



Hospital, Institution, Health Care Facility Professional Liability Application

Each question of this application is material and must be completed in detail. If a question does not apply, please indicate accordingly. If additional space is needed, please use the Additional Remarks Section at the end of the application.

Section I - Facility Information

Name of Applicant		
D.B.A.	Name of Parent Company	
Name of Administrator	Name of CFO	
Federal Tax Identification Number	Annual Receipts \$	Annual Payroll \$

Applicant is: (check all boxes applicable)

- | | | | |
|---|--|---|--|
| A. <input type="checkbox"/> Children's hospital
<input type="checkbox"/> Geriatric hospital
<input type="checkbox"/> General hospital
<input type="checkbox"/> Psychiatric hospital
<input type="checkbox"/> Rehabilitation hospital
<input type="checkbox"/> Teaching hospital
<input type="checkbox"/> Skilled nursing home
<input type="checkbox"/> Intermediate care home
<input type="checkbox"/> Assisted living home
<input type="checkbox"/> Independent living home
<input type="checkbox"/> Surgery Center
<input type="checkbox"/> Dialysis Center
<input type="checkbox"/> Physical & Rehabilitation Center
<input type="checkbox"/> Other: (Please specify Type _____) | B. <input type="checkbox"/> Individual
<input type="checkbox"/> Partnership
<input type="checkbox"/> Corporation
<input type="checkbox"/> Joint venture
<input type="checkbox"/> Government | C. <input type="checkbox"/> Profit
<input type="checkbox"/> Non-profit
<input type="checkbox"/> Charitable | D. <input type="checkbox"/> Accredited by J.C.A.H.O.
<input type="checkbox"/> Licensed by state
<input type="checkbox"/> Accredited by A.O.A.
<input type="checkbox"/> Medicare approved
<input type="checkbox"/> Member of A.H.A.
<input type="checkbox"/> Accredited by C.A.R.F. |
|---|--|---|--|

1. Are there any subsidiaries of this business facility that provide health care related services? Yes No
2. Is the facility eligible to be licensed to provide medical professional services? Yes No
(If yes, has licensed been issued and by whom?)
3. Does this facility provide services to Medicaid recipients, State and School Employees Health? Yes No
Insurance Program participants and Children's Health Insurance Program participants?

For Agent's Use Only (If applicable)			
Name of Agency: _____	Name of Agent: _____		
Address: _____	Phone Number: _____		
Signature: _____	Date: _____		
Are you licensed as a property/casualty insurance agent by the Mississippi Department of Insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	License Number: _____	Renewal Date: _____
Do you have active Errors and Omissions Insurance Coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy Number: _____	Policy Term: _____ to _____

Section II - Practice Locations

Primary Practice Address (Street, City, State, Zip Code)		
County	Primary Practice Phone Number	Primary Practice Fax Number

Secondary Practice Address (Street, City, State, Zip Code)		
County	Secondary Practice Phone Number	Secondary Practice Fax Number

1. May we communicate with you by fax? Yes No
2. May we communicate with you by e-mail? Yes No E-Mail Address _____
3. Do you have additional office locations not listed above? Yes No

Section III – Professional Liability Claims-Made Coverage Selection

Important: Coverage offered by The Advocate, MD Medical Malpractice Availability Plan is written on a claims-made form. Coverage will not apply to any medical incident, as defined by the Company, which occurred prior to the coverage effective date. Failure to obtain Reporting Coverage/Tail Coverage from your expiring carrier may leave you without complete coverage.

Upon cancellation of this claims-made policy it is necessary to purchase either Prior Acts Coverage from your new carrier or Reporting Coverage from The Advocate, MD Medical Malpractice Availability Plan.

1. Requested Effective Date of Coverage: _____ (12:01 a.m. Standard Time)
Month Day Year

Important: Coverage will become effective only after the completion of all underwriting functions, acceptance by the Company, and receipt of the appropriate payments.

