APPLICATION FOR HOSPITALS PROFESSIONAL AND/OR GENERAL LIABILITY INSURANCE
(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by HOSPITAL ADMINISTRATOR.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

PART I - ALL APPLICANTS MUST COMPLETE

1. APPLICANT INFORMATION

a. Full name of applicant (NOTE: Attach list of any entities to be considered as additional Insureds, and include a brief explanation of their interests and operations and their relationship to applicant):

_____

b. Principal business premise address (Attach list of additional locations): _____
(Street)

_____
(County) (City) (State) (Zip)

c. Applicant is: (Check appropriate box in each column)

Specialty	Ownership	Operations
☐ General Hospital	☐ Individual	☐ Operated for Profit
☐ Children's Hospital	☐ Partnership	☐ Not for Profit
☐ Research Hospital	☐ Corporation	
☐ Osteopathic Hospital	☐ Governmental	
☐ Convalescent or Nursing Home	☐ Charitable	
☐ Other _____	☐ Other _____	

2. OPERATIONS

a. Are you:

(i) Approved for Medicare? ..... ☐ Yes ☐ No

(ii) Accredited by the Joint Commission on Accreditation of Healthcare Organizations? ..... ☐ Yes ☐ No

Date of most recent JCAHO accreditation ____/____/____

Number of years accredited:____

(iii) A member of the American Hospital Association? ..... ☐ Yes ☐ No

(iv) Licensed and certified as required by state and federal laws and regulations? ..... ☐ Yes ☐ No

(v) A member of the State Association? ..... ☐ Yes ☐ No

If the answer to any item above is "NO," or if accreditation, license, approval or membership has been denied, canceled or made provisional, please attach an explanation.

b. Please complete the following financial summary for the past 3 years and submit copies of the hospital's most recent audited financial statements.

Fiscal Year (Ending Date)	Revenue from Operations	Profit (Loss) from Operations	Sum of Fund Balances	% Medicare	% Medicaid	% Blue Cross	% Other
	$	$	$				
	$	$	$				
	$	$	$				

c. Please estimate number of upcoming year:

(a) Average daily occupied beds --short-term beds _____
(b) Average daily occupied beds --long-term beds _____
(c) Average daily occupied beds --bassinets _____
(d) Total emergency department visits* _____
(j) Total number of births _____
Total number of C-Sections _____
(k) Total heliport landings per year _____
(l) Total helicopter flights per year _____

(e) Total other outpatient visits* _____

(f) Total home health visits _____

(g) Total inpatient surgical procedures _____

(h) Total outpatient surgical procedures _____

(i) Total number surgical (inpatient and outpatient):

(a) Weight reduction _____

(b) Sex change _____

(c) Experimental _____

No. of Licensed Beds:

Short term: _____

Long term: _____

Bassinets: _____

*Use visits rather than occasions of service. For example, a patient referred to the hospital by a physician for a laboratory test and an x-ray would be counted as one visit, but two occasions of service. A visit is a threshold crossing which may involve multiple occasions of service from more than one clinical department.

d. Do you advertise your professional services in any manner (other than a listing in a telephone directory)? .... ☐ Yes ☐ No
If yes, attach a copy of ALL of your advertisements and/or scripts. Please indicate total annual expense for all advertising: $ _____.

e. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... ☐ Yes ☐ No

If yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... ☐ Yes ☐ No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available at https://www.markelcorp.com/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

3. SERVICES

a. Please check all that apply:

- ☐ Abortion Clinic
- ☐ No. Of procedures
- ☐ Ambulance
- ☐ ACLS Provider
- ☐ Ambulatory Care Clinics
- ☐ Blood Bank
- ☐ Burn Unit
- ☐ CCU
- ☐ No. of beds
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Day Care
- ☐ No. of children
- ☐ No. of adults
- ☐ Dental
- ☐ Dialysis
- ☐ Durable Medical Equipment Service
- ☐ Emergency Services
- ☐ Freestanding Emergency Services
- ☐ Genetic Counseling
- ☐ Heliport*
- ☐ Helicopter Service
- ☐ HMO Affiliation
- ☐ Home Health Care
- ☐ Hospice
- ☐ ICU
- ☐ No. Of beds
- ☐ Intermediate Care
- ☐ Laundry
- ☐ Neonatal ICU
- ☐ No. Of beds
- ☐ Nuclear Medicine
- ☐ Nursery
- ☐ Obstetrics
- ☐ Occupational Therapy
- ☐ Oncology
- ☐ Open Heart Surgery
- ☐ Operating Room
- ☐ Organ Bank
- ☐ Other Alternative Health Care
- ☐ Orthopedics
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pharmacy
- ☐ Physical Fitness Center
- ☐ Physical Therapy
- ☐ PPO
- ☐ Psychiatric Unit
- ☐ No. Of beds
- ☐ Radiology
- ☐ Rehabilitation
- ☐ Cardiac
- ☐ CNS
- ☐ Respiratory Therapy
- ☐ Restaurant
- ☐ Same Day Surgery
- ☐ Self Care
- ☐ Skilled Nursing Care
- ☐ Training Program
- ☐ Type_____
- ☐ Transplants
- ☐ Trauma Center
- ☐ Wellness Center

* Is the Heliport FAA approved? ☐ Yes ☐ No

b. **Non-Physician Support Personnel***

	Employed # of persons	Contracted # of persons
Physician Assistant	_____	_____
Psychologist	_____	_____
RN	_____	_____
LPN	_____	_____
Nurse Practitioner	_____	_____
CRNA	_____	_____

	Employed # of persons	Contracted # of persons
Lab Technician	_____	_____
X-Ray Technician	_____	_____
Radiation Therapists	_____	_____
Nuclear Medicine Technicians	_____	_____
Physical Therapists	_____	_____
Pharmacists	_____	_____
Respiratory Therapists	_____	_____
Emergency Medical Technicians	_____	_____

*NOTE: Be sure to include the support personnel in the figures as "Contracted," if they are employees of the physician and on your premises.

c. **Other Non-Physician Professionals**: List on Separate Sheet
(i.e., Reg. Dietician, Social Worker, Patient Rep., Med. Records-RPA/ART)

PART II - COMPLETE ONLY IF PROFESSIONAL LIABILITY COVERAGE IS DESIRED

1. ADMINISTRATIVE PROCEDURES

a. Physicians Orders - Required in writing and signed by physician? ☐ Yes ☐ No

b. Patient Consent - Are admission consent, operation permit and release forms signed by patients? ☐ Yes ☐ No

c. Are Nursing Charts maintained, including hospital record of patients' condition at discharge? ☐ Yes ☐ No

d. How long are records in items a - c kept? _____

e. Does the hospital have a patient discharge procedure? ☐ Yes ☐ No
Must the attending physician approve all discharges? ☐ Yes ☐ No

f. Does the hospital have an infection committee? ☐ Yes ☐ No
If no, please attach explanation.

g. Are written procedures in effect for incident reporting? ☐ Yes ☐ No

h. Provide name and title of individual responsible for reviewing incident reports and determining whether corrective action is necessary: _____

2. STAFF PRIVILEGES

a. Are credentials for new staff doctors checked and approved prior to granting staff privileges? ☐ Yes ☐ No
If yes, by whom? _____

b. Describe your **verification process** for all employed and attending physicians' degrees and experience:

_____

_____

_____

c. Are privileges probationary for at least 6 months for new staff doctors? ☐ Yes ☐ No

d. Do you have any restricted license physicians on staff? ☐ Yes ☐ No
If yes, please explain on separate sheet.

e. Is all staff doctors' work evaluated by the department chief in accordance with a written evaluation procedure? ☐ Yes ☐ No

f. Describe your peer review process for physicians: _____

_____

_____

g. Do the hospital By-Laws require certificates of insurance from all staff doctors? ☐ Yes ☐ No
If yes, what are the minimum limits of liability that are required? $_____

NOTE: PLEASE ATTACH A COPY OF THE BY-LAWS

h. How often are the certificates of insurance audited to assure continued compliance? _____

3. ANESTHESIA

a. Is anesthesia administered by a contract group? ☐ Yes ☐ No
If yes, does the contract group furnish the applicant with hold-harmless agreement(s) and certificate(s) of insurance? If yes, please attach copy of agreement or certificate. ☐ Yes ☐ No

b. Is anesthesia administered by your employees? ☐ Yes ☐ No

If yes, complete the following:

(i) How many anesthesiologists are employed? _____

(ii) Are the anesthesiologists insured separately? ☐ Yes ☐ No
If yes, name of carrier(s): _____ Limits of Liability: _____

(iii) Number of RNs employed who are licensed to administer anesthesia: _____

(iv) Are the above RNs insured separately? ☐ Yes ☐ No
If yes, Name of carrier(s): _____ Limits of liability: _____

