Professional Security Insurance Company℠
a MagMutual company

HOSPITAL PROFESSIONAL LIABILITY APPLICATION

NOTICE: PROFESSIONAL LIABILITY AND EMPLOYEE BENEFITS LIABILITY COVERAGE ARE PROVIDED ON A CLAIMS-MADE BASIS. OTHER COVERAGE WITHIN THE POLICY MAY BE PROVIDED ON A CLAIMS-MADE OR OCCURRENCE BASIS. PLEASE REVIEW THE SPECIFIC POLICY FORM QUOTED TO CONFIRM HOW COVERAGE APPLIES.

APPLICANT

Legal Name:		Telephone No:	
Address:			
City:	County:	State:	ZIP:
Years in Operation:	Years Under Present Ownership:		
Website: www.			

Please list any affiliates or subsidiaries for which this insurance will apply. Please include a complete description of the operations of each listed entity and the relationship to the Applicant. (Attach a separate sheet if necessary):

REQUESTED & CURRENT COVERAGE STRUCTURE:

Requested Coverage: ☐ Primary ☐ Umbrella/Excess ☐ Both	Effective Date:	Retroactive Date:

Primary		**Umbrella/Excess**	
Per Claim Limit:		Per Claim Limit:	
Aggregate Limit:		Aggregate Limit:	
Per Claim Deductible/Retention:		Retained Limit:	
Aggregate Deductible/Retention:			

Self Insured Retention:	What coverage(s) does the SIR contemplate?	
	Limits of coverage provided by the SIR?	
	Do defense expenses erode the limit?	
	Is there a dedicated trust?	
	Who handles claims within the SIR?	

Current Coverage	PL	GL	Umbrella/Excess	AL	EL	Helipad
Carrier						
Policy Period						
Limits						
Deductible or Retention						
Claims Made or Occurrence						
Retroactive Date						
# Years Insured by Current Carrier						

* On a separate sheet of paper, please provide the information requested above for all other medical professional liability coverage(s) Applicant has had in the past five years.

GENERAL INFORMATION: *(check all that apply)*		
General Hospital ☐	Teaching Hospital ☐	For Profit ☐
Critical Access Hospital ☐	Research Hospital ☐	Not for Profit ☐
Long Term Acute Care Hospital ☐	Government Hospital ☐	Medicare Approved ☐
Psychiatric Hospital ☐	Nursing Home ☐	Partnership ☐
Children's Hospital ☐	Clinic ☐	Corporation ☐
Other Specialty		

Is this facility licensed by the State?	Yes ☐	No ☐
Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency?	Yes ☐	No ☐
If "Yes", please explain:		
Has the Applicant entered into any joint ventures or limited partnerships?	Yes ☐	No ☐
If "Yes", please explain. (Attach additional sheets of paper, if necessary)		
Is any part of the Applicant operated/leased by a management corporation?	Yes ☐	No ☐
If "Yes", please give the name of the corporation and details of structure. Please attach a separate sheet of paper if necessary.		
Does the Applicant participate in any teaching programs?	Yes ☐	No ☐
If "Yes", please explain:		
Is the program hospital-sponsored?	Yes ☐	No ☐
If "Yes", please provide the name of the sponsoring institution:		
Does the Applicant anticipate any facility expansions (increase in licensed beds) within the next year?	Yes ☐	No ☐
If "Yes", please explain:		

PERSONNEL:

Please indicate, by classification, the number of employed or contracted FTEs for whom coverage is desired under this policy:

Classification	FTEs	Classification	FTEs	Classification	FTEs
Physicians & Surgeons		Nurse Practitioners		Nurses Aides	
Residents		Midwives		Paramedics	
Dentists		Pharmacists		Emergency Medical Technicians	
CRNAs		Registered Nurses		Respiratory Therapists	
Physician Assistants		Licensed Vocational/Practical Nurses		Laboratory or X-Ray Technicians	

*On a separate sheet provide a detailed roster with retro date, specialty, term date (if applicable) etc.

