PHYSICIANS LIABILITY INSURANCE COMPANY
Application Guideline

Thank you for your consideration of PLICO for your professional liability insurance needs. Since 1979, PLICO has been the leading choice by Oklahoma physicians for protecting themselves and their practices. Wholly owned by the Oklahoma State Medical Association and directed by a board of peer physicians, PLICO exists solely for the benefit of other physicians and is the largest and longest standing medical professional liability carrier in the state.

Please note the following instructions for the included application. If you have any questions, please do not hesitate to call Ramona Edwards at 405.815.4851 or PLICO Financial, Inc. at 405.815.4880

- All questions must be answered. If a question does not apply, enter "N/A" for that question.

- Section 2 – Coverage Information (page 1): Previous Insurance Company information for the preceding 5 years must be provided. Proof of insurance from each carrier should accompany the application. If there are previous denials, non-renewals, cancellations, exclusion of specific procedures, or restrictions on the professional liability insurance, please explain on the Additional Information Section, or on a separate sheet of paper.

- *Entity coverage* - for associations, partnerships, corporations, or companies, on shared or separate limits basis, please provide the following documents/information:

  1. Copy of the W-9 and 1099 (IRS) forms for the entity,

  2. Copy of the OES-3 form with a notation of employee's position for the entity,

  3. Copy of the Articles of Incorporation or Formation for the entity,

  4. Provide a current Certificate of Insurance for each employed or contracted physicians not insured by PLICO.

- *License restrictions or investigations*– explain any restrictions or investigation in the Additional Information Section, or on a separate sheet of paper.

- *Physicians' Section 9 and Ancillaries' Section 5* – Explain any "Yes" answers in the Additional Information Section, or on a separate sheet of paper.

- *Medical and Surgical Procedures* (Physicians' Section 8) - indicate the procedures that you will perform under this policy/coverage.

- ***CLAIMS HISTORY* – issued by all previous insurance carriers must be submitted with every application, even if you are not aware of any claims. It is imperative that we receive complete claims history from every previous carrier for the past 10 year period.**

PLICO

Accounting [405] 815-4824 • Claims [405] 815-4802 • Marketing [405] 815-4803 • Risk Mgt. [405] 815-4803
Underwriting [405] 815-4801 • Toll Free [866] 867-4566 • Main Phone Number [405] 815-4800

Fax: (405) 815-4900

MISCELLANEOUS FACILITIES
PROFESSIONAL LIABILITY INSURANCE APPLICATION

THIS FORM PROVIDES CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY.

SECTION 1 - GENERAL INFORMATION	
1. Name of Applicant:	2. Tax ID:
3. Indicate other names (DBA):	
4. Office Address:	
5. Contact Person:	
6. Billing address (***if different than Office Address***) :	
7. Phone:	8. Fax:
9. E-mail:	10. Web Site:
11. I hereby name as my insurance agent: _____	

SECTION 2 - COVERAGE INFORMATION

1. Requested Effective Date: _____ 2. Requested Retroactive Date: _____

3. Requested Limits of Liability:

☐ $100,000 / $300,000 ☐ $500,000 / $1 million ☐ $1 million / $1 million
☐ $1 million / $3 million ☐ $2 million / $2 million ☐ $2 million / $4 million

4. Retention: ☐ Deductible ☐ SIR (self insured retention plan):

Per Medical Incident: _____ Annual Aggregate: _____

Defense: ☐ Inside the Limits of Liability ☐ Outside the Limits of Liability

5. ***Insurance History***

Year	Insurance Company	Policy Type	Policy Period	Retroactive Date
Current Year:				
1st year prior:				
2nd year prior:				
3rd year prior:				
4th year prior:				
5th year prior:				

6. Has the facility ever been denied professional liability insurance or has its coverage ever been non-renewed or cancelled? If "Yes", provide details on Section 8. Yes☐ No☐

PLICO

7. Has the present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on the facility's coverage? If "Yes", provide details on Section 8.	Yes☐ No☐
8. Has the facility ever practiced without professional liability insurance or without any other type of risk transfer instrument? If "Yes", provide details on Section 8.	Yes☐ No☐

