HEALTHCARE PROFESSIONALS INSURANCE COMPANY
217 Great Oaks Blvd., Albany, NY 12203
(866) 374.HPIC

HOSPITAL LIABILITY INSURANCE POLICY APPLICATION
(OCCURRENCE FORM)

A. APPLICANT

1. Legal Name of Applicant: _____

2. Address: _____ City:_____
   County: _____ State: _____ Zip: _____ - ____.

3. Telephone Number: _____ Fax: _____

   Website: www._____

4. How many years has the Applicant been in operation? ___

5. How many years has the Applicant been under present ownership? ___

6. Please list all affiliates and subsidiaries of the Applicant to which this insurance is to apply. Please include a complete description of the operations of each affiliate/subsidiary, and the relationship to the Applicant. (Please attach a separate sheet as necessary)

Name and Location of Entity	Description of Operations	Relationship to Applicant including any ownership Interest (%)	Other In-Force Insurance Issued to the Entity (Carrier, Dates of Coverage, Limits)

B. REQUESTED COVERAGE

PRIMARY ☐ UMBRELLA ☐ GENERAL LIABILITY ☐

EXCESS ☐ PROFESSIONAL LIABILITY ☐

Effective Date: _____

Aggregate Limit:	$_____	Per Claim Deductible/Retention:*	$_____
Per Claim Limit:	$_____	Aggregate Deductible/Retention: *	$_____

***** (Circle Deductible or Retention) If Applicant has Self-Insured Retention (SIR):

1. Do defense costs erode the limits of the SIR? $_____

2. Who supervises the handling of claims within the SIR?

_____

3. Which law firm(s) provide(s) defense for claims within the SIR?

Name of Firm	Address and Telephone Number	Primary Contact

C. GENERAL INFORMATION

Please check all that apply to the Applicant:

☐General Hospital	☐Individual	☐For-Profit
Member of:		
☐Psychiatric Hospital	☐Governmental	☐Not-For Profit
☐AHA	☐FAH	☐AOHA
☐Children's hospital	☐Charitable	☐Long Term Care Facility
☐Teaching Hospital*	☐Medicare Approved	☐ Other Specialty*
☐Corporation		

*Other:

_____

Accredited by JCAHO Yes ☐ No ☐

Date of Last Accreditation: _____

Conditional Accreditation by JCAHO? Yes ☐ No ☐

If conditional accreditation, please attached a copy of any Type 1 recommendations made at last accreditation visit.

For teaching hospitals, please identify the medical school affiliation on the comments section.

Does the Applicant anticipate any mergers/acquisitions, additional services in the next year?

Yes ☐ No ☐

1. Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental agency? Yes ☐ No ☐

   If yes, please give complete details:

   _____

   _____

2. Has the Applicant entered into any joint ventures or limited partnerships? Yes ☐ No ☐

   If yes, please give complete details:

   _____

   _____

3. Is any part of the entity operated/leased by a management entity? Yes ☐ No ☐

   If yes, please give the name of the management entity and complete details:

   _____

   _____

4. Does the Applicant anticipate any facility expansions (increase in licensed beds) within the next year? Yes ☐ No ☐

   If yes, please give complete details:

   _____

   _____

D. PERSONNEL

Please indicate the number of persons employed by or working under the control of the Applicant

in each of the following classifications:

Certified Registered Nurse Anesthetists	____	Nurse Practitioners	____
Dentists	____	Paramedics	____
Emergency Medical Technicians	____	Registered Nurses	____
Interns	____	Respiratory Therapists	____
Laboratory or X-Ray Technicians	____	Pharmacists	____
Licensed Vocational/Practical Nurses	____	Physicians Assistants	____
Nurses' Aides	____	Physicians Assistants	____
Physicians and Surgeons	____	Nurse Midwives	____
Residents	____	Other (Explain Below)*****	____

*****Other:

_____

E. OPERATIONS

1. SERVICES (Please indicate if the Applicant presently provides, plans to provide, or presently operates any of the following:

Abortion Clinic ☐	HMO ☐	Off-Premises Clinic ☐
Ambulance Service ☐	Home Health Care ☐	Off-Premises Labs ☐
Base Hospital ☐	Hospice ☐	Oncology ☐
Blood Bank ☐	Hospital Foundation ☐	Open Heart Surgery ☐
Burn Units ☐	Inhalation Therapy ☐	Organ Bank ☐
Cardiac Cath. Centers ☐	Intensive Care Unit ☐	Organ Transplants ☐
Coronary Care Unit ☐	Lifeline ☐	Out-Patient Surgicenters ☐
Day Care ☐	Mobile Unit (blood-mobile mammography, CAT scan, etc)☐	Pharmacy ☐
Dental Services ☐	Neonatal ☐	Transportation Services ☐
Dialysis ☐	Nursery ☐	Weight Management ☐*****
Emergency Room ☐	Ob/Gyn ☐	Other ☐ (please explain below)

