

# AMERICAN INTERNATIONAL COMPANIES®

## APPLICATION FOR HOSPITAL PROFESSIONAL LIABILITY/GENERAL LIABILITY AND UMBRELLA EXCESS LIABILITY INSURANCE

Please review this application carefully and discuss it with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

### Instructions:

1. Please use Microsoft Word to type text directly onto the application.
2. Answer **ALL** questions completely, leaving no blanks. If any questions, or part thereof, do not apply, state "N/A."
3. If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.
4. When necessary, check all boxes that apply.

### **SECTION I**

Please attach the following:

1.  Loss History, hard copy carrier loss runs and, when available, in electronic format:
  - a. Ten years of historical PL and GL losses including current year, ground-up and unlimited, including all self insured, insured, and uninsured losses.
  - b. Date of loss valuation must be within past ninety days.
  - c. Lost run must include: carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL), and narrative of claim.
  - d. Full details of allegations on all losses paid or outstanding in excess of \$50,000 even if greater than 10 years old.
2.  Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or if accrediting agency reports are unavailable please submit the state licensure report with recommendations and the institution's response to any contingencies.
3.  CPA prepared and audited financial statement, including balance sheet, income statement, and cash flow.
4.  Identity of each employed physician, indicating name, specialty, date of hire, retro date, primary PL carrier, primary occurrence or claims made, PL limits. See Section IV, B 2 for table.
5.  Identity of each Named Insured on the policy including a brief explanation of their relationship to the applicant and their retro date (if historically written on claims made basis).
6.  Copy of current risk management and quality improvement plan.
7.  Recent actuarial review supporting the funding of any self insured retention.
8.  Copy of current Organizational Chart (Corporate and Risk Management)
9.  Copy of Claim Management Procedures.
10.  Completed Hospital Addendum. Please request addendum from your broker.
11.  Completed Bariatric Surgery Addendum, if applicable. Please request addendum from your broker.
12.  Complete schedule of locations owned, leased or operated.

- 13.  For Excess coverages (when AIG is not primary carrier) please provide copies of all underlying policies.
- 14.  For Umbrella coverages please provide copies of Primary Declaration pages or COI for all applicable coverages (auto, employers liability, heliport, helipad, etc.)
- 15.  Copy of underlying automobile carrier's loss run for the past 5 years including the following information: carrier, date of loss, report date, total incurred, status (open or closed), and narrative of claim. Date of loss valuation must be within past ninety days.

***The items requested above are mandatory before a quotation can be promulgated.***

**SECTION II**

**A. General Information:**

New Applicant  or Renewal

Employers Federal Tax ID #

Requested Effective Date of Coverage:

Retro Date:

Applicant name (the legal name of the hospital or entity to be insured)

Address

City

County

State

Zip

Website Address

Contact Person

Title

E-mail

Phone Number

Fax#

Number of years in operation

Number of years under current ownership

**B. Applicant is (check all that apply):**

<input type="checkbox"/> Hospital – General Acute Care	<input type="checkbox"/> Profit	<input type="checkbox"/> Individual	<input type="checkbox"/> Accredited by JCAHO
<input type="checkbox"/> Hospital – Children's	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Partnership	<input type="checkbox"/> Accredited by AOA
<input type="checkbox"/> Hospital – Teaching	<input type="checkbox"/> Governmental	<input type="checkbox"/> Corporation	<input type="checkbox"/> Accredited by CARF
<input type="checkbox"/> Hospital – Psychiatric		<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Licensed by State
<input type="checkbox"/> Hospital – Rehabilitation			<input type="checkbox"/> Medicare Approved
<input type="checkbox"/> Hospital – LTAC			<input type="checkbox"/> Member of AHA
<input type="checkbox"/> Hospital – Women's			<input type="checkbox"/> Member of NPSF
<input type="checkbox"/> Other – Please explain			