2. Coverage Limit Sought

- \$1,000,000 each medical incident/\$3,000,000 annual aggregate
- \$500,000 each medical incident/\$2,000,000 annual aggregate

3. Type (select one)

- Private/Group Practice
- Political Subdivision

4. Occurrence General Liability (Optional)

- Yes
- No

Section IV - Insurance History

1. Has this facility ever operated without professional liability coverage? Yes No
2. Has this facility ever operated without commercial general liability coverage? Yes No
3. Was professional liability coverage for this facility ever placed with a non-admitted carrier? Yes No
4. If previously insured on a claims-made form, has this facility ever failed to obtain Extended Reporting Coverage? Yes No
5. Has this facility ever had its coverage denied, policy cancelled or non-renewed or had a policy issued that contained restrictions or special exclusions? Yes No

If the answer to questions 1 - 5 above is "Yes", please provide dates and explanations below:

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Professional Liability:

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date and Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

General Liability:

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date and Expiration Date					
Limits of Liability					

Section V – Employed Healthcare Providers

Following is list of Professional Employees for which coverage does not extend automatically. Coverage may be available, with an additional premium charge, for your employees while acting within the scope of their employment to you. Each Professional Employee listed below is required to complete an individual application if coverage is desired.

Professional Employees: (Indicate the total number of employees in each category and total employed and/or contracted)

Total: _____	Employed physicians	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Employed surgeons	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Podiatrists	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Oral surgeons/Dentists	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Physician assistant/Surgeon assistant	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Nurse midwives	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Nurse anesthetists	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Nurse practitioner	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Psychologist	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Profusionists	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Chiropractor	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Certified Nurse Anesthetists	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Cytotechnologist	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Emergency Medical Technicians	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Residents/Interns	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Optometrist	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____
Total: _____	Total Professional Employees	<input type="checkbox"/> Employed # _____	<input type="checkbox"/> Contracted # _____

Other Covered Employees: (Indicate the total number of employees in each category.)

Total: _____	Registered nurses
Total: _____	LPN's
Total: _____	Student nurses
Total: _____	X-Ray technicians
Total: _____	Pharmacists
Total: _____	Physical Therapists
Total: _____	Paramedics
Total: _____	Volunteers
Total: _____	Other employees
Total: _____	Total Other Covered Employees:

Section VI - Exposure Data Information

Facilities and Services Available: (Please check all that apply)

<input type="checkbox"/>	Abortion Clinic	<input type="checkbox"/>	Ambulance	<input type="checkbox"/>	Blood Bank
<input type="checkbox"/>	Burn Unit	<input type="checkbox"/>	CCU	<input type="checkbox"/>	Coronary Rescue
<input type="checkbox"/>	Day Care	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	Dietary
<input type="checkbox"/>	Emergency	<input type="checkbox"/>	Gift Shop	<input type="checkbox"/>	ICU
<input type="checkbox"/>	Inhalation Therapy	<input type="checkbox"/>	Long-Term Care	<input type="checkbox"/>	Morgue
<input type="checkbox"/>	Neonatal ICU	<input type="checkbox"/>	Nursery	<input type="checkbox"/>	Obstetrical
<input type="checkbox"/>	Open Heart	<input type="checkbox"/>	Operating Rooms	<input type="checkbox"/>	Pathology
<input type="checkbox"/>	Pharmacy	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	Radiology	<input type="checkbox"/>	Restaurant	<input type="checkbox"/>	Self-Care
<input type="checkbox"/>	Shock Trauma	<input type="checkbox"/>	X-Ray	<input type="checkbox"/>	Other _____

Indicate if department is staffed by employees, contractors, or staff and limits of liability required? (Please provide verification of coverage for contract services)

Department	Staffing	Insurance Limits
Anesthesiology	<input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contract Physicians <input type="checkbox"/> Staff Physicians	
Radiology	<input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contract Physicians <input type="checkbox"/> Staff Physicians	
Emergency Department	<input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contract Physicians <input type="checkbox"/> Staff Physicians	
Pharmacy	<input type="checkbox"/> Employed Pharmacists <input type="checkbox"/> Contract Pharmacists <input type="checkbox"/> Staff Pharmacists	

How many surgical procedures were performed in the last year by:

Employed Physicians _____ Staff Surgeons _____ Interns _____ Residents _____

Do you operate an Emergency Room? Yes No

Level of care given in Emergency Room? Level I Level II Level III Level IV

Professional Liability Exposures: (Please indicate zero where not applicable. Provide number of licensed beds and average occupied for past 12 month)

Acute Care:

Subacute Care:

Skilled Care:

Intermediate Care:

Assisted Living:

Personal Care:

Independent Living:

Psychiatric/Mental Health Beds:

Chemical Dependency / Rehabilitation

Beds:

ICS/CCU/NICU:

Bassinets:

# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	

Inpatient Surgeries and Outpatient Visits: (Please indicate zero where not applicable. Provide number of procedures for previous 12 months and number of outpatient visits projected for the next 12 month)

Inpatient Surgeries:

Outpatient Surgeries:

Births Total:

Vaginal Births

Cesarean Sections

Health Institutional (clinical) Visits:

Chemical Dependency:

Emergency Room Services:

Counseling/Therapy Visits:

Home Health/Hospice Visits:

Mental Health (psychiatric) Visits:

All other Outpatient Visits:

# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
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# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	

Section VII - Rating Information

1. Does your institution engage in formal clinical research under the auspices of an institutional review board? Yes No
2. Does your institution engage in administration of non-FDA approval pharmaceuticals? Yes No
3. Does your institution engage in bio-medical device research and development? Yes No
4. Does your institution engage in animal research? Yes No
5. Does your institution engage in medical and/or surgical experimentation that is not approved by institutional review board? Yes No
6. Have your licenses, certifications or ability to participate with Medicare or Medicaid ever been suspended, revoked, placed on probation or voluntarily surrendered? Yes No
7. Do you own or operate a blood bank? Yes No

If no, from where is the blood product obtained? _____

8. Does your facility meet current life safety code requirements as published in Fire/Code Uniform Fire Code? Yes No
9. Does your facility maintain a written patient transfer plan for all contingencies which includes an audit process that is monitored through committee? Yes No
10. Is your facility accredited by J.A.C.H.O. or A.H.C.A., or equivalent? Yes No
If yes, does your accreditation have outstanding contingencies? Yes No
11. Does your facility perform background checks on all staff who have patient or resident contact (employees, leased workers and volunteers) including criminal history (5 years), felonies, misdemeanors, sexual offenses, abuse, theft, assault, credit history, verification of all education, verification of references, US citizenship status/Visa, and substance test? Yes No
12. Does your facility operate solely in the State of Mississippi? Yes No
13. Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff? Yes No
14. Do facility by-laws require staff doctors, employed doctors, and contract doctors to carry medical malpractice insurance of at least \$1,000,000 each medical incident/\$3,000,000 annual aggregate? Yes No
15. Does your facility require certificates of insurance for all contract services? Yes No
16. Do you require all employed, contract, and staff doctors to be Board Certified or Board Eligible? Yes No
17. Are privileges probationary for at least six months for all staff doctors? Yes No
18. Are all new physicians required to be proctored by a member of the active medical staff? Yes No
19. Are staff physician's privileges and overall performances evaluated periodically? Yes No
20. Are all privileges granted to staff physicians detailed in writing? Yes No
21. Does the facility utilize the unit-dose system of dispensing medicine? Yes No
22. Is the pharmacy for patient-use only? Yes No

If the answer to questions 1 - 22 above is "Yes", provide detailed explanation below.

