Claims –Made	Coverage Desired? Y?N
		%				
		%				
		%				
		%				
		%				

Licensing

List all licenses held by the Applicant including type and expiration dates.

Has the Applicant’s license been suspended, revoked or placed under probation? Yes No

If yes, provide a detailed explanation in the Comments section, including the date the license was reinstated.

Has the Applicant ever filed for bankruptcy? Yes No

Medicare/Medicaid

Is the Applicant approved for Medicare or Medicaid? Yes No

Has the Applicant been denied a Medicare or Medicaid certification? Yes No

Has the Applicant had its Medicare or Medicaid certification limited, suspended or revoked? Yes No

If yes, please explain in the Comments section.

Has the Applicant been accused of any Medicare or Medicaid fraud or abuse violations or paid any fines or penalties? Yes No

If yes, please explain in the Comments section.

Inspections/Surveys

When was the last inspection/survey of the Applicant by an outside entity? _____

Who performed the inspection? _____

Indicate total number of deficiencies: _____

Was a Corrective Action Plan accepted? Yes No

How many patient/family complaints were investigated in the past three (3) years? _____

How many complaints were substantiated? _____

PART V – PREMISES AND OPERATIONS

List all premises owned, rented, leased, occupied or used by the Applicant. Attach a separate schedule if more space is needed.

Address	Use	Year Built	Construction Type Number*	Fire Class	Number of Stories	Sprinkler System	Total Area

*Construction Type Number: 1 = Frame, 2 = Joisted Masonry, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive

Does each location meet applicable NFPA building codes? Yes No

Does the Applicant have a written emergency evacuation plan? If yes, please attach a copy of the plan. Yes No

List any planned major fund-raising activities or sporting events which will be sponsored by the Applicant during the next year:

Are any construction projects planned for the next year? Yes No
If yes, provide a description below, including estimated cost and duration of the project.

PART VI – ADMINISTRATION AND STAFF

Medical Director

Does the Applicant employ or contract a medical director? Yes No
If yes, please answer the following questions.

What is the name of the medical director? _____

What is the employment status of the medical director? Employee Contractor

What is the medical specialty of the medical director? _____

How many hours per month, on average, is the medical director on-site at the facility? _____

Does the medical director have direct patient contact? Yes No
If yes, indicate the insurance carrier and limits of liability carried.

Insurance Carrier: _____ Limits of Liability: _____

Is the medical director involved in credentialing facility medical staff? Yes No

Is the medical director an active participant in the facility's quality improvement program? Yes No

Is the medical director responsible for hiring and firing? Yes No

Is the medical director involved with peer review of physicians? Yes No

Insurance Requirements – Please explain any "No" answers in the Comments section.

Does the Applicant require the following health care professionals to carry professional liability insurance?

Physicians or Surgeons Yes No Limits \$ _____

Allied Healthcare professionals Yes No Limits \$ _____

Please indicate if the following procedures are included in the hiring and screening process:

Verification of educational background, including licensure and/or certification? Yes No

Confirm hospital privileges for physicians? Yes No

How often is the list of specific privileges updated? _____

Check for any license suspensions, revocations or any disciplinary actions? Yes No

Check criminal history? Yes No

Require information regarding medical professional claims history? Yes No

Do the procedures apply to: Employees Contractors Volunteers

Does the Applicant have a formal/documented orientation program in place? Yes No

Does the Applicant have a formal/documented credentialing program in place? Yes No

Are workers transporting patients? Yes No

If yes, are driving records (MVRs) verified? Yes No How often? _____

PART VII – MEDICAL EQUIPMENT/PRODUCTS

Does the Applicant sell, rent, lease or distribute any of the following? Yes No

Durable Medical Equipment/Supplies Expendable Medical Equipment/Supplies Medical Products

If yes, check the appropriate category and answer the following questions:

Does the Applicant provide service or maintenance for the equipment/products? Yes No

If an outside vendor provides maintenance, what limits of liability insurance are required? \$ _____

Does the Applicant repackage or redesign the equipment/products? Yes No

Describe the type of equipment/products sold or leased in the Comments section.

Does the Applicant manufacture any type of medical equipment and/or products? Yes No

If yes, describe type of equipment and/or products in the Comments section.

PART VIII – CONTRACTUAL AGREEMENTS

Does the Applicant have an attorney review all contracts before signing? Yes No

If no, who reviews the contracts? _____

Has the Applicant signed any contractual agreements to provide services to others? Yes No

If yes, describe the types of services: _____

Has the Applicant signed any contractual agreements where others are providing healthcare services on behalf of the Applicant? Yes No

If yes, describe the types of services: _____

Specify the minimum limits of liability that are required: \$ _____

Is proof of this coverage verified? Yes No

Does the contract contain an indemnification (hold harmless) clause? Yes No

PART IX – CLAIMS INFORMATION

Have any claims or suits ever been made or brought against you? Yes No

Indicate number of previous claims or suits (this includes closed, dismissed, and/or dropped cases). _____

Indicate the number of pending claims or suits.* _____

The attached Supplementary Claims Information Form must be completed for each case indicated above.

Do you have any knowledge of any claims which might be made against you (other than those indicated above) or activities that might reasonably give rise to a claim or suit being brought against you even if you believe the claim or suit would be without merit? (Include any requests for medical records.) Yes No

* A narrative from the applicant and the defense attorney describing each pending claim must be attached.

SPECIFIC CONSENT TO CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this 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 WV Mutual Insurance Company, 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.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant who makes an application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee.

Applicant's Signature _____

Date _____

AGREEMENTS & NOTICES

Notice to West Virginia 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 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 on misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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 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, denial of insurance benefits, and civil damages.

Applicant's Signature: _____

Date: _____

IMPORTANT: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. Below is an Authorization to Release Information form which requires your signature. Please read carefully.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by WV Mutual Insurance Company (the "Company") hereby authorizes the applicant's present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon the applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, the Company, its directors, officers, employees and agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing the information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the undersigned original.

Name: _____

Signature: _____

Date: _____