**C. Teaching Hospitals:**

- 1. Please identify the type of training program(s) offered:  
 Residency , Nursing , Physicians Assistants , Physical Therapy  other  
 Please provide the number of trainees enrolled in each program in the past 12 months: Residency \_\_\_\_\_,  
 Nursing \_\_\_\_\_, Physicians Assistants \_\_\_\_\_, Physical Therapy \_\_\_\_\_, other \_\_\_\_\_
- 2. The training program(s) is/are accredited by \_\_\_\_\_

**D. Accreditation:**

1. Accredited Programs:
2. Please provide date of most recent JCAHO accreditation.
3. Accreditation Decision:  
 Accredited    Provisional Accreditation    Conditional Accreditation    Preliminary Denial of Accreditation  
 Denial of Accreditation    Preliminary Accreditation
4. Requirements for Improvement?    Yes    No  
 If yes, please provide list of standards scored as non-compliant:
5. Did the survey identify any life safety issues?    Yes    No  
 If yes, please explain
6. Were partially compliant standards identified in the supplemental findings?    Yes    No  
 If yes, please explain

**E. Current Insurance Coverage:** (expand the table with additional rows as needed, or attach separate page)

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	Ded <input type="checkbox"/> or SIR <input type="checkbox"/>	Premium
Professional Liab PL							
General Liab GL							
Employee Benefits							
<b>Excess/Umbrella</b>							
Underlying PL							
Underlying GL							
Auto Liab.							
Employers' Liab.							
Employee Benefits							
Helipad/Aviation							
Other:							

1. Are defense/expenses within policy limits?    Yes    No
2. Is underlying/retention eroded by indemnity only    or indemnity plus defense/expenses?

**\*Please specify by layer if more than one Retroactive Date applies.**

**F. Prior Insurance History:**

If commercially insured, please provide the following primary and excess/umbrella PL coverage information for each of the past 5 years.

Policy Period	Carrier	PL Limits Per Occ/Agg Primary	PL Limits Per Occ/Agg Excess/Umbrella	Ded <input type="checkbox"/> or SIR <input type="checkbox"/>	Occ. or Claims Made	Premium
Current						

**G. Insurance Coverage Desired:**

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	**Ded <input type="checkbox"/> or SIR <input type="checkbox"/>
Professional Liab PL						
General Liab GL						
Employee Benefits						
<b>Excess/Umbrella</b>						
Underlying PL						
Underlying GL						
Auto Liab.						
Employers' Liab.						
Employee Benefits						
Helipad/Aviation						
Other:						

1. Will defense/expenses be within policy limits?  Yes  No
2. Will underlying/retention be eroded by indemnity only  or indemnity plus defense/expenses?

\*Please specify by layer if more than one Retroactive Date applies.

\*\*Deductibles require AIG approved Letter of Credit.

**H. SIR Accounts:**

1. To what line(s) of coverage will the SIR apply?
2. What are the limits of liability for the SIR? \$ \_\_\_\_\_ per occurrence, \$ \_\_\_\_\_ aggregate.
3. Are loss adjustment expenses part of  or outside  the SIR limit?
4. Is there a dedicated trust?  Yes  No.  
If yes, what financial institution manages the trust?  
If not, is there a captive?  Yes  No.  
Details.
5. Has an independent actuarial review been completed?  Yes  No  
If yes, please provide the name of the firm \_\_\_\_\_ Date: \_\_\_\_\_

**I. Claims Management:**

1. Who, within the organization, is responsible for claims management activities?  
Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_
2. Do you have written claims management procedures: Yes , please attach. No
3. Does a Third Party Administrator manage claims within the SIR? Yes  No   
If yes, please provide name of TPA Firm and Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_
4. Please provide names of defense firms who currently represent you in professional liability matters:

**SECTION III**

**A. Services Provided (check all that apply):**

☛ If checked below, please answer applicable questions in Sections B-I .