If coverage is requested for the following, please indicate:

CRNA	Yes ☐	No ☐
Physician Assistant	Yes ☐	No ☐
Nurse Midwives	Yes ☐	No ☐
Employed Physicians & Surgeons	Yes ☐	No ☐
Residents	Yes ☐	No ☐

OPERATIONS:
SERVICES (Please indicate if the Applicant provides, or plans to provide, any of the following):

Abortion Clinic ☐	Open Heart Surgery ☐	Intensive Care Unit ☐
Ambulance Service ☐	Off – Premises Clinic ☐	Organ Bank ☐
Base Hospital ☐	Day Care ☐	Organ Transplants ☐
Blood Bank ☐	Outpatient Surgery Centers ☐	Dental Services ☐
Burn Units ☐	Emergency Room ☐	Lifeline ☐
Cardiac Catheter Centers ☐	Home Health Care ☐	Nursery ☐
Coronary Care Unit ☐	Hospice ☐	Neonatal ☐
Dialysis ☐	Hospital Foundation ☐	Pharmacy ☐
OB/GYN ☐	Inhalation Therapy ☐	Off Premises Labs ☐
Oncology ☐	HMO ☐	Mobile Unit (bloodmobiles, mammography, CAT scan, etc.) ☐
	Transportation Services ☐	

OCCUPANCY: (Provide average number of occupied beds in each category)

BEDS:

	Licensed	Projected	Current Year		Licensed	Projected	Current
Acute / ICU				Psychiatric			
Cribs / Bassinets				Rehabilitation			
Long Term Acute Care				Chemical Dependency			

Extended Care					Hospice			
Skilled Nursing					Other			

INPATIENT SERVICES:

	Projected	Current Year		Projected	Current Year
Inpatient Surgery			Cesarean Sections		
Deliveries (excluding C-Sections and VBACs)			VBACs		

OUTPATIENT SERVICES:

Emergency Room			Rehabilitation		
Outpatient Surgery			Home Health Care		
Other Outpatient Visits			Clinic Visits		
Psychiatric Visits			Physician Visits		
Alcohol/Drug Counseling			Reference Labs		

ANESTHESIA SERVICES:

Staffing is by:	☐ Contracted Physicians ☐ Employed Physicians	☐ Residents ☐ CRNAs
Are all physicians board certified?	☐ Yes ☐ No	
If under contract, to whom?		
Are contracted physicians required to carry professional liability insurance?	☐ Yes ☐ No	
If "Yes", what limits are required?		
If staffing is provided by CRNAs, are CRNAs:	☐ Employed by Applicant ☐ Employed by the Surgeon	☐ Employed by the Anesthesiologist ☐ Independent
Do CRNAs work under the direct supervision of an anesthesiologist?	☐ Yes ☐ No	

RADIOLOGY SERVICES:

Staffing is contracted by:	☐ Contracted Physicians	☐ Employed Physicians
	☐ Residents	
Are all physicians board certified?	☐ Yes ☐ No	
Are contract physicians required to carry professional liability insurance?	☐ Yes ☐ No	
If "Yes", what limits are required?		

OBSTETRICS:

Is the Applicant a regional referral center for newborns requiring intensive care?	☐ Yes ☐ No
If "No", does a written procedure exist for transferring all high risk mothers and/or babies?	☐ Yes ☐ No

Does the Applicant have a separate birthing center?	Yes ☐ No ☐

Can cesarean sections be performed within thirty (30) minutes at all times?	Yes ☐ No ☐
Do CNMs practice at your hospital?	Yes ☐ No ☐
If "Yes", are they supervised by OB physicians?	Yes ☐ No ☐
If employed, do CNMs deliver babies at home?	Yes ☐ No ☐
Do Family Physicians perform obstetrical services?	Yes ☐ No ☐
Do Family Physicians or CNMs perform VBACs or C-Sections?	Yes ☐ No ☐

If the Applicant has a neonatal intensive care unit (NICU), state:	
Total number of neonates admitted to NICU in the past twelve (12) months:	
Total number of neonates admitted to NICU who were transferred from other facilities:	
Whether full-time attending neonatologists on-site in NICU twenty-four (24) hours per day:	
If the Applicant does not have a NICU, please state the total number of neonates transferred from the institution to other facilities in the past twelve (12) months:	

EMERGENCY ROOM:		
Does the Applicant provide emergency room (ER) service?	Yes ☐ No ☐	
If "Yes", please answer the following questions:		
Staffing is by:	☐ Contracted Physicians	☐ Employed Physicians
	☐ Residents	☐ Physician Assistants
Are all physicians board certified?	Yes ☐ No ☐	
If under contract, to whom is staffing contracted?		
Are contract physicians required to carry professional liability insurance?	Yes ☐ No ☐	
If "Yes", what limits are required?		