(v) Types of anesthesia used: _____

(vi) Describe procedures for storage of anesthetics: _____

_____

_____

4. EMERGENCY ROOM

a. Is the emergency room:

(i) Operated by a service group under contract? ☐ Yes ☐ No

(ii) Operated by the applicant? ☐ Yes ☐ No

(iii) If the emergency room is operated by others, is separate insurance maintained and a certificate of insurance furnished to hospital? ☐ Yes ☐ No
If yes, what limits of liability are maintained? _____

Note: Please attach a copy of the agreement or certificate.

b. Is the emergency room equipped with the following on a 24-hour basis:

(i) Anesthetics? ☐ Yes ☐ No

(ii) Oxygen? ☐ Yes ☐ No

(iii) Blood (at least "O" negative)? ☐ Yes ☐ No

(iv) Intravenous fluid? ☐ Yes ☐ No

(v) Drugs essential to save life? ☐ Yes ☐ No

(vi) Cardiopulmonary resuscitation facilities? ☐ Yes ☐ No

(vii) Electrocardiograph machine? ☐ Yes ☐ No

(viii) X-ray machine capable of accommodating an unconscious patient in any position? ☐ Yes ☐ No

c. Is a licensed physician on duty at all times? If no, please attach explanation. ☐ Yes ☐ No

d. What are the minimum qualifications required of the senior medical professional in the emergency room (Surgeons, G.P., Resident, Intern, Nurse)? _____

_____

_____

e. Are patients transferred in accordance with the COBRA legislation requirements? ☐ Yes ☐ No
If no, please attach explanation.

f. Do you have a list of hospitals that you prefer to use for transferring patients? ☐ Yes ☐ No
If yes, attach a copy of the list. If no, attach explanation.

5. RADIOLOGY

a. Number of annual x-ray exposures for diagnosis _____; for treatment _____.

b. If x-ray treatment is given, what qualifications are required of the staff? _____

_____

c. Do you use radium or other isotopes? ☐ Yes ☐ No

If yes, describe safety precautions taken: _____

_____

d. What is the type and frequency of tests for stray x-ray radiation? _____

_____

e. What is the frequency of calibration tests and by whom are the tests performed? _____

_____

f. Do floor and ceiling of room(s) where the radium or x-ray is used have lead lining or equivalent protection? ☐ Yes ☐ No

If no, please explain: _____

_____

g. Have there been any accidents involving the use of radium or x-ray? ☐ Yes ☐ No
If yes, attach explanation.

6. OBSTETRICAL SERVICES

a. Describe your procedure for identifying infants: _____

_____

_____

b. Is fetal monitoring performed on all patients in active labor? ☐ Yes ☐ No

c. Is attending physician required to approve use of oxytocic drugs during labor? ☐ Yes ☐ No

d. Does a written procedure exist for transferring all high risk mothers and/or babies whom the hospital is not qualified to treat? ☐ Yes ☐ No

7. MEDICAL TRAINING

a. If applicant has a training school, complete the following. Attach separate schedule, if needed.

Profession for Which Students are Being Trained		Max. No. of Students Per Session	No. of Sessions Per Year	% of Time Involved in Clinical Setting	Number of Faculty	Qualification of Faculty (e.g. MD, RN, PhD, etc.)

b. (i) Does applicant have any involvement with any accredited residency program? ☐ Yes ☐ No

(ii) If YES: Owned _____ Consortium _____ Neither _____.
Name other parties involved on separate sheet.
Explain program including names and relationship to your hospital on separate sheet.

(iii) Number of residents in the program:

Allergy & Immunology	_____	Orthopedic Surgery	_____
Anesthesiology	_____	Otolaryngology	_____
Colon & Rectal Surgery	_____	Pathology	_____
Dermatology	_____	Pediatrics	_____
Family Practice	_____	Physical Medicine &	
General Practice	_____	Rehabilitation	_____
General Surgery	_____	Plastic Surgery	_____
Internal Medicine	_____	Preventative Medicine	_____
Neurological Surgery	_____	Psychiatry	_____
Neurology	_____	Radiology	_____
Nuclear Medicine	_____	Thoracic Surgery	_____
Obstetrics-Gynecology	_____	Urology_____	_____
Ophthalmology	_____	Other (identify)	_____

8. PROFESSIONAL LIABILITY INSURANCE HISTORY

a. Have any claims been made or incidents reported during the last 5 years against the applicant? ..... ☐ Yes ☐ No
If yes, please complete the following:

Annual Policy Period	Name of Carrier	Deductible	No. of Claims	Total Reserves	Total Paid Claims	Total Incurred Losses
				$	$	$
				$	$	$
				$	$	$
				$	$	$
				$	$	$

It is agreed that if there are any claims made or incidents reported shown above, claim(s) emanating there from will not be covered under the policy for which application is being made.

b. Do any of the losses shown in Question 8(a) exceed $5,000? ..... ☐ Yes ☐ No

If yes, attach explanation of each of the loss, including date of incident, year suit instituted or claim made, claimant, allegations, disposition and amount paid or currently reserved. Attach updated, validated loss runs by policy period.

c. List professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form? Yes	No	Retro Date
						☐	☐	
						☐	☐	
						☐	☐	
						☐	☐	

d. Is the applicant aware of any act, error or omission in professional services which may result in a malpractice claim or suit being made or brought against the applicant?..... ☐ Yes ☐ No
If yes, attach explanation. It is agreed that if there is knowledge of any act, error or omission, claim(s) emanating therefrom will not be covered under the policy for which application is being made.

e. Does the applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism?..... ☐ Yes ☐ No

PART III - COMPLETE ONLY IF GENERAL LIABILITY COVERAGE IS DESIRED

1. PREMISES - HOSPITAL SAFETY

a. Identify all buildings by use - i.e., Hospital, Clinic, Extended Care Facility, etc.

Buildings by Use	Total Beds	No. Of Fire Divisions	Date Built	No. Of Stories	Fire Resistive Construction Yes	No	Complete Sprinkler System Yes	No
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

b. All other premises owned, leased or occupied by the Applicant. Attach separate schedule, if needed.

Address	Use	Date Built	No. Of Stories	Fire Resistive Construction Yes	Fire Resistive Construction No	Complete Sprinkler System Yes	Complete Sprinkler System No
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

c. Is there a written emergency evacuation plan? ..... ☐ Yes ☐ No

d. Frequency of evacuation drills. _____

e. Frequency of fire drills _____

f. Are all patient care facilities equipped with:

(i) At least two clearly marked exits on each floor? ..... ☐ Yes ☐ No

(ii) Self-closing fire doors on each floor? ..... ☐ Yes ☐ No

(iii) Exit doors of at least 42 inches width from all sleeping, diagnostic and treatment rooms? ..... ☐ Yes ☐ No

(iv) Automatic fire alarm system connected to local fire department? ..... ☐ Yes ☐ No

(v) Smoke detectors? ..... ☐ Yes ☐ No

(vi) Emergency electrical system? ..... ☐ Yes ☐ No

2. PRODUCT/SERVICES INDEMNIFICATION

a. Estimated annual sales of medical equipment supplies: $_____

b. Estimated annual rental receipts of medical equipment: $_____

c. Estimated annual receipts from servicing equipment of others: $_____

d. Do you obtain revenue from contracting with others for services (i.e., laundry, food, maintenance)? .. ☐ Yes ☐ No
If yes, sales from service contract: $_____

e. Do you modify the design or function of any medical equipment? ..... ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

f. Describe other products or services: _____

_____

_____

3. HISTORY

Provide general liability loss experience.

a. Frequency for each of the last 2 years.

Annual Policy Period	Name of Carrier	No. of Claims	Total Incurred Losses (Paid Loss & Reserves)

b. Severity for each of the last 5 years (losses exceeding $5,000 including expense). Attach additional schedule, if needed.

Date of Occurrence	Brief Description of Occurrence (Paid or Reserved)	Loss Amount Expense

c. Are you aware of any circumstances which may result in a general liability claim or suit being made or brought against you? ..... ☐ Yes ☐ No
If yes, attach explanation. It is agreed that if there is knowledge of any incidents, claim(s) emanating therefrom will not be covered under the policy for which application is being made.

d. List general liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Insurance Company	Policy Number	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form? Yes	No
						☐	☐
						☐	☐
						☐	☐
						☐	☐

e. Attach copy of most recent property and boiler inspection reports. If available, also include recent liability survey report and diagrams of professional buildings.

f. Who is the present fire insurer? _____

Hospital Building Rate? _____

g. Who is the present boiler insurer? _____

h. Has any insurance company or Lloyd's of London ever canceled, declined, refused to renew or accepted only on special terms your professional liability or general liability insurance? ..... ☐ Yes ☐ No
If yes, please explain.

Primary Limits of Liability requested: $ _____

Aggregate Limits of Liability requested: $ _____

Effective Date Requested: _____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We hereby authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

_____ _____
Name of Applicant Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.