Accounting (405) 815-4824 • Claims (405) 815-4802 • Marketing (405) 815-4880 • Risk Mgt. (405) 815-4803
Underwriting (405) 815-4801 • Toll Free (866) 867-4566 • Fax (405) 815-4900

MEDICAL FACILITIES
PROFESSIONAL AND GENERAL LIABILITY INSURANCE APPLICATION

THIS IS AN APPLICATION FOR CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY. IF A POLICY IS ISSUED, THE APPLICATION BECOMES PART OF THE POLICY, AS IF IT WAS PHYSICIALLY ATTACHED. IT IS NECESSARY THAT ALL QUESTIONS BE ANSWERED ACCURATELY AND COMPLETELY.

In order to expedite the review of your application, we must receive complete information. Please follow these guidelines to assure that your application is complete and that it will be processed promptly:

- All questions must be answered. If a question does not apply, enter “N/A” for that question. **DO NOT LEAVE ANY QUESTION BLANK!**

- 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 or information:

  1. Names of all current principals/shareholders of the entity,
  2. Function or operations of the entity, if other than practice management,
  3. Advise if the entity offers ancillary services such as MRI’s, x-rays, medical testing, etc. If so, please provide the number of procedures associated with each type of service.
  4. Copy of the W-9 and 1099(IRS) forms for the entity,
  5. Copy of the Employers Quarterly Contribution Report with a notation of employee’s position for the entity,
  6. 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' Application Section 9 and Ancillaries' Application Section 5* – Explain any "Yes" answers in the Additional Information Section or on a separate sheet of paper.

- *Medical and Surgical Procedures* (Physicians' Application 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.**

REQUIRED DOCUMENTATION	
Please include a copy of the following documents with this application.	
Attached	**Documentation**
	Facility: 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: ☐ 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 Employers Quarterly Contribution Report ☐ W-9 form (IRS) ☐ 1099 (IRS)
	Copy of the Risk Management Plan, Credentialing Procedures, and Emergency Plan.

MEDICAL FACILITIES
PROFESSIONAL AND GENERAL LIABILITY INSURANCE
APPLICATION

SECTION 1 - GENERAL INFORMATION		
1. Name of Applicant:		2. Tax ID:
3. Indicate other names (DBA):		
4. Office Address:		
5. Contact Person:		6. Phone:
7. Billing address (***if different than the Office Address above)***:		
8. Phone:	9. Fax:	10. E-mail:
11. Web Site:	12. Insurance Agent:	

SECTION 2 – REQUESTED INSURANCE COVERAGE

Effective Date: ___________ **Retroactive Date:** ___________ **Deductible/Retention:** ____________

A.	**Facility Professional Liability:**	☐ $100,000 / $300,000 ☐ $1 million / $1 million ☐ $2 million / $2 million	☐ $500,000 / $1 million ☐ $1 million / $3 million ☐ $2 million / $4 million
B.	**General Liability:** ☐ Claims-Made ☐ Occurrence	☐ $100,000 / $300,000 ☐ $1 million / $1 million ☐ $2 million / $2 million	☐ $500,000 / $1 million ☐ $1 million / $3 million ☐ $2 million / $4 million
C.	**Individual Providers:**	☐ $100,000 / $300,000 ☐ $1 million / $1 million ☐ $2 million / $2 million	☐ $500,000 / $1 million ☐ $1 million / $3 million ☐ $2 million / $4 million

SECTION 3 – GENERAL INFORMATION

1. How many years has the Applicant been in operation?	
2. How many years has the Applicant been under the present ownership? If less than three (3) years under present ownership, who was the prior owner?	_______________
Note: If the answer to any of the following questions is "Yes", provide details and explanations on Section 11 or in a separate sheet of paper	
3. Has the facility ever been denied professional liability insurance or has its coverage ever been non-renewed or cancelled?	Yes☐ No☐
4. Has the facility or any subsidiary ever lost its license or been placed on probation by any governmental licensing agency?	Yes☐ No☐
5. Does the Applicant confirm the education and experience of all employees, including the investigation of criminal background?	Yes☐ No☐

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

7. Does the Applicant plan or anticipate any mergers/acquisitions/additional services in the new year? Yes☐ No☐

8. Has the facility discontinued offering any services/procedures in the past 5 years? Yes☐ No☐

9. Does the Applicant plan to increase outpatient services within the next year? Yes☐ No☐

10. Are any of the Applicant's activities managed by a third party? Yes☐ No☐

11. Does the Applicant provide management services to other entities for a fee? Yes☐ No☐

12. Has the Applicant agreed to hold harmless or indemnify others under contract? Yes☐ No☐

13. Is the Applicant indemnified (held harmless) by others? Yes☐ No☐

14. Does the Applicant sponsor recreational events involving patients, their families, or members of the community Yes☐ No☐

15. Has the present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on the coverage? Yes☐ No☐

16. Has the facility ever practiced without professional liability insurance? Yes☐ No☐

17. Are all physicians insured, or will all physicians be insured by PLICO? Yes☐ No☐
Provide a certificate of insurance for each physician not insured by PLICO

18. Will the physicians share limits with the facility? Yes☐ No☐

19. Has the Applicant or any of its employees had during the past five (5) years:

a. A complaint filed with a regulatory authority? Yes☐ No☐

b. Any professional/narcotic license or permit investigated, suspended, revoked, restricted, or placed under probation? Yes☐ No☐

20. List the licenses and certifications held by the facility:

a. Agency:___________________________ Issue/Expiration Date: ________________________

b. Agency: ___________________________ Issue/Expiration Date: ________________________

c. Agency: ___________________________ Issue/Expiration Date: ________________________

21. Is the Applicant accredited by any non-governmental body or other organization? Yes☐ No☐
For example: [**JCAHO** (Joint Commission on Accreditation of Healthcare Organizations), **CARF** (Commission for Accreditation of Rehabilitation Facilities), **AAAHC** (Accreditation Association For Ambulatory Healthcare), etc.]

22. Does the facility carry separate General Liability insurance? Yes☐ No☐
If "Yes" provide a certificate of insurance.

23. Does the facility participate in any teaching programs? Yes☐ No☐
If "