PROASSURANCE
Treated Fairly

HEALTH CARE FACILITY APPLICATION (HOSPITAL)

NEW BUSINESS

Standard Hospital Underwriting Office
PO Box 590009 • Birmingham, AL 35259-0009
800.282.6242 • 205.877.4400 • Fax 205.802.4710

Community-Based Hospital Underwriting Office
PO Box 45650 • Madison, WI 53744-5650
800.279.8331 • 608.831.8331 • Fax 608.831.0084

SECTION I – INTRODUCTORY INFORMATION

A. Hospital Name: _____ No. of Years in Operation: _____

Address: _____ Telephone No.: ( ) _____

_____ Fax No.: ( ) _____

County: _____ Hospital Fiscal Year Begins: _____

Contact: _____ Tax ID No.: _____

Contact Email: _____ NPI No.: _____

Website Address: _____ Desired Effective Date: _____

B. **Instructions**

1. If this is a new business submission for our company, please review and complete this application. If a policy is issued, the application will become part of the policy as if physically attached.
2. Please type or print clearly.
3. When necessary, check all boxes that apply.
4. If you need more space for your responses, continue on a separate sheet indicating question number.

SECTION II – APPLICATION ADDENDUM

Please attach the following:

A. Loss history, hard copy carrier loss runs and, when available, in electronic format:

1. Ten years of historical PL and GL losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.
2. Date of loss valuation must be within the past 90 days.
3. Loss 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.
4. Full details of allegations on all losses paid or outstanding in excess of $100,000 even if greater than 10 years old.

B. 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.

C. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.

D. Identity of each employed physician including name, specialty, date of hire, retro date, primary PL carrier, primary occurrence or claims-made and PL limits (if applicable).

E. Identity of each Other or Named Insured on the policy including a brief explanation of their relationship to the applicant, scope of operations and their retro date (if historically written on claims-made basis).

F. Copy of current risk management and quality improvement plan.

G. Recent actuarial review supporting the funding of any self-insured retention, applicable SIR Trust documents and balance of SIR Trust account.

H. Copy of current organizational chart (corporate and risk management).

I. Copy of claim management procedures.

J. Completed Bariatric Supplemental Application required (if applicable).

K. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.

L. Copy of current declaration pages for PL and GL policies.

M. For Excess/Umbrella coverages, please provide copies of primary declaration pages or COI for all applicable coverages (auto, employers' liability, etc.).

N. Copy of underlying auto carrier's loss run for the past five years including the following information: carrier, date of loss, report date, total incurred, status (open or closed) and a narrative of claim. Date of loss valuation must be within the past 90 days.

The items requested above are <u>mandatory</u> before a quotation can be provided.

SECTION III – GENERAL INFORMATION

Applicant is: (**check all boxes applicable**)

A. ☐ Children's hospital
☐ Geriatric hospital
☐ General hospital
☐ Psychiatric hospital
☐ Rehabilitation hospital
☐ Teaching hospital
☐ Women's hospital
☐ Other:_____

B. ☐ Individual
☐ Partnership
☐ Corporation
☐ Joint Venture
☐ Government

C. ☐ Profit
☐ Non-profit
☐ Charitable

D. ☐ Accredited by JCAHO
☐ Licensed by state
☐ Medicare approved
☐ Member of AHA

E. **Teaching Hospitals:**

1. Please identify the type of training program(s) offered:

☐ Residency
☐ Nursing
☐ Physician Assistants
☐ Physical Therapy
☐ CRNA's
☐ Other:_____

Provide the number of trainees enrolled in each program in the past 12 months:

_____ Residency
_____ Nursing
_____ Physician Assistants
_____ Physical Therapy
_____ CRNA's
_____ Other:_____

2. The training program(s) is/are accredited by:_____

F. **Accreditation (if applicable):**

1. Please provide date of most recent JCAHO accreditation: _____

2. Accreditation decision:

☐ Accredited
☐ Provisional Accreditation
☐ Conditional Accreditation
☐ Preliminary Denial of Accreditation
☐ Denial of Accreditation
☐ Preliminary Accreditation

3. Requirements for improvement? ☐ Yes ☐ No

If "Yes", please provide a list of standards scored as non-compliant: _____

_____

4. Did the survey identify any life safety issues? ☐ Yes ☐ No

If "Yes", please explain: _____

_____

5. Were partially compliant standards identified in the supplemental findings? ☐ Yes ☐ No

If "Yes", please explain: _____

_____

G. **Current Insurance Program**

1. Primary Insurance:

a. Please list all general liability and hospital professional liability policies for the past five years.

Policy Period	Insurer GL / PL	Policy Limits GL / PL	Deductibles GL / PL	Claims-Made / Occurrence	Premium

If claims-made, state retroactive date: GL - _____ PL - _____

b. Has professional, general, automobile or employers' liability coverage ever been cancelled or non-renewed by a previous carrier? ☐ Yes ☐ No

If "Yes", please provide details: _____

_____

2. Self-Insured Retention Program (if applicable):

a. What is the limit of liability for the self-insured retention?

Professional liability: _____ per claim _____ annual aggregate

General liability: _____ per claim _____ annual aggregate

b. Has an independent actuarial study been completed? ☐ Yes ☐ No

If "Yes", please provide the name of firm and date the study was completed: _____

_____

3. Excess/Umbrella Insurance (if applicable):

   a. Is Excess/Umbrella coverage desired? ☐ Yes ☐ No

      If "Yes", indicate desired limits: GL - _____ PL - _____

   b. Please list all excess/umbrella policies for the past five years.

Policy Period	Insurer	Limits	Premium

If claims-made, state retroactive date: GL - _____ PL - _____

   c. Do different retroactive dates apply to specific excess layer limits? ☐ Yes ☐ No

      If "Yes", please provide: _____

      _____

   d. Has any carrier 1) refused to renew or 2) cancelled coverage? ☐ Yes ☐ No

      If "Yes", please explain: _____

      _____

4. Other Liability Insurance:

   Please list all other primary policies for which excess coverage may be desired.

	Policy Period	Insurer	Policy Number	Limits of Liability
Automobile:				
Employers' Liability:				
Ambulance:				
Helipad:				
Non-owned Aircraft:				
Other:				

For each line of insurance above, describe any claims in excess of $10,000.

5. Does a Patient Compensation Fund or similar type program exist in the state in which you operate. Please provide details.

_____

_____

_____

_____

SECTION IV – PROFESSIONAL EXPOSURES

A. **Inpatient Beds**

	Licensed	In Service	Inpatient Days
Total Hospital Beds (including Bassinets):			
Breakdown of Beds:			
General			
Psychiatric - Do you accept involuntary admissions? ☐ Yes ☐ No			
Intensive Care			
Coronary Care			
Drug & Alcohol			
(Physical) Rehabilitation			
Pediatrics			
Self-Care Unit			
Licensed Nursing Home (Coverage may not be available)			
*Extended Care/Convalescent Care/Assisted Living			
Maternity			
Bassinets (Maternity)			
Bassinets (Neonatal/spl.case)			

**Application Required – Refer to Company*

Number of Annual Admissions:_____

B. **Hospital Outpatient Utilization**

For requested visit classifications, complete number of visits and <u>not</u> number of procedures. For example, if someone came in and had more than one type lab work done, or maybe lab work and then x-ray, that would be just one visit and <u>not</u> the total number of procedures. For requested procedure classifications, provide the actual number of procedures.

Emergency Room:	Number of Visits:	
Organized Outpatient Clinic:	Number of Visits:	
Other Outpatient Services (Referred for lab, x-ray, other diagnostic test, etc.):	Number of Visits:	
Psychiatric Outpatients:	Number of Visits:	
One Day Surgery:	Number of Procedures:	
Bariatric Surgery:	Number of Procedures:	
Drug & Alcohol:	Number of Visits:	
Physical Rehabilitation:	Number of Visits:	

C. **Other Hospital Based or Free Standing Outpatient Utilization and Services**

Description	Number		Description	Number	
Abortion Clinic	_____	Occupied Beds	Mental Health Counseling	_____	Occupied Beds
	_____	Visits		_____	Visits
Ambulance Service	_____	Staff	Municipal Health Department	_____	Visits
*Bariatric Surgery	_____	Procedures	Ocular Lab	_____	Ann.Receipts
Birthing Center	_____	Occupied Beds	Optical Establishment	_____	Ann.Receipts
	_____	Visits	Organ Bank-Direct Processing	_____	Ann.Receipts
Blood or Plasma Bank	_____	Donations	Organ Bank-No Direct Processing	_____	Ann.Receipts
Cardiac Rehab.	_____	Occupied Beds	Other Outpatient Services	_____	Visits
	_____	Visits	Pathology Lab	_____	Ann.Receipts
College/University Health Center	_____	Occupied Beds	Pharmacy (retail only)	_____	Ann.Receipts
	_____	Visits	Physical/Occupational Rehab.	_____	Occupied Beds
Outpatient/Community Health Clinic	_____	Occupied Beds		_____	Visits
	_____	Visits	Psychiatric Outpatients	_____	Visits
Crises Stabilization Center	_____	Occupied Beds	Quality Control/Reference Lab	_____	Ann.Receipts
	_____	Visits	Radiation/Oncology Center	_____	Occupied Beds
Dental Lab	_____	Ann.Receipts		_____	Procedures
Developmental Disability Rehab.	_____	Occupied Beds	Substance Abuse-Counseling	_____	Occupied Beds
	_____	Visits		_____	Visits
Dialysis Center	_____	Visits	Substance Abuse-Skilled Medical	_____	Occupied Beds
Emergicenter	_____	Occupied Beds		_____	Visits
	_____	Visits	Surgicenter	_____	Occupied Beds
Fitness Center	_____	Members		_____	Procedures
	_____	Ann.Receipts	Trauma Rehab.-Skilled Medical	_____	Occupied Beds
Home Care-Durable Equipment	_____	Ann.Receipts		_____	Visits
Home Care-Intravenous Therapy	_____	Visits	Trauma Rehab.-Therapy	_____	Occupied Beds
Home Care-Personal Care	_____	Visits		_____	Visits
Home Care-Rehabilitation	_____	Visits	Trauma Rehab.-Transitional Living	_____	Occupied Beds
Home Care-Respiratory Therapy	_____	Visits		_____	Visits
Home Care-Skilled Care	_____	Visits	Urgicenter	_____	Occupied Beds
Hospice Care	_____	Occupied Beds		_____	Visits
	_____	Visits	Weight Loss Center	_____	Occupied Beds
Medical Lab	_____	Ann.Receipts		_____	Visits
			X-ray/Imaging Center	_____	Ann.Receipts

**Bariatric Supplemental Application required.*

D. **Non-Physician Personnel**

Non-Physician Personnel	# Employed	# Contracted
Aids or Orderlies		
Licensed Anesthesia Assistants		
Chiropractors		
Dental Hygienists / Technicians		
*Dentists		
Dietitians / Nutritionists		
Inhalation / Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
Nuclear Medicine Technicians		
Nurse Anesthetists - Are they supervised by anesthesiologists? ☐ Yes ☐ No		
Nurse Midwives (Coverage cannot be provided)		
Nurse Practitioners		
Occupational / Physical Therapists		
Opticians		
Optometrists		
Oral Surgeons		
Paramedics or EMT's		
Perfusionists		
Pharmacists		
Physician Assistants		
Podiatrists		
Psychologists / Psychotherapists		
RNs		
Social Workers		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe)		

**Separate Application Required – Refer to Company*

_____ Total number of all employees including professional, clerical, executive and maintenance.

_____ Number of Leased Employees. Provide a list of positions where utilized.

E. Physicians/Medical Staff - Employed and Contracted (include Residents and Interns):

1. Are credentials of staff physicians checked and approved prior to the granting of privileges? ☐ Yes ☐ No
2. Are privileges probationary for at least six months for all staff physicians? ☐ Yes ☐ No
3. Are all new physicians required to be proctored by a member of the active medical staff? ☐ Yes ☐ No
4. Are staff physician privileges and overall performances evaluated periodically? ☐ Yes ☐ No
5. Are there procedures in place to restrict or suspend any staff physician's privileges? ☐ Yes ☐ No
6. Has there been any requirement to notify the National Practitioners Data Bank of any suspension, peer review action or liability payment involving any member of the medical or dental staff? ☐ Yes ☐ No

   If "Yes", please explain:_____

   _____
7. Are all privileges granted to staff physicians detailed in writing? ☐ Yes ☐ No
8. Do the hospital by-laws and/or the medical staff by-laws specify that staff physicians maintain malpractice insurance for themselves and their employees who may work in the institution? ☐ Yes ☐ No

   If "Yes", what limits are required:_____

   _____
9. If coverage is desired for physicians, Physician Applications must be completed, returned, approved and written by the Physician Underwriting Department.
10. Number of Physicians with admitting privileges:_____

F. **Other Services Provided by Insured**

☐ Assisted Living Facilities (Application Required)
☐ Dialysis
☐ Laundry
☐ Morgue
☐ Schools or Professional Training Programs (Nursing, EMT, CRNA, etc.) Provide details.
☐ Durable Medical Equipment, Sales and Rental
Annual Receipts: $_____
☐ Management Co. (Mgmt. of non-owned entities) (Application Required)
☐ MCO/PHO (Coverage cannot be provided)
☐ Nuclear Medicine
☐ Nuclear Therapy
☐ Nursing Home (Coverage may not be provided)
☐ Open Heart Surgery
☐ Pathology
☐ Pharmacy Retail Sales
Annual Receipts: $_____
☐ Radiology
☐ Respiratory Therapy
☐ Social Services

1. Ambulances:
   a. Is excess/umbrella coverage desired for ambulance(s)? ☐ Yes ☐ No
   b. Are ambulances used as: ☐ First responders ☐ Patient transport ☐ Both
   c. Number of ambulances in fleet: _____
   d. Service radius: _____ miles
   e. Number of emergency runs in the past 12 months: _____
2. Bariatric Surgery:

   A completed supplemental application is required for bariatric surgery programs.
3. Blood Banks:
   a. Please identify the screening test(s) utilized by the hospital: _____

      _____
   b. Accredited by:

      ☐ American Assn. of Blood Banks ☐ College of American Pathologists
      ☐ American Blood Centers ☐ JCAHO
      ☐ American Red Cross ☐ Other: _____
   c. Is any blood or blood product bought or obtained from outside the U.S.? ☐ Yes ☐ No

      If "Yes", please explain: _____

      _____
   d. Does the blood bank outsource its blood testing? ☐ Yes ☐ No

      If "Yes", please provide details: _____

      _____
   e. Number of volunteered and paid donations in the past 12 months: _____
   f. Number of pheresis procedures in the past 12 months: _____
   g. Number of outpatient transfusions in the past 12 months: _____
   h. Number of therapeutic plasma exchanges in the past 12 months: _____
4. Day Care:
   a. Is the day care center on the hospital premises? ☐ Yes ☐ No
   b. Is the day care center open to the public? ☐ Yes ☐ No
   c. Number of children enrolled in the past 12 months: _____
5. Fitness Center:
   a. Is the fitness center on the hospital premises? ☐ Yes ☐ No
   b. Is the fitness center open to the public? ☐ Yes ☐ No
   c. Number of members enrolled in the past 12 months: _____
   d. Types of programs provided: _____

      _____

6. Skilled Nursing/Extended Care:
   a. Long term care beds are located: ☐ Within the hospital ☐ In a stand-alone facility

      If a stand-alone facility:

      (1) Is the stand-alone facility on the hospital premises? ☐ Yes ☐ No

      (2) Does the stand-alone facility fall under the hospital's risk management? ☐ Yes ☐ No

      (3) Does the stand-alone facility follow policies established by the hospital? ☐ Yes ☐ No

7. Heliport:
   a. Does the hospital have a heliport? ☐ Yes ☐ No

      If "Yes", please provide the number of landings in the past 12 months: _____

8. Transplant:
   a. Number of tissue donations: _____ Past 12 months _____ Projected next 12 months

   b. Number of organ donations: _____ Past 12 months _____ Projected next 12 months

   c. Accredited by:

      ☐ Assn. of Organ Procurement Organization ☐ Eye Bank Assn. of America

      ☐ American Assn. of Tissue Banks ☐ Other: _____

   d. Does the hospital have a formal policy regarding the informed consent process? ☐ Yes ☐ No

   e. Has the hospital been involved in any tissue FDA recalls? ☐ Yes ☐ No

      If "Yes", please explain: _____

      _____

   f. Has the hospital initiated any voluntary tissue recalls in the past 5 years? ☐ Yes ☐ No

      If "Yes", please explain: _____

      _____

   g. Are any tissues procured/recovered from outside the U.S.? ☐ Yes ☐ No

      If "Yes", please explain: _____

      _____

   h. Are any non-human tissues used in any way at the hospital? ☐ Yes ☐ No

      If "Yes", please explain: _____

      _____

   i. Do you accept "John Doe" donors? ☐ Yes ☐ No

   j. Do you participate in a living donor program? ☐ Yes ☐ No

   k. Has the hospital agreed to unilaterally hold harmless or indemnify others under contract? ☐ Yes ☐ No

   l. Does the hospital place all organs through United Network for Organ Sharing? ☐ Yes ☐ No

      If "No", do you have a protocol for ensuring compatibility? ☐ Yes ☐ No

m. Please indicate all of the transplant operations at the hospital:

☐ Eye Procurement	☐ Tissue Processing	☐ Organ Procurement Operations
☐ Lab Testing	☐ Tissue Procurement	☐ Other:_____
☐ Tissue Storage	☐ Tissue Distribution	☐ Other:_____
☐ Tissue Labeling	☐ OR for Procurement	☐ Other:_____

9. Research:

   Please list research programs conducted:_____

   _____

10. Are there any new services or operations scheduled to begin during the next fiscal year? ☐ Yes ☐ No

    If "Yes", please explain:_____

    _____

SECTION V – MEDICAL SERVICE DEPARTMENTS

A. **Emergency Department:**

1. Is the emergency department staffed and operational 24 hours a day? ☐ Yes ☐ No
2. Is emergency department staffed by:

   ☐ Employed physicians ☐ Contract group ☐ Rotating Staff

3. a. If under contract, name of group:_____

   b. If contract group, are certificates of insurance required? ☐ Yes ☐ No

      If "Yes", what minimum limits are required: _____ per claim _____ aggregate

4. a. Are all physicians Board Certified or eligible in Emergency Medicine? ☐ Yes ☐ No

   b. Are the emergency physicians required to respond to Cardiac/Respiratory arrests or other medical emergencies occurring in the institution? ☐ Yes ☐ No