SURGERY:	
Are any of the following performed at your facility:	
☐ Experimental Surgery	☐ Neurosurgery
☐ Open Heart Surgery	☐ Weight Reduction Surgery

SPECIAL SERVICES:							
Ambulance		Number of Vehicles		Blood Banks		Number of donors (pints)	
		Number of runs per year				Number of pints purchased from others	
Organ Tissue Bank		Number of donors		Day Care		Number of children per day	
						Number of days per week	
		Number of organ/tissue donations per year			On hospital premises?	Yes ☐	No ☐
					Open to the public?	Yes ☐	No ☐

STAFF PRIVILEGES:	
Are credentials for new staff members checked and approved prior to granting staff privileges?	Yes ☐ No ☐
If "No", please explain:	
Does the Applicant have any staff members who have restricted licenses or privileges?	Yes ☐ No ☐
If "Yes", please explain:	
Are all staff privileges reviewed at least every two (2) years?	Yes ☐ No ☐
Does the Applicant require all foreign school graduates to be certified by the Educational Council for Foreign Medical School graduates?	Yes ☐ No ☐
Are all staff members required to maintain professional liability insurance?	Yes ☐ No ☐

RISK MANAGEMENT:		
Is there a written, formalized risk management program?	Yes ☐ No ☐	
Who is in charge of implementing this program and any changes?	Name:	
	Title:	
	Phone:	
	Email:	
To whom does the Risk Manager or Director of Risk Management report?		

CONTRACTUAL AGREEMENTS:			
Are any of the following services performed at the hospital by contract professionals?			
☐ Pathology	☐ Laboratory		
☐ Pharmacy	☐ Other		
Does the Applicant require these contractors to provide evidence of insurance?		Yes ☐	No ☐
If "Yes", what limits of liability does the Applicant require?			
Are there any other service contracts in effect?	Yes ☐	No ☐	
If "Yes", please describe services:			
Does the Applicant indemnify (hold harmless) the service provider?	Yes ☐	No ☐	

PHYSICAL PREMISES:						
Please indicate below all the buildings the Applicant owns, controls or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. Please attach a separate schedule if more space is needed.						
	Address:				Year Built:	
	Construction (brick, fire-resistive, etc.)		No. of Stories:		Total Sq. Feet:	
	Use:		Inpatient / Outpatient:			

	Address:				Year Built:	
	Construction (brick, fire-resistive, etc.)		No. of Stories:		Total Sq. Feet:	
	Use:		Inpatient / Outpatient:			
	Address:				Year Built:	
	Construction (brick, fire-resistive, etc.)		No. of Stories:		Total Sq. Feet:	
	Use:		Inpatient / Outpatient:			

Does the Applicant use security guards?	Yes ☐ No ☐	
If "Yes", complete the following questions:	Services are provided by:	Employees ☐ Contractors ☐
	Do guards carry guns?	Yes ☐ No ☐

AUTO LIABILITY EXPOSURE

Indicate the number of vehicles in each of the following categories that the Applicant owns or operates:	**Vehicle Type**	
	Private Passenger	Patient Transport
	Service	Ambulance
	Other (describe):	

HELIPAD EXPOSURE:

Does the Applicant have a heliport / helipad?	Yes ☐ No ☐	
If "Yes", please complete the following:	Where is it located (e.g. parking lot, top of building, etc.)	
	How far is it from the Applicant?	
	Please list the dimensions:	
	Please describe the type of construction:	
	Estimated number of landings per year:	

COVERAGE:	
Past coverage:	Has any insurer canceled or declined to renew professional liability coverage? Yes ☐ No ☐
Claims / Incidents:	Please attach a loss run describing all claims/incidents during the past 7 years made against the Applicant or any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. (Attach additional sheets, if necessary). If answer is "none", so state:

Neither the Applicant nor any individual or entity proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows.

If answer is "none", so state:

ADDITIONAL INFORMATION:

Please disclose any information material to the risk which has not otherwise been addressed in this application (please attach additional sheets of paper if necessary).

Please provide the following information:

1. Historical Exposure for the last ten (10) years
2. Loss history for the last ten (10) years, including any claim paid or outstanding. Detailed losses should be provided including any paid or reserved amounts. Losses should be valued no earlier than ninety (90) days prior to the proposed effective date.
3. Employed Physician Schedule, including the name, specialty and retro date for each employed physician.
4. The Applicant's most recent annual report
5. A copy of the most recent JCAHO/State report and response to any contingencies
6. The Applicant's most recent financial statements
7. Copy of expiring Medical Professional Liability insurance policy
8. Current balance of the self-insured trust fund*
9. Trust Agreement*
10. Recent actuarial study supporting the funding of the self-insured trust*

*These items apply if Applicant has set up a self-insured trust fund

THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER'S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE OR ISSUE A POLICY.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

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 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 ARKANSAS APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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, WHICH IS A CRIME.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Applicant (signature):	Date:
By (CEO/President – Print Name)	

NOTE: This Application must be signed by the Chief Executive Officer or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance