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

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	Patient Care 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 night 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.

PART X - COMMENTS

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: ______________________________