5. Is the emergency room equipped with the following:

   a. Is Emergency Resuscitation cart equipped with defibrillator? ☐ Yes ☐ No

   b. Electrocardiograph machine? ☐ Yes ☐ No

   c. Staffed radiology room(s)? ☐ Yes ☐ No

   d. Dedicated triage area and staff? ☐ Yes ☐ No

   e. Dedicated trauma room(s)? ☐ Yes ☐ No

   f. Dedicated laboratory personnel? ☐ Yes ☐ No

6. Do any of the emergency department staff routinely work more than a 12-hour shift? ☐ Yes ☐ No

   If "Yes", please explain:_____

   _____

7. Are all emergency room patients seen by a physician before discharge? ☐ Yes ☐ No

B. **Anesthesiology:**

1. Is anesthesiology department staffed by:

   ☐ Employed physicians ☐ Contract group ☐ Employed CRNA's ☐ Staff physicians

2. a. If under contract, name of group:_____

   b. If contract group, are certificates of insurance required? ☐ Yes ☐ No

   If "Yes", what minimum limits are required: _____ per claim _____ aggregate

3. Are all anesthesiologists required to be Board Certified or eligible in Anesthesiology? ☐ Yes ☐ No

4. Is there an anesthesiologist or CRNA on the premises 24 hours a day? ☐ Yes ☐ No

5. Is the anesthesia care performed by CRNA's supervised and reviewed by the anesthesiologists? ☐ Yes ☐ No

   If "No", please explain:_____

   _____

6. Do any of the anesthesia services staff routinely work more than a 12-hour shift? ☐ Yes ☐ No

   If "Yes", please explain:_____

   _____

C. **Radiology:**

1. Is radiology department staffed by:

   ☐ Employed physicians ☐ Contract group ☐ Staff physicians

2. a. If under contract, name of group:_____

   b. If contract group, are certificates of insurance required? ☐ Yes ☐ No

   If "Yes", what minimum limits are required: _____ per claim _____ aggregate

3. Are all radiologists required to be Board Certified or eligible in Radiology and/or Nuclear Medicine? ☐ Yes ☐ No

4. Is there a radiologist on the premises 24 hours a day? ☐ Yes ☐ No

D. **Obstetrics:**

1. a. Is the facility a regional referral center for newborns requiring intensive care or high risk pregnancies? ☐ Yes ☐ No

   b. If "No", does a written procedure exist for transferring all high risk mothers and/or babies who the hospital is not qualified to treat? ☐ Yes ☐ No

   c. Do you have the following nurseries:

   ☐ Level I: Well baby Number of bassinets:_____

   ☐ Level II: Intermediate care Number of bassinets:_____

   ☐ Level III: Neonatal intensive care Number of bassinets:_____

   d. Is "Rooming-In" offered? ☐ Yes ☐ No

2. How many births at your facility: (previous 12 months) _____

3. a. How many cesarean sections: (previous 12 months) _____

   b. Are all C-sections performed by obstetricians? ☐ Yes ☐ No

   If "No", what other specialties perform C-sections: _____

   c. How many vaginal births after C-section : (previous 12 months) _____

4. Is continuous electronic fetal monitoring performed on all patients in active labor? ☐ Yes ☐ No

   If "No", please explain: _____

   _____

5. Do nurse midwives practice at your hospital? ☐ Yes ☐ No

E. **Surgery:**

1. Indicate the total number of surgical procedures performed in the last year: _____

   a. Number of inpatient surgeries: _____ b. Number of outpatient surgeries: _____

2. Does the facility have a surgical site identification procedure in place? ☐ Yes ☐ No

3. Are sponge, needle and instrument counts performed in the course of a surgical procedure? ☐ Yes ☐ No

   If "Yes", at what intervals of the operation: _____

4. Are any of the following performed at your facility:

Open heart surgery?	☐ Yes	☐ No	Neurosurgery?	☐ Yes	☐ No
Experimental surgery?	☐ Yes	☐ No	Sex-change operations?	☐ Yes	☐ No
Weight reduction surgery?	☐ Yes	☐ No	Laser assisted surgery?	☐ Yes	☐ No

5. Are "scope" surgical procedures routinely videotaped? ☐ Yes ☐ No

F. **Pharmacy:**

1. Does the facility utilize the unit-dose system of dispensing medicine? ☐ Yes ☐ No

2. Is the pharmacy for patient-use only? ☐ Yes ☐ No

   If "No", annual receipts for non-patient medications are: $_____

3. Is the pharmacy staffed by a contract group? ☐ Yes ☐ No

   If under contract, name of group: _____

SECTION VI – Hospital Administration and Management

A. Are operations managed by employees of the hospital? ☐ Yes ☐ No

B. Are operations operated and managed by a contract Management Company? ☐ Yes ☐ No

1. Name of Management Company: _____

2. What operational positions are occupied by contracted Management Company employees?

   _____

   _____

3. Is the Management Company required to maintain the following policies of insurance:
   a. Commercial General Liability ☐ Yes ☐ No
   b. Directors & Officers including Errors and Omissions ☐ Yes ☐ No
   c. Fiduciary & Crime ☐ Yes ☐ No

C. **Hospital Corporate Organization**

1. Please provide a schedule of the applicant's entities for which coverage is to be considered, a detailed scope of operations and tax identification number for each. See Schedule A attached.
2. If coverage is to be considered for any "additional insureds" please provide a schedule of entities. Additional insureds are entities extended vicarious liability coverage subject to policy provisions as a result of the actions of the policyholder or the actions of the policyholder's scheduled entities and subsidiaries. See Schedule B attached.

D. **Risk Management**

1. Who coordinates your risk management program:

   Name:_____ Title:_____

   Telephone number:__( )_____
2. Is there a written risk management program that has been approved by the governing body? ☐ Yes ☐ No
3. Does the governing body review the effectiveness of the program and approve necessary changes? ☐ Yes ☐ No
4. Is the risk manager accountable and solely responsible for risk management? ☐ Yes ☐ No

   If "No", explain other responsibilities:_____
5. Does the risk management program include the following:
   a. Occurrence reporting? ☐ Yes ☐ No
   b. Claim management? ☐ Yes ☐ No
   c. Formal link to quality management? ☐ Yes ☐ No
   d. Contract review and evaluation? ☐ Yes ☐ No
   e. Review and participation in medical staff committees? ☐ Yes ☐ No
   f. Safety program and safety committee? ☐ Yes ☐ No
6. Risk Management Questionnaire will be forwarded to new insureds.

SECTION VII – PREMISES AND OPERATIONS

A. Are there any construction plans for the next twelve months? ☐ Yes ☐ No

   If "Yes", please provide cost of project:_____

B. Total square footage of Parking Lots or Decks:_____

C. Annual Parking Lot Receipts: $_____

D. Retail Cafeteria/Restaurant Receipts: $_____

E. Other retail operations provided to the public:_____

F. Schedule of Special Events:_____

G. Provide a complete schedule of locations owned, leased or operated to be covered including address, square footage, construction and occupancy.

IMPORTANT: PLEASE READ CAREFULLY

GENERAL FRAUD WARNING – 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.

COLORADO FRAUD WARNING – 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder 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 Agencies.

FLORIDA FRAUD NOTICE – 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 of the third degree.

KENTUCKY FRAUD WARNING – 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.

NEW JERSEY FRAUD WARNING – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW YORK FRAUD WARNING – 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.

OHIO FRAUD WARNING – 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.

OKLAHOMA FRAUD 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.

PENNSYLVANIA FRAUD WARNING – 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.

VIRGINIA FRAUD WARNING – 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.

WISCONSIN EXCEPTION – If the company agrees to be bound under the terms of this application, your policy will be cancelled if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application.

AUTHORIZED HOSPITAL REPRESENTATIVE:

Name: _____ Signature: _____

Date: _____ Title: _____

DESIGNATED HOSPITAL CONTACT IF OTHER THAN ABOVE:

Name: _____ Phone: _____

Title: _____ Email: _____

Insurance Agent/Broker (if applicable):

Agent: _____ Phone: ( )

Agency: _____ Fax: ( )

Address: _____ Email: _____

_____ License No.: _____

Signature: _____

INSURED ENTITIES
SCHEDULE A

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Ownership and relationship to the policyholder: _____
_____
Description of all operations and activities: _____
_____

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Ownership and relationship to the policyholder: _____
_____
Description of all operations and activities: _____
_____

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Ownership and relationship to the policyholder: _____
_____
Description of all operations and activities: _____
_____

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Ownership and relationship to the policyholder: _____
_____
Description of all operations and activities: _____
_____

Please attach additional sheets if necessary.

ADDITIONAL INSURED VICARIOUS LIABILITY COVERAGE
SCHEDULE B

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Relationship to the policyholder: _____
_____
Description of services provided to policyholder/subsidiaries: _____
_____

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Relationship to the policyholder: _____
_____
Description of services provided to policyholder/subsidiaries: _____
_____

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Relationship to the policyholder: _____
_____
Description of services provided to policyholder/subsidiaries: _____
_____

Entity Name: _____
Address: _____
_____
Tax ID No.: _____
Relationship to the policyholder: _____
_____
Description of services provided to policyholder/subsidiaries: _____
_____

Please attach additional sheets if necessary.