*****Weight Management, please complete Weight Management Supplemental Application

Other:

_____

2. OCCUPANCY

   a. Beds:

Total Licensed Beds: _____

Total Average Annual: _____

Occupancy Breakdown (Provide average number of occupied beds in each category)

	Projected		**Current Policy Year**	
	# Beds	% Occupancy	# Beds	% occupancy
Acute Care	____	____	____	____
Cribs/Bassinets	____	____	____	____
Extended Care	____	____	____	____
Skilled Nursing Beds	____	____	____	____
Psychiatric	____	____	____	____
Rehabilitation	____	____	____	____
Chemical Dependency	____	____	____	____
Hospice	____	____	____	____
Other (please explain below)	____	____	____	____

*****Other:

_____

b. Outpatient Services (please provide the number of services performed each year):

	Projected # of Visits	**Current Year # of Visits**
Emergency Room	____	____
Outpatient Surgery	____	____
Other Outpatient Visits (Patient per Registration Day)	____	____
Alcohol/Drug Abuse	____	____
Psychiatric Visits	____	____
Rehabilitation	____	____
Home Health Care	____	____
Clinic Visits	____	____
Reference Lab	____	____

c. Inpatient Services

	Projected	**Current Year**
Inpatient Surgeries	____	____
Deliveries (excludes C-Sections and VBACs)	____	____
C-Sections	____	____
VBACs	____	____

d. Please provide the following information for the most recent calendar year:

Inpatient Days (include bassinets, exclude SNF): ____

Convalescent skill nursing patient days: ____

Outpatient visits: ____

Births: ____

Inpatient surgeries: ____

3. ANESTHESIA SERVICES

a. Staffing is by:

Contract Physicians ☐

Employed Physicians ☐

Residents ☐

Certified Registered Nurse Anesthetists (CRNAs) ☐

b. Number of Anesthesiologists? Full-Time ____ Part-Time ____

c. Are all physicians board certified or eligible? Yes ☐ No ☐

If "no", please explain:

_____

d. If under contract, to whom is staffing contracted?

Are contracted physicians required to carry professional liability insurance? If "yes", what limits are required? _____

Does the Applicant obtain a Certificate of Insurance? Yes ☐ No

e. Describe the minimum qualifications required for administration of general anesthesia:

_____

_____

_____

f. CRNAs:

i. Do CRNAs provide anesthesia service? Yes ☐ No ☐

If "Yes", please describe the relationship between the Applicant and the CRNAs below. Are they :

Employed by the Applicant? Yes ☐ No ☐

Employed by the Anesthesiologist?□ Yes ☐ No ☐

Employed by the Surgeon? Yes ☐ No ☐

Independent? □ Yes ☐ No ☐

ii. Do CRNAs work under the supervision of an anesthesiologist?

Yes ☐ No ☐

If "No", please submit a copy of the Applicant's written guidelines developed with the collaborative physician or qualified physician designee of the primary physician or the dentist responsible for the patient's immediate care.

4. RADIOLOGY SERVICES

a. Staffing is by:

Contract Physicians ☐

Employed Physicians ☐

Residents ☐

Certified Registered Nurse Anesthetists (CRNAs) ☐

b. Number of Anesthesiologists? Full-Time ____ Part-Time ____

c. Are all physicians board certified or eligible? Yes ☐ No ☐

If "no", please explain:

_____

d. If under contract, to whom is staffing contracted?

Are contracted physicians required to carry professional liability insurance? If "yes", what limits are required? _____

Does the Applicant obtain a Certificate of Insurance? Yes ☐ No ☐

5. OBSTETRICS

a. 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 ☐

b. Number of Labor Rooms: ____

c. Number of Delivery Rooms: ____

d. Does the Applicant have a birthing center? Yes ☐ No ☐

e. Is the delivery room separate from the surgery suite? Yes ☐ No ☐

f. Can Cesarean Sections be performed within thirty (30) minutes at all times?

Yes ☐ No ☐

g. Is an anesthesiologist available in-house twenty-four (24) hours per day for the obstetrical suite? Yes ☐ No ☐

If "No" what is the maximum time for arrival at the hospital? _____

h. Is an obstetrician available in-house twenty-four (24) hours per day for the obstetrical suite? Yes ☐ No ☐

If "No" what is the maximum time for arrival at the hospital?

i. 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 ☐

j. Do Family Practice physicians perform obstetrical services? Yes ☐ No ☐

k. Do Family Practice physicians or CNMs perform VBAC or C-Sections?

Yes ☐ No ☐

l. If the Applicant has a neonatal intensive care unit (NICU), state:

i. total number of neonates admitted to the NICU in the past twelve (12) months:

ii. total number of neonates admitted to the NICU who were transferred from other facilities:

iii. whether a full-time attending neonatologist is on-site in NICU twenty-four (24) hours per day ? Yes ☐ No ☐

m. If the Applicant does not have a NICU, please state the number of neonates transferred from the institution to other facilities in the past twelve (12) months:

_____

6. EMERGENCY ROOM

Does the Applicant provide emergency room (ER) service? Yes ☐ No ☐

If "Yes", please answer the following questions:

a. What level of service do you provide (based on the standards of JCAHO)?

I (Tertiary) ☐ II (Comprehensive) ☐ III (Basic) ☐

b. The Applicant provides:

Standby Services? ☐
Basic Services? ☐
Comprehensive Emergency Services? ☐
Trauma Center? ☐

c. Staffing is by:

Contract Physicians ☐ Employed Physicians ☐ Residents ☐

Number of ER physicians? ____ Full-Time Part-Time ____

Are all physicians board certified or eligible? Yes ☐ No ☐

If "No", please explain: _____

d. If under contract to whom is the staffing contracted?

_____

Are contracted physicians required to carry professional liability insurance? If "yes", what limits are required? _____

Does the Applicant obtain a Certificate of Insurance? Yes ☐ No ☐

7. SURGERY

a. When are the sponge, needle and instrument counts performed?

_____

b. Are any of the following performed at your facility?

Experimental Surgery Yes ☐ No ☐
Neurosurgery Yes ☐ No ☐
Open Heart Surgery Yes ☐ No ☐
Weight Reduction Surgery Yes ☐ No ☐ *****

*****If "Yes", please complete please complete Weight Management Supplemental Application.

8. SPECIAL SERVICES

a.	Ambulance	Number of vehicles: ____ Number of runs per year: ____
b.	Blood Banks	Number of donors (pints): ____ Number purchased from others: ____
c.	Organ Tissue Bank	Number of donors: ____ Number Organ/Tissue donations/year: ____
d.	Day Care	Number of children per day ____ Number of children per day ____ On hospital premises Yes ☐ No ☐ Open to public Yes ☐ No ☐

F. STAFF PRIVILEGES

1. Please indicate the number of staff physicians in the following categories:

Active	____	Consulting	____	Emeritus	____
Associate	____	Courtesy	____	Probationary	____

2. Are credentials for new staff members checked and approved prior to granting staff privileges? Yes ☐ No ☐

If "Yes", by whom ?

_____

How are the Applicant's degree(s) and experience verified?

_____

3. Are privileges provisional for at least six (6) months for all new staff members? Yes ☐ No ☐

4. Does the Applicant have any staff members who are not licensed or who have restricted licenses or privileges? Yes ☐ No ☐

5. Do Department heads evaluate the work of their staff members? Yes ☐ No ☐

6. Is an ongoing medical audit maintained on all staff members clinical work? Yes ☐ No ☐

7. Are all staff privileges reviewed each year? Yes ☐ No ☐

8. Does the Applicant require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? Yes ☐ No ☐

9. Staff members' professional liability insurance:

   a. Are all staff members required to maintain professional liability insurance?

      Yes ☐ No ☐

   b. Is this insurance required by the by-laws? Yes ☐ No ☐

   c. What limits are required? _____

   d. What evidence of compliance is required?

      _____

G. RISK MANAGEMENT

1. Is there a written, formalized risk management program? Yes ☐ No ☐

   If "Yes", please provide a synopsis of the program:

   _____

   _____

   _____

2. Is the program periodically reviewed for effectiveness and necessary changes implemented? Yes ☐ No ☐

3. Who is in charge of implementing this program and any changes?

   Name: _____

   Title: _____

   Phone: _____

Fax: _____

E-Mail:_____

4. Does the Applicant have a formalized quality assurance program?

Yes ☐ No ☐

5. To whom does the Risk Manager or Director of Risk Management report?

Name: _____

Title: _____

Phone: _____

Fax: _____

E-Mail:_____

H. CONTRACTUAL AGREEMENTS

1.

a. Does the Applicant lease or rent any equipment from others? Yes ☐ No ☐

If "Yes", please provide a description of the equipment:

_____

_____

_____

b. Does the Applicant indemnify (hold harmless) the owner for liability?

Yes ☐ No ☐

2.

a. Please identify any contract or professional services performed at the hospital:

Housekeeping	____	Laundry	____	Pharmacy	____
Laboratory	____	Pathology	____	Other*****:	____

*****Other:

_____

b. Does the Applicant require these contractors to provide evidence of insurance?

Yes ☐ No ☐

If "Yes", what limits of liability does the Applicant require?

_____

(Please provide a copy of each contract)

3.

a. Are there any other contracts in effect? Yes ☐ No ☐

If "Yes", please describe services:_____

_____

b. Does the Applicant agree to indemnify (hold harmless) the service provider against any liability claims?

Yes ☐ No ☐

If "Yes", please submit a copy of the complete contract or agreement that contains the indemnification agreement.

I. PHYSICAL PREMISES

1. Please list 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 sheet if more space is needed.

a. _____
(NAME OF FACILITY/LOCATION)

Address: _____

_____

_____

_____

Year Built: _____
No. of stories: _____
Use: _____
Construction (brick, fire-resistive, etc.) _____
Total Sq. Ft.: _____
Complete sprinkler system? Yes ☐ No ☐
Smoke Detectors? Yes ☐ No ☐

b. _____
(NAME OF FACILITY/LOCATION)

Address: _____

_____

_____

_____

Year Built: _____
No. of stories: _____
Use: _____
Construction (brick, fire-resistive, etc.) _____
Total Sq. Ft.: _____
Complete sprinkler system? Yes ☐ No ☐
Smoke Detectors? Yes ☐ No ☐

c. _____
(NAME OF FACILITY/LOCATION)

Address: _____

_____

_____

_____

Year Built: _____
No. of stories: _____
Use: _____

Construction (brick, fire-resistive, etc.) _____
Total Sq. Ft.: _____
Complete sprinkler system? Yes ☐ No ☐
Smoke Detectors? Yes ☐ No ☐

d. _____
(NAME OF FACILITY/LOCATION)

Address: _____
_____
_____
_____

Year Built: _____
No. of stories: _____
Use: _____
Construction (brick, fire-resistive, etc.) _____
Total Sq. Ft.: _____
Complete sprinkler system? Yes ☐ No ☐
Smoke Detectors? Yes ☐ No ☐

e. _____
(NAME OF FACILITY/LOCATION)

Address: _____
_____
_____
_____

Year Built: _____
No. of stories: _____
Use: _____
Construction (brick, fire-resistive, etc.) _____
Total Sq. Ft.: _____

Complete sprinkler system? Yes ☐ No ☐
Smoke Detectors? Yes ☐ No ☐

2. Does the Applicant have a heliport/helipad? Yes ☐ No ☐

If "Yes":

a. where is the pad located? (e.g. parking lot, top of building, etc.)? _____

b. How far is it from the Applicant's principal location? _____

c. Please list the dimensions of the helipad: _____

d. Please describe the type of construction: _____

e. Estimated number of landings per year: _____

J. INSURANCE COVERAGE

1. Please list all of the Applicant's current insurance coverages, including property, excess or umbrella coverages.

	PL	GL	Excess	Umbrella	Helipad
Carrier					
Policy Period					
Limits					
Deductible/SIR (circle one)					
Claims Made/Occurrence (Circle one)					

2. Prior Coverage:

Has any insurer canceled or declined to issue professional liability insurance for the Applicant?

Yes ☐ No ☐ If "Yes", please provide full details of the circumstances:

_____

_____

3. Claims/Incidents:

a. Please describe any/all incidents that may give rise to claim(s) against any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. (Attach additional sheet(s) as necessary) In addition, please attach copies of the Applicant's log/list of incident reports during the last three (3) years.

b. In the past five (5) years, have any demands (including but not limited to lawsuits, arbitrations, or other proceedings) been made against you for damages due to an actual or alleged error, omission, negligent act, misstatement, misleading statement or breach of duty arising out of the rendering or failing to render your professional services (whether covered or uncovered by insurance)? If yes, please describe the facts and circumstances of each such demand. (Attach additional sheet(s) as necessary):

c. In the past five (5) years, have any investigations been initiated or proceedings brought against you (including but not limited to a disciplinary proceeding), by any regulatory agency or other governmental authority or by any professional association, due to an actual or alleged error, omission, negligent act, misstatement, misleading statement or breach of duty, ethical violation or other misconduct arising out of the rendering or failing to render your professional services? If yes, please describe the facts and circumstances of each such investigation or proceeding. (Attach additional sheet(s) as necessary):

_____

d. Are any demands, investigations or proceedings, whether or not first made in the past five (5) years, still open or unresolved? If yes, please describe the facts and circumstances of each such demand. (Attach additional sheet(s) as necessary):

_____

_____

_____

_____

K. ADDITIONAL INFORMATION

Please disclose any information material to the risk which has not otherwise been addressed in this application (Please attach other sheets as necessary).

1. Please provide the following:

   a. Loss history for the past ten (10) years, including current year and a breakdown of all current losses, paid losses, and outstanding losses, separated by year for all underlying coverages. Please include:

      i. a schedule of all open claims, actions, and proceedings to which the Applicant or any person to be insured is a party;

      ii. a schedule of all other claims, actions, and proceedings to which the Applicant or any person to be insured has been a party in the last ten (10), other than actions, claims and proceedings described in response to ii. above.

   b. Applicant's most recent CPA audited financial statements.

   c. Copy of most recent JCAHO report and response to any contingencies.

   d. Recent Actuarial Study supporting funding of self-insurance fund.*

   e. Last Five years ICR Exhibit 3 listing historical exposure data

L. ADDITIONAL INFORMATION

1. PERSONNEL

Please indicate the number of persons employed by or working under the control of the Applicant in each of the following classifications:

Certified Registered Nurse Anesthetists	____	Nurse Practitioners	____
Dentists	____	Paramedics	____
Emergency Medical Technicians	____	Registered Nurses	____
Interns	____	Respiratory Therapists	____
Laboratory or X-Ray Technicians	____	Pharmacists	____
Licensed Vocational/Practical Nurses	____	Physicians Assistants	____
Nurses' Aides	____	Physicians Assistants	____
Physicians and Surgeons	____	Nurse Midwives	____
Residents	____	Other (Explain Below)*****	____

*****Other:

_____

2. For each of the above individuals, please attach a schedule listing;

   a. Name;
   b. Medical Specialty;
   c. Average number of hours worked per week;
   d. Details concerning their private professional or commercial liability insurance.

NOTE: If employed physicians have their own individual liability insurance coverage, they will not be covered under your HPIC policy. No premium change will be made. No names will appear on your policy. They should provide valid Certificates of Insurance from a primary carrier documenting individual professional liability coverage in amounts not less than $1,300,000 per claim/$3,900,000 aggregate.

3. Do you utilize licensed residents on an intermittent, part-time basis ("Moonlighting")?

Yes ☐ No ☐

If Yes, please complete the following schedule:

Resident	**Specialty**	**Department**	**Service/Month**	**Coverage Needed***
____	____	____	____	Yes ☐ No ☐
____	____	____	____	Yes ☐ No ☐
____	____	____	____	Yes ☐ No ☐
____	____	____	____	Yes ☐ No ☐

*****If a "moonlighter" has their own individual insurance, they should not need coverage under this policy. If, however, their policy specifically excludes "moonlighting" please check yes under Coverage Needed column.

4. Does the hospital utilize the services of physicians engaged under contract? Yes ☐ No ☐

If Yes, list department(s) staffed by contract physicians:

_____

_____

_____

Does the Applicant require its contract physicians to have their own professional liability insurance coverage? Yes ☐ No ☐

If Yes:

a. Does the Applicant obtain a copy or other verification of coverage?

Yes ☐ No ☐

b. what limits of insurance are required?

$_____ per occurrence/incident/ $_____ aggregate.

If "Yes", please provide full details of the circumstances:

_____

_____

M. CERTIFICATE HOLDERS

List below all those parties (individuals, corporations, public authorities) for which the Named Insured's requests that a Certificate of Insurance be issued. Use additional sheets as necessary.

Name, Address, and Contact Information of each Certificate Holder	Reason/Purpose for Issuance of Certificate. Why Needed?

THE COMPANY SHALL BE 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.

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 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.

APPLICANT		
BY *(CEO/PRESIDENT/CHAIRMAN)*	TITLE	DATE

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER, PRESIDENT OR CHAIRMAN OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS PROPOSED FOR THIS INSURANCE.

REQUIRED INFORMATION

PRODUCED BY (*INSURANCE AGENT)*	
INSURANCE AGENCY	
INSURANCE AGENCY TAXPAYER ID	AGENT LICENSE NO.
ADDRESS	
E-MAIL ADDRESS	

Submitted By *(Insurance Agency)*
Insurance Agency Taxpayer ID _____Agent License # _____
Address (#, Street, City, State, Zip)
_____
_____

Comments/Additional Information