



500 Virginia Street, East  
Suite 1200  
Charleston, WV 25301

Tel: 304.343.3000  
Toll-Free: 888.998.7642  
Fax: 304.342.0985  
[www.wvmic.com](http://www.wvmic.com)

Agent Information	
Agency	_____
Address	_____
Producer	_____

**CANCER TREATMENT CENTER LIABILITY APPLICATION**

Please complete the entire application. Indicate not applicable (N/A) where appropriate. Incomplete applications cannot be processed.

**PART I – ORGANIZATION INFORMATION**

**A. CONTACT INFORMATION**

Applicant Name (Legal Corporation Name) \_\_\_\_\_

Mailing Address, City, State, Zip Code \_\_\_\_\_ County \_\_\_\_\_

Street Address (If Different) \_\_\_\_\_

Contact Person Name \_\_\_\_\_ Title \_\_\_\_\_

Business Phone \_\_\_\_\_ Business Fax \_\_\_\_\_ Residence Phone \_\_\_\_\_

Website Address \_\_\_\_\_

**B. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM)** \_\_\_\_\_

**PART II – GENERAL INFORMATION**

**A. CERTIFICATIONS/ACCREDITATIONS HELD BY YOUR FACILITY:**

CARF     JCAHO     ISO     Other \_\_\_\_\_

Please provide a copy of your Certificate/Accreditation including any recommendations made.

**B. HOW MANY CANCER TREATMENT CENTER LOCATIONS DO YOU HAVE?** \_\_\_\_\_

If you have multiple locations, are all locations accredited/certified?  Yes  No

If no, please provide details: \_\_\_\_\_

**C. DO YOU PLAN TO ADD ANY LOCATIONS DURING THE NEXT 12 MONTHS?**  Yes  No

If yes, please explain: \_\_\_\_\_

**D. ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS DURING THE NEXT 12 MONTHS?**  Yes  No

**E. MEDICAL DIRECTOR:**

Name of Medical Director \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

**F. ANNUAL PAYROLL AND RECEIPTS**

Total Annual Payroll: \_\_\_\_\_ Total Projected Annual Receipts: \_\_\_\_\_

**PART III – CANCER TREATMENT CENTER OPERATIONS**

**A. PLEASE PROVIDE PATIENT/VISIT INFORMATION FOR THE FOLLOWING GENERAL CATEGORY OF PROCEDURES:**

UTILIZATION	CURRENT (LAST 12 MONTHS) PATIENTS/VISITS	PROJECTED (NEXT 12 MONTHS) PATIENTS/VISITS
Radiation Oncology/Therapy		
Non-Radiological Oncology		
Surgical Oncology		
All Other		

**B. PLEASE INDICATE WHICH OF THE SERVICES BELOW ARE BEING PROVIDED BY YOUR FACILITY:**

- |   |  |
|---|--|
| <input type="checkbox"/> Radiation Therapy  | <input type="checkbox"/> Chemotherapy          |
| <input type="checkbox"/> Internal Radiotherapy (Brachytherapy) – Radioactive Implants             | <input type="checkbox"/> Pain Management       |
| <input type="checkbox"/> External Radiotherapy (Teletherapy) – External Beam Therapy, Gamma Knife | <input type="checkbox"/> Mind-Body Medicine    |
| <input type="checkbox"/> Stereotactic Radiosurgery (SRS)  | <input type="checkbox"/> Naturopathic Medicine |
| <input type="checkbox"/> Stereotactic Radiotherapy (SRT)  | <input type="checkbox"/> Nutritional           |
| <input type="checkbox"/> Intensity-Modulated Radiation Therapy (IMRT)                             | <input type="checkbox"/> Urea Therapy          |
| <input type="checkbox"/> Three Dimensional Imaging  | <input type="checkbox"/> Cryotherapy           |

**C. ARE THERE ANY CHANGES PLANNED TO SERVICES YOU OFFER IN THE NEXT 12 MONTHS? (i.e., ARE YOU ADDING OR DISCONTINUING ANY SERVICES?)**  Yes  No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**D. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS?**  Yes  No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

**E. DO YOU HAVE THE FOLLOWING EQUIPMENT AT YOUR FACILITY?**

- |  |  |
|--|--|
| 1. Crash cart with full cardiac life support capabilities and necessary IV fluids? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Defibrillator?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. EKG?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Oxygen?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**F. WHAT PROVISIONS HAVE BEEN MADE FOR EMERGENCY CARE/TRANSFER PROTOCOL?**

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**G. HOSPITAL PROVIDING EMERGENCY CARE:**

Name \_\_\_\_\_

Address \_\_\_\_\_

**H. DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL LABORATORY, PHARMACY, RADIOLOGY, ETC.?)**  Yes  No

If yes, please explain and provide associated receipts or outpatient visits: \_\_\_\_\_  
 \_\_\_\_\_

**I. HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY?**  Yes  No

If yes, please complete a separate research supplemental questionnaire.





**E. IS THERE A WRITTEN INCIDENT REPORTING PROCEDURE?**

- 1. If yes, does this procedure require review and appropriate corrective action be taken?
- 2. Is follow-up made to assure compliance?

Yes  No  
 Yes  No  
 Yes  No

**F. IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE?**

- 1. If yes, is the person responsible for risk management a member of this committee?
- 2. To whom is the quality assurance committee accountable?

Yes  No  
 Yes  No

\_\_\_\_\_  
Name

\_\_\_\_\_  
Title

- 3. What quality indicators are monitored? (Please list)

\_\_\_\_\_

- 4. Do you monitor infection rates at your facilities?

Yes  No

**G. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS WHICH IS PART OF THE QUALITY MANAGEMENT PROGRAM?**

Yes  No

If no, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**H. IS THERE AN ON-GOING CONTINUING EDUCATION PROGRAM FOR:**

Nursing Staff?  Yes  No  
 Other Allied Health Professionals?  Yes  No

**PART VI – CREDENTIALING**

**A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF DO YOU:**

- 1. Verify educational background?
- 2. Check all references including past employers?
- 3. Check for pending license suspensions, revocations, or disciplinary actions by other facilities?
- 4. Check criminal history?
- 5. Require prior medical professional claim history?

Yes  No  
 Yes  No  
 Yes  No  
 Yes  No  
 Yes  No

**B. ARE CREDENTIALS FOR EACH PHYSICIAN REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES?**

Yes  No

**C. IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK?**

Yes  No

**D. DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN WORKING AT YOUR FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE?**

Yes  No

- 1. If yes, what are the minimum limits of liability required? \$ \_\_\_\_\_ / \$ \_\_\_\_\_
- 2. Are Certificates of Insurance obtained at least annually from each individual to verify coverage is in place?

Yes  No

**E. WHAT ARE THE MINIMUM LIMITS OF LIABILITY YOU REQUIRE NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT YOUR FACILITY TO CARRY?**

\$ \_\_\_\_\_ / \$ \_\_\_\_\_

**F. HAS THE LICENSE OF ANY PHYSICIAN BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS?**

Yes  No

**G. HAVE YOU MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK OF ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF DURING THE LAST FIVE YEARS?**

Yes  No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART VII – PHYSICAL PLANT**

A. PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY YOU. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE, PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.

Address of property to be insured	Use/occupancy	Square footage	Age	Type of construction	Number of stories	Fire protection*
Patient Care Buildings:						
Other Buildings:						

\*For each building indicate if there is a: Sprinkler System – Full, Partial, or No Sprinkler  
Smoke Detector, Heat Detector  
Fire Alarm – Central Station or Local Alarm

B. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATE (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER?  Yes  No

If no, please explain: \_\_\_\_\_

**PART VIII – GENERAL LIABILITY**

DO YOU DESIRE GENERAL LIABILITY COVERAGE?  Yes  No

If yes, complete this section.

A. IS THERE A PREVENTIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR THE BIO-MEDICAL EQUIPMENT AND SURGICAL MACHINES OR DEVICES AT THE FACILITY?  Yes  No

1. How often are non-expendable medical or surgical machines or devices inspected and maintained? \_\_\_\_\_

2. Who performs the maintenance of the above equipment?  Employees  Independent Contractors

3. If independent contractors, what are the minimum general liability limits that you require them to carry?

\$ \_\_\_\_\_ / \$ \_\_\_\_\_

4. Do you obtain a Certificate of Insurance annually to verify this coverage is in place?  Yes  No

B. DO YOU OWN OR OPERATE A LINEAR ACCELERATOR?  Yes  No

C. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS?  Yes  No

If yes, who is responsible for the preventive maintenance, inspection and repair of the equipment?  
\_\_\_\_\_

D. DO YOU LEND OR DONATE YOUR BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE?  Yes  No

If yes, describe: \_\_\_\_\_

E. DO YOU RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS?  Yes  No

If yes, who is responsible for the maintenance of the equipment?

F. DO YOU USE AN ADVERTISING AGENCY?  Yes  No

1. If yes, what is the minimum professional liability limit that you require them to carry?

\$ \_\_\_\_\_ / \$ \_\_\_\_\_

2. Are you included as an additional insured on the advertising agency's policy?  Yes  No

3. Is there a hold harmless agreement in the contract in favor of your facility?  Yes  No

**G. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS?**

Yes  No

If yes, please describe the changes planned including the time frame and the estimated cost:

\_\_\_\_\_

**H. DO YOU LEASE OR RENT SPACE TO OTHERS?**

Yes  No

If yes, indicate the following:

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Square footage Occupancy/Use of space

- 1. Does your lease require the tenant to carry general liability insurance with at least a \$1,000,000 limit?  Yes  No
- 2. Do you obtain a Certificate of Insurance annually to verify this coverage is in place?  Yes  No
- 3. Is the tenant required to list you as an additional insured on their general liability policy?  Yes  No

**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:** \_\_\_\_\_