<input type="checkbox"/> Abortion	<input type="checkbox"/> Home Health	<input type="checkbox"/> Open Heart
<input type="checkbox"/> Ambulance ☛	<input type="checkbox"/> ICU	<input type="checkbox"/> Operating Rooms
<input type="checkbox"/> Bariatric Surgery ☛	<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Pathology
<input type="checkbox"/> Blood Bank ☛	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Pharmacy ☛
<input type="checkbox"/> Burn Unit	<input type="checkbox"/> Laser Assisted Surgery	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Cath Lab	<input type="checkbox"/> Lithotripsy	<input type="checkbox"/> Plastic / Cosmetic Surgery
<input type="checkbox"/> CCU	<input type="checkbox"/> Long Term Care☛	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Clinical Trials	<input type="checkbox"/> Morgue	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Coronary Rescue	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Radiology
<input type="checkbox"/> Day Care ☛	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Research
<input type="checkbox"/> Dialysis	<input type="checkbox"/> NICU	<input type="checkbox"/> Self-Care

<input type="checkbox"/> Dietary	<input type="checkbox"/> Nurse Call	<input type="checkbox"/> Sex Change
<input type="checkbox"/> Emergency	<input type="checkbox"/> Nursery	<input type="checkbox"/> Shock Trauma
<input type="checkbox"/> Fitness Center ☻	<input type="checkbox"/> OB/Gyn	<input type="checkbox"/> Surgery
<input type="checkbox"/> Gift Shop	<input type="checkbox"/> Oncology	<input type="checkbox"/> Transplant ☻

- Does the hospital intend to commence a service identified above within the next 12 months?  Yes  No  
If yes, please explain.
- Does the hospital intend to cease a service identified above within the next 12 months?  Yes  No  
If yes, please explain.

**B. Ambulances:**

- Is excess/umbrella AL coverage desired for ambulance(s)?  Yes  No
- Are ambulances used as first responders , patient transport , or both ?
- Number of ambulances in fleet:
- Service radius: \_\_\_\_\_ miles.
- Number of emergency runs in the past 12 months:

**C. Bariatric Surgery:**

A completed supplemental application is required for Bariatric Surgery Programs. Please request the addendum from your broker.

**D. Blood Banks:**

- Please identify the screening test(s) utilized by the hospital.
- Accredited by AABB , ARC , ABC , CAP , JCAHO , other \_\_\_\_\_
- Is any blood or blood product bought or obtained from outside the U.S.?  Yes  No  
If yes, please explain.
- Does the blood bank outsource its blood testing?  Yes  No  
If yes, please provide details:
- Number of volunteer and paid donations in the past 12 months:
- Number of pheresis procedures in the past 12 months:
- Number of outpatient transfusions in the past 12 months:
- Number of therapeutic plasma exchanges in the past 12 months:

**E. Day Care:**

- Is the day care center on the hospital premises?  Yes  No
- Is the day care center open to the public?  Yes  No
- Number of children enrolled in the past 12 months:

**F. Fitness Center:**

- Is the fitness center on the hospital premises?  Yes  No
- Is the fitness center open to the public?  Yes  No
- Number of members enrolled in the past 12 months:

**G. Long Term Care:**

- Are the long term care beds located within the hospital  or in a stand-alone facility?
- Is the stand-alone facility on the hospital premises?  Yes  No
- Does the stand-alone facility fall under the hospital's Risk Management?  Yes  No
- Does the stand-alone facility follow policies established by the hospital?  Yes  No

**H. Pharmacy:**

- Does the hospital utilize the unit dose system of dispensing medicine?  Yes  No
- Is the pharmacy for patient use only?  Yes  No  
If no, annual receipts for non-patients medications are \$ \_\_\_\_\_
- Is the pharmacy staffed by a contract group?  Yes  No  
If yes, please explain:

**I. Transplant:**

1. Number of tissue donations in the past 12 months: \_\_\_\_\_ and projected next 12 months: \_\_\_\_\_
2. Number of organ donations in the past 12 months: \_\_\_\_\_ and projected next 12 months: \_\_\_\_\_
3. Accredited by AOPO , AATB , EBAA , other \_\_\_\_\_
4. Does the hospital have a formal policy regarding the informed consent process?  Yes  No
5. Has the hospital been involved in any tissue FDA recalls?  Yes  No  
If yes, please explain.
6. Has the hospital initiated any voluntary tissue recalls in the past 5 years?  Yes  No  
If yes, please explain.
7. Are any tissues procured/recovered from outside the U.S.?  Yes  No  
If yes, please explain.
8. Are any non-human tissues used in any way at the hospital?  Yes  No  
If yes, please explain.
9. Do you accept John Doe Donors?  Yes  No
10. Do you participate in a living donor program?  Yes  No
11. Has the hospital agreed to unilaterally hold harmless or indemnify others under contract?  Yes  No
12. Does the hospital place all organs through UNOS?  Yes  No  
If no, do you have a protocol for ensuring compatibility?  Yes  No
13. Please indicate all of the transplant operations at the hospital:

<input type="checkbox"/> OPO	<input type="checkbox"/> Eye Procurement	<input type="checkbox"/> Tissue Procurement	<input type="checkbox"/> Tissue Processing
<input type="checkbox"/> Tissue Labeling	<input type="checkbox"/> Tissue Distribution	<input type="checkbox"/> Tissue Storage	<input type="checkbox"/> Lab Testing
<input type="checkbox"/> OR for Procurement	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

**SECTION IV**

**A. Professional Liability Exposures:**

Beds	No. of Licensed Beds	No. of Occupied Beds Projected Next 12 months	No. of Occupied Beds Current Year	1 <sup>st</sup> Year Prior	2 <sup>nd</sup> Year Prior	3 <sup>rd</sup> Year Prior	4 <sup>th</sup> Year Prior
Acute Care							
Cribs & Bassinets							
Psychiatric							
Chemical Dependency							
Rehabilitation							
Long Term Care							
Hospice							
Swing Beds							
Other:							
Other:							
Other:							
Other:							
<b>Total</b>							

Inpatient Services	No. Projected 12 Mos.	No. in Current Policy Year	1 <sup>st</sup> Year Prior	2 <sup>nd</sup> Year Prior	3 <sup>rd</sup> Year Prior	4 <sup>th</sup> Year Prior
Inpatient Surgeries						
Bariatric Surgeries						
Births-no Csection/VBACs						
C-Sections						
VBACs						
Other:						
<b>Total</b>						

<b>Outpatient Services</b>	<b>No. Projected 12 Mos.</b>	<b>No. in Current Policy Year</b>	<b>1<sup>st</sup> Year Prior</b>	<b>2<sup>nd</sup> Year Prior</b>	<b>3<sup>rd</sup> Year Prior</b>	<b>4<sup>th</sup> Year Prior</b>
Outpatient Surgeries						
Chemical Dependency						
Rehab/Therapy OPVs						
Psychiatric OPVs						
Home Health Visits						
Outpatient Clinic Visits						
Emergency Room Visits						
Other:						
<b>Total</b>						

**B. Professional Employees:**

1. Please provide the number of professionals employed by the hospital:

<b>Type</b>	<b>No. of Full Time Equivalent</b>	<b>Employed Full Time Equivalent</b>	<b>Contracted Full Time Equivalent</b>
Physicians			
Fellows			
Residents			
Interns			
Podiatrists			
Chiropractors			
Physicians Assistants			
Midwives			
Nurse Practitioners			
CRNAs			
Registered Nurses			
Licensed Practical Nurses			
Student Nurses			
X-Ray Technicians			
Lab Technicians			
Pharmacists			
Paramedics			
Perfusionists			
Dentists			
Oral Surgeons			
Other: _____			
Other: _____			
<b>Total Number of</b>			

2. Please complete the following information for each physician or surgeon for whom primary and/or excess (sharing limits with the hospital) coverage is requested. (Expand the table with additional rows as needed, or attach additional page):

Complete when coverage is requested for Excess only:

<b>Name</b>	<b>Specialty</b>	<b>Surgery, No Surgery, or Minor Surgery</b>	<b>Retro Date</b>	<b>Employed or Contracted</b>	<b>Primary PL Carrier</b>	<b>Limits of Liability</b>

3. Please complete the following information for each terminated physician or surgeon for whom coverage should be continued (sharing limits with the hospital) (Expand the table with additional rows as needed, or attach separate page):

Name	Date of Hire	Retro Date	Termination Date

**C. Medical Credentialing / Staffing:**

1. Is history of previous employment verified?  Yes  No
2. Are references checked?  Yes  No
3. Has the license of any physician ever been restricted or suspended?  Yes  No  
If yes, please provide details:
4. 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  
If yes, please explain:
5. How many physicians are board certified or board eligible?
6. Do physicians, residents, and interns carry their own insurance?  Yes  No
7. Are credentials of physicians approved by the medical staff and/or hospital review board before privileges are granted?  Yes  No
8. Is there a probationary period of at least six months for all physicians?  Yes  No
9. Are physicians' performance periodically reviewed by medical staff and/or hospital review board?  Yes  No
10. Do hospital by-laws require staff physicians to carry medical malpractice insurance?  Yes  No  
If not, please identify on a separate sheet of paper those physicians that are "bare."  
If yes, what are the required limits? \$ \_\_\_\_\_ per occurrence, \$ \_\_\_\_\_ aggregate.  
If yes, is evidence of compliance required by certificate of insurance?  Yes  No  
If yes, are there any exceptions to this requirement?  Yes  No  
If yes, please provide details:
11. Are all privileges granted to staff physicians detailed in writing?  Yes  No
12. Number of current Staff MDs:

**SECTION V**

**A. Anesthesia:**

1. The anesthesia department is staffed by: Empl Physicians , CRNAs , Staff Physicians , Contract Group .
2. If service provided by a contract group:  
Name of group:  
Does the hospital require the contract group to carry professional liability insurance?  Yes  No  
If yes, what limits are required? \$ \_\_\_\_\_ per occurrence, \$ \_\_\_\_\_ aggregate.  
Are the limits shared  or per physician ?  
Does the hospital require contract physicians to furnish certificates of insurance?  Yes  No
3. If service provided by CRNAs:  
Is each CRNA's anesthesia care supervised and reviewed by an Anesthesiologist?  Yes  No  
If no, please explain:  
Are the CRNAs employed by the hospital , the anesthesiologists , the surgeons , or are they independent contractors ?
4. Are the Anesthesiologists required to be board certified or board eligible in Anesthesiology?  Yes  No
5. Is an Anesthesiologist on the premises 24 hours a day?  Yes  No
6. Do any of the anesthesia department staff routinely work more than a 12-hour shift?  Yes  No  
If yes, please explain:

**B. Radiology:**

1. The radiology department is staffed by: Employed Physicians , Staff Physicians , Contract Group .
2. If service provided by a contract group:  
Name of group:  
Does the hospital require the contract group to carry professional liability insurance?  Yes  No  
If yes, what limits are required? \$ \_\_\_\_\_ per occurrence, \$ \_\_\_\_\_ aggregate.  
Are the limits shared  or per physician ?

- Does the hospital require contract physicians to furnish certificates of insurance?  Yes  No
- Are the Radiologists required to be board certified or board eligible in Radiology and/or Nuclear Medicine?  
 Yes  No
  - Is a Radiologist on the premises 24 hours a day?  Yes  No

**C. Emergency Department:**

- The emergency department is staffed by: Empl Physicians , Rotating Staff Physicians , Contract Group .
- If service provided by a contract group:  
Name of group:  
Does the hospital require the contract group to carry professional liability insurance?  Yes  No  
If yes, what limits are required? \$ \_\_\_\_\_ per occurrence, \$ \_\_\_\_\_ aggregate.  
Are the limits shared  or per physician ?  
Does the hospital require contract physicians to furnish certificates of insurance?  Yes  No
- Are the emergency department physicians required to be board certified or board eligible in Emergency Medicine?  
 Yes  No
- The emergency department is JCAHO classified as: Level I (Tertiary) , Level II (Comprehensive) , Level III (Basic) , None (Standby) , or Other \_\_\_\_\_
- Are the emergency department physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution?  Yes  No
- Is the emergency room equipped with the following:  
Emergency resuscitation care equipped with defibrillator?  Yes  No  
Electrocardiograph machine?  Yes  No  
Staffed radiology room(s)?  Yes  No  
Dedicated triage area and staff?  Yes  No  
Dedicated trauma room(s)?  Yes  No  
Dedicated laboratory personnel?  Yes  No
- Do any of the emergency department staff routinely work more than a 12-hour shift?  Yes  No  
If yes, please explain: \_\_\_\_\_

**D. Obstetrics:**

- Is the hospital a regional referral center for high risk pregnancies or newborns requiring intensive care?  Yes  No  
If no, does a written procedure exist for transferring all high-risk mothers and/or babies which the hospital is not qualified to treat?  Yes  No
- Does the hospital have the following nurseries:  
Level I: Well baby?  Yes  No If yes, number of bassinets: \_\_\_\_\_  
Level II: Intermediate care?  Yes  No If yes, number of bassinets: \_\_\_\_\_  
Level III: Neonatal intensive care?  Yes  No If yes, number of bassinets: \_\_\_\_\_
- Are all C-sections performed by Obstetricians?  Yes  No  
If no, please identify the specialties of the physicians performing C-sections: \_\_\_\_\_
- Is continuous electronic fetal monitoring performed on all patients in active labor?  Yes  No  
If no, please explain: \_\_\_\_\_
- Do nurse midwives practice at the hospital?  Yes  No  
If yes, how many? \_\_\_\_\_
- Are nurse midwives subject to the hospital's credentialing process?  Yes  No
- Do nurse midwives deliver babies in patients' homes?  Yes  No
- Is an Obstetrician on the premises 24 hours a day?  Yes  No

**E. Surgery:**

- Are sponge, needle and instrument counts performed in the course of a surgical procedure?  Yes  No  
If yes, at what intervals of the operation? \_\_\_\_\_
- Are any of the following performed at the hospital?  
Experimental Surgery  Yes  No  
Sex Change Operations  Yes  No  
Bariatric Surgery  Yes  No  
Laser Assisted Surgery  Yes  No
- Is there a surgeon on the premises 24 hours a day?  Yes  No

**SECTION VI**

**A. Other Exposures:**

1. How many patient care buildings does the hospital own, lease, or operate?
2. How many other, non-patient care buildings does the hospital own, lease, or operate?
3. Do all the patient care buildings have:  
Sprinklers?  Yes  No  
Smoke detectors?  Yes  No  
Heat detectors?  Yes  No  
Automatic alarms?  Yes  No
4. Does the hospital conduct period evacuation drills?  Yes  No  
If yes, how often?
5. Does the hospital conduct period fire drills?  Yes  No  
If yes, how often?
6. Does the hospital have a written Emergency Management Preparedness Plan?  Yes  No  
If yes, please provide a copy.
7. Is new construction and/or abatement contemplated  or pending ?  Yes  No  
If yes, please explain:
8. Does the hospital have a heliport or helipad?  Yes  No  
If yes:  
How many landings in the past 12 months?  
Where is it located?  
What is the distance between the heliport or helipad and the closest hospital building?  
Does the hospital require the heliport or helipad to carry liability coverage?  Yes  No  
If yes, what limits are required? \$ \_\_\_\_\_ per occurrence, \$ \_\_\_\_\_ aggregate.  
What is the name of the commercial carrier?
9. Does the hospital own, lease, or operate any aircraft?  Yes  No  
If yes, how many of each:  
Please describe purpose:
10. Does the hospital own, lease, or operate any watercraft?  Yes  No  
If yes, how many of each:  
Please describe purpose:
11. Is the hospital's administration managed by an outside vendor?  Yes  No  
If yes:  
Please identify the name of the management company:  
Please describe the nature of the contract between the hospital and the management company:  
  