Section VIII - Risk Management

Who coordinates your risk management program?	
Name:	_____
Title:	_____
Telephone Number:	_____
Is there a written risk management program that has been approved by a governing body?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the risk manager accountable and solely responsible for risk management?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your facility maintain a written continuing education plan which includes risk management topics for nursing, physicians, administration, governing board and department heads?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your risk management program include occurrence reporting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your risk management program include review and participation in medical staff committees?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your risk management program include contract review and evaluation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your risk management program include claim management?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your risk management program include safety program and safety committee?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section IX - Loss Information

1. Are you now, or have you ever been involved, directly or indirectly in a claim, potential claim, or a suit arising out of the rendering or failing to render professional services? Yes No
- If "Yes" A. Indicate number closed, dropped, dismissed _____
- B. Indicate number pending or open _____
- C. Total number of cases (A+B) _____
- If "Yes," Have all claim/suits indicted in "C" above been reported to your current or prior professional liability carrier? Yes No
2. Other than those claims/suits indicated in question 1 above, do you have knowledge of any incident, potential claim, suit, or circumstances that might reasonably lead to a claim or suit being brought against you arising out of the rendering or failing to render professional services ? Yes No
- If "Yes" How many? _____
- If "Yes" Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? Yes No

Important: For each loss indicated in questions 1 and 2 above 1) you are required to complete the attached Supplementary Loss Information Form and 2) A 5-Year Carrier Loss Run is needed from your current and/or previous professional liability carrier(s). The Loss Run should include date of occurrence, date of report, description, indemnity amount paid, indemnity amount reserved, defense amount paid, defense amount reserved and current status.

Section X - Nursing Care Facilities Only

1. Years under current management: _____
2. Does a management company manage the facility? Yes No
- If yes, Name of Management Company: _____
- If yes, Number of years with current company: _____
3. Total number of units: _____
4. Total Number of Resident at Full Occupancy: _____
5. Are residents checked on every day? Yes No
6. Are residents allowed to have home health care aids? Yes No
7. Is the Director of Nursing a Registered Nurse? Yes No
8. Do you require nurses to carry malpractice coverage? Yes No
9. Total number of nurse employees? _____

Section XI - General Liability

<u>Location Including Patient Care Buildings, Other Buildings and Parking Lots</u>	<u>Square Footage</u>	<u>Age</u>	<u>Type of Construction</u>	<u>Number of Floors</u>	<u>Type of Fire Protection</u>

Application Checklist:

- Copy of most current declaration page
- Five-year Company Loss History
- Copy of Business Letterhead
- Supplemental Loss Information for each loss
- Individual Application for each Professional Employee
- Signature and Date on Application
- Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies
- Current audited financial statement
- Copy of medical staff by-laws
- A.H.A. Survey of hospitals
- Risk Management and quality improvement plan
- Verification of professional liability coverage for all contracted services
- All hold harmless agreements

Return Application to the Underwriting Department at:

Advocate, MD

811 Barton Springs Road

Suite 800

Austin, TX 78704

Phone: 888-239-2501

Fax: 512-275-1240

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section IX - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- | | | |
|---|---|---|
| <input type="checkbox"/> Incident report only | <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Suit filed but dropped by claimant |
| <input type="checkbox"/> Summary judgment in your favor | <input type="checkbox"/> Jury verdict in your favor | <input type="checkbox"/> Jury verdict in favor of the plaintiff |
| <input type="checkbox"/> Suit settled out of court | <input type="checkbox"/> Suit filed awaiting mediation | <input type="checkbox"/> Suit filed awaiting court action |

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section IX - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- | | | |
|---|---|---|
| <input type="checkbox"/> Incident report only | <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Suit filed but dropped by claimant |
| <input type="checkbox"/> Summary judgment in your favor | <input type="checkbox"/> Jury verdict in your favor | <input type="checkbox"/> Jury verdict in favor of the plaintiff |
| <input type="checkbox"/> Suit settled out of court | <input type="checkbox"/> Suit filed awaiting mediation | <input type="checkbox"/> Suit filed awaiting court action |

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____