SECTION 2 - COVERAGE INFORMATION (continued)

9. Will the physicians share limits with the facility?	Yes☐ No☐
10. Are all physicians insured, or will all physicians be insured by PLICO? Provide a certificate of insurance for each physician not insured by PLICO	Yes☐ No☐
11. Has the medical license of any physician practicing at your facility ever been suspended, revoked, denied, or limited in any State? If "Yes", provide details on Section 8.	Yes☐ No☐
12. Has the applicant or any of its employees had during the past five (5) years: a. A complaint filed with a regulatory authority? b. Any professional/narcotic license or permit investigated, suspended, revoked, restricted, or placed under probation?	 Yes☐ No☐ Yes☐ No☐
13. List the licenses and certifications held by the facility: a. Agency:_____ Issue Date: _____ Expiration Date: _____ b. Agency: _____ Issue Date: _____ Expiration Date: _____	
14. Is the facility accredited by any non-governmental body or other organization? [**JCAHO** (Joint Commission on Accreditation of Healthcare Organizations), **CARF** (Commission for Accreditation of Rehabilitation Facilities), **AAAHC** (Accreditation Association For Ambulatory Healthcare), etc.]	Yes☐ No☐
15. Does the facility carry General Liability insurance? If "Yes" provide a certificate of insurance.	Yes☐ No☐
16. Does the facility participate in any teaching programs? If "Yes", provide details on Section 8, including brief description of the program, who are the sponsors, number of students and faculty, etc..	Yes☐ No☐
17. Do you anticipate any expansion of services/locations within the next year? If "Yes", provide details on Section 8.	Yes☐ No☐
18. Has the facility discontinued offering any services/procedures in the past 5 years? If "Yes", provide details on Section 8.	Yes☐ No☐
19. Has the facility entered into any joint ventures or limited partnerships agreements? If "Yes", provide details on Section 8.	Yes☐ No☐
20. Is the facility or any part of it operated or leased by a management company? If "Yes", provide details on Section 8.	Yes☐ No☐

SECTION 3 – UNDERWRITING

1. Check the boxes that best describe your practice:

☐ Surgery Center ☐ Dialysis Center ☐ Cancer Center

☐ Blood Bank ☐ Laboratory (diagnostic) ☐ Radiology (diagnostic)

☐ Urgi/Emergency Center ☐ Other _____

PLICO

2. Indicate the types of procedures performed at the facility:

_____

_____

_____

_____

_____

_____

SECTION 3- UNDERWRITING (continued)

3. Does the facility employ any of the following? If so, indicate number of providers:

☐ Physician: _____ ☐ Surgeon: _____ ☐ Physician Assistant: _____

☐ CRNA: _____ ☐ Midwife: _____ ☐ Nurse Practitioner: _____

☐ RN: _____ ☐ LPN: _____ ☐ Podiatrist: _____

☐ Chiropractors: _____ ☐ Other: _____

Technicians:

☐ EEG/EKG: _____ ☐ Medical/Lab.: _____ ☐ Operating Room: _____

☐ Perfusionist: _____ ☐ Physical therapist: _____ ☐ Respiratory: _____

☐ Phlebotomist: _____ ☐ Radiology: _____ ☐ Radiation: _____

☐ X-ray: _____ ☐ Physical Therapist: _____ ☐ Orthotist/Prosthetist: _____

☐ Respiratory therapist: _____ ☐ Other: _____

4. Complete a separate PLICO application (Physicians or Ancillary Medical Personnel) for each of the above professionals for whom individual limits of liability are requested.

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

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

7. Do department heads evaluate the work of their staff? Yes☐ No☐

8. How often are staff's privileges reviewed? ☐ 6 months ☐ 1 Year ☐ Other

9. Do you require that all medical staff maintain professional liability?
If "Yes", what limits are required? _____

10. Has any member of the medical staff brought any complaints or suits against the facility? Yes☐ No☐
If "Yes", provide details on Section 8.

11. Does the facility have a formalized Risk Management Program? Yes☐ No☐

If "Yes", how often is the risk management plan reviewed and necessary changes implemented? ☐ Annually ☐ Every 2 Years ☐ Rarely ☐ Never

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

PLICO

12. Does the facility have a formalized Quality Assurance Program?	Yes☐ No☐
13. Does the facility have a Medical Director? If "Yes", please indicate their names and departments.	Yes☐ No☐
14. Do you contract with any PPO, HMO or other organization involved in contract medicine? If "Yes", please provide the names of the healthcare plans in Section 8. Does the contract include an indemnity (hold harmless) agreement?	Yes☐ No☐ Yes☐ No☐
15. Estimated percentage of practice that involves PPO or HMO patients: _____	
16. Does the facility have written job descriptions for all medical personnel?	Yes☐ No☐

SECTION 4 – RISK MANAGEMENT	
1. Do you provide informed consent prior to any surgical procedure?	Yes☐ No☐
2. Does the informed consent disclose possible risks associated with such procedure?	Yes☐ No☐
3. Are sponges, needles, and instruments counted before and after surgeries?	Yes☐ No☐
4. Are nursing charts maintained, including patients condition at discharge?	Yes☐ No☐
5. Are patients charted by nursing staff a minimum of once a shift?	Yes☐ No☐
6. How long are orders, consent forms, Doctor's orders, Doctor's notes, ancillary reviews and charts retained after discharge?	Yes☐ No☐
7. Are credentials for new staff members checked and approved prior to granting staff privileges? If "Yes", by whom? _____	Yes☐ No☐
8. Are privileges probationary for at least six (6) months for all staff members?	Yes☐ No☐
9. Do department heads evaluate the work of their staff members? If "Yes", are these evaluations done in writing?	Yes☐ No☐ Yes☐ No☐
10. Is an ongoing medical audit maintained on all staff members' clinical work?	Yes☐ No☐
11. Are all staff privileges reviewed at a minimum of every other year?	Yes☐ No☐
12. Have you received any complaints or suits brought by a member of the medical staff? If "Yes", provide details on Section 8.	Yes☐ No☐
13. Do you have a written, formalized Risk Management program? If "Yes": a. How often is the program reviewed for effectiveness? _____ b. Who is in charge of implementing this program? _____ c. Are necessary changes implemented?	Yes☐ No☐

PLICO

14. Do you contract with outside entities or vendors for the removal and/or disposal of the following wastes?		
a.	Low level radioactive	Yes☐ No☐
b.	Other radioactive materials	Yes☐ No☐
c.	Hazardous or toxic	Yes☐ No☐
d.	Medical or infectious	Yes☐ No☐
If "Yes" to any of the above, indicate what limits of liability and if proof of insurance is required.		
15. Have you been identified as a potentially responsible party (PRP) in Federal or State Administrative Environmental Enforcement Actions(s)? If "Yes", provide details and the status of such action(s) in detail on Section 8.		Yes☐ No☐
16. Have there been any complaints, claims, or suits made or filed against you which relate in any way to the handling, removal, treatment, storage, or disposal of waste? If yes, provide details and the status of such action(s) in detail on Section 8.		Yes☐ No☐
17. Do you have any on-site dumps, landfills or to other disposal areas? If "Yes", is the site currently utilized?		Yes☐ No☐

SECTION 4 – RISK MANAGEMENT (continued)

18. Do you own, rent, or lease any biomedical or other equipment used for diagnosis, monitoring, or treatment purposes? If "Yes", who is responsible for inspection wand maintenance of the equipment? _____ Employees ____ Independent contractor	Yes☐ No☐
Are manufacturers recommendations followed for all maintenance and repair of equipment?	Yes☐ No☐

19. Do you sell or lease any medical equipment or products to patients or others in connection with your operation? Yes☐ No☐

If "Yes", please indicate:

Category 1 - Expendable items: intend for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.).

Total Annual Sales: $ _____ **Total Annual Lease/Rental Receipts: $** _____

Category 2 - Non –Expendable items excluding diagnostic or treatment equipment or devise. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts, or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc. and prosthetic devices and IV stands including medical and surgical instruments unless considered diagnostic or treatment, etc..

Total Annual Sales: $ _____ **Total Annual Lease/Rental Receipts: $** _____

Category 3 - Diagnostic or treatment devices: this category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment not used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.

Total Annual Sales: $ _____ **Total Annual Lease/Rental Receipts: $** _____

Category 4 – Life sustaining or critical life monitoring equipment or devices. – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors, or any other equipment that malfunctions/failure or improper function of which could result in death or serious deterioration in health condition.

Total Annual Sales: $ _____ **Total Annual Lease/Rental Receipts: $** _____

20. Have any products that you distribute ever been recalled? Yes☐ No☐

21. Do you provide preventative maintenance or repairs on medical equipment leased to others? Yes☐ No☐

If "Yes", provide details on Section 8.

SECTION 5 – CLAIMS HISTORY/ REPORT

1. Has the facility or any non-physician employee been involved in a professional liability claim/suit in the past ten (10) years? Yes☐ No☐

2. Have all claims/suits/incidents been reported to your current/prior professional liability carrier? Yes☐ No☐
If "No", please explain on Section 8.

3. ***Complete the following questions for all claims or incidents in which you have been directly or indirectly involved. We require ten (10) year claim or incident history/report from your current insurer with a recent valuation date, even if you have not had any claims/suits.***

Claim #	Patient's Initials	Insurance Company	Date of Loss	Date Reported	Date Closed	*Award's Amount

*Attributed to the facility's involvement: $ _____ *Paid by All Parties $ _____

What is/was the facility or employee's status in the case?

☐Primary Defendant ☐Co-defendant ☐Other (explain)_____

If the claim or suit is pending, when was the last contact with the Plaintiff's attorney? _____

What is/was the alleged harm to the patient? _____

What were the allegations made against the facility/employee? _____

Describe the patient's illness and related effects of the alleged harm _____

Describe any other details you believe are pertinent to the case _____

Name of other parties named in the suit: _____

SECTION 6 - COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following documents with this application.

Attach	Documentation
	Attach a copy of the facility's current policy, including the Declarations Page and all endorsements. Physicians/Group Applicants: attach a copy of your Certificate of Insurance.
	Current Federal DEA Registration Certificate.
	Ten (10) years claims history/report, recently prepared, from all previous insurance companies other than PLICO (even if you have not had any claims).

	For partnership, corporate, or association coverage include: ☐ Copy of the Articles of Incorporation ☐ List of Principals or Shareholders ☐ List of all ancillary medical personnel, indicate duties and medical license ☐ Brief description of operations, if other than those consistent with your medical practice or medi cal specialty. ☐ Copy of the latest Oklahoma Employers Security Commission report (OES – 3) ☐ W-9 form (IRS) ☐ 1099 (IRS)
	Copy of the Risk Management Plan, Credentialing Procedures, and Emergency Plan.

SECTION 7 - WAIVER OF LIABILITY & CONSENT FOR RELEASE OF INFORMATION

I HEREBY DECLARE that all statements and answers herein are full, complete, and true to the best of my knowledge and belief, and that no material circumstance or information concerning the subject matter of the questions has been withheld or omitted.

I UNDERSTAND that the statements and answers herein will be relied upon by Physicians Liability Insurance Company and are material in determining whether insurance coverage will be issued or renewed.

I AUTHORIZE any professional societies, prior, or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to PLICO, or to the Oklahoma State Medical Association (Association) upon the request of either. I authorize the use of a copy of this authorization in place of the original.

In order to facilitate the risk management program, I authorize **PLICO** to provide the Association with any records and information concerning claims arising under any policy or insurance issued in connection with this application.

I declare that to the best of my knowledge and belief I have reported all known incidents, claims, and suits to the previous or current carrier(s), and that I have no knowledge of any incident that occurred or happened during the past ten (10) years that could result in a medical negligence claim or suit, and no knowledge of any pending medical negligence claims or suits that may be or have been made or filed against the facility in the last 10 years that have not been reported to the applicable insurance company or risk transfer entity (self-insured retention plan).

I understand that submission of false or misleading information may result in cancellation or rescission of any policy issued by PLICO in reliance upon such information.

Signature_____ Date_____

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.

SECTION 8 – ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please, make as many copies of this page as it may be required to fully answer all questions. As appropriate, note Section number and question number being addressed:

Section/
Question #