Is the management company to be named as an Additional Insured under the hospital's insurance policy?  
 Yes  No  
Is the management company also involved in the management of clinical services at the hospital?  Yes  
 No  
If yes, please explain:
12. Who coordinates your risk management program?  
Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Telephone: \_\_\_\_\_
13. Is there a written risk management program that has been approved by a governing body?  Yes  No
14. Does the governing body review the effectiveness of the risk management program and approve necessary changes?  Yes  No
15. Is the risk manager accountable and solely responsible for risk management?  Yes  No  
If not, explain other responsibilities:
16. Does the risk management program include the following:  
Occurrence reporting  Yes  No  
Claim management  Yes  No  
Formal link to quality management  Yes  No  
Safety program and safety committee  Yes  No

Review and participation in medical staff committees  Yes  No  
 Contract review and evaluation  Yes  No

17. Has the hospital agreed to hold harmless or indemnify others under contract?  Yes  No  
 If yes, please explain:

18. Does the hospital rent or lease any equipment from an outside vendor?  Yes  No  
 If yes, please explain:

19. Does the hospital conduct formal clinical research under the auspices of an Institutional Review Board (IRB)?  
 If yes,  Internal IRB  External IRB

**B. Excess Automobile Liability:**

Vehicle Type	Service Radius (in miles per vehicle)	Number of Urban Use Vehicles	Number of Non Urban Use Vehicles	Used for Patient Transport?
Private Passenger Delivery				<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Passenger Service				<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Passenger Other				<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Ambulance				<input type="checkbox"/> Yes <input type="checkbox"/> No
Non Emergency Van (< 8 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Non Emergency Van (8-15 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Delivery				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Service				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Other				<input type="checkbox"/> Yes <input type="checkbox"/> No
Medium Truck				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bus (15-30 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bus (> 30 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Hired & non-Owned Autos				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:				<input type="checkbox"/> Yes <input type="checkbox"/> No

**C. Employer's Liability and Employee Benefit Liability:**

- Number of employees:
- Are employee benefits self-administered?  Yes  No  
 If not, are they administered by an outside vendor?  Yes  No  
 If yes, what is the name of the vendor:

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

**NOTICE TO ARKANSAS 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 COLORADO APPLICANTS:** "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY

WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.”

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** “WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.”

**NOTICE TO FLORIDA APPLICANTS:** “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.”

**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 OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.”

**NOTICE TO LOUISIANA 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 MAINE 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.”

**NOTICE TO NEW JERSEY APPLICANTS:** “ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.”

**NOTICE TO NEW MEXICO 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 CIVIL FINES AND CRIMINAL PENALTIES.”

**NOTICE TO NEW YORK APPLICANTS:** “ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.”

**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 OKLAHOMA APPLICANTS:** “WARNING: 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” (365:15-1-10, 36 §3613.1).

**NOTICE TO PENNSYLVANIA APPLICANTS:** "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

**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 AND DENIAL OF INSURANCE BENEFITS."

Signature of Applicant: \_\_\_\_\_  
(must be an officer or principal of the Insured)

Print Name:

Title:

Date:

Signature of Producer: \_\_\_\_\_

Print Name:

Company:

License #:

Date:

NJ SLA# (if a NJ Risk):

Broker responsible for Surplus Lines  
Filings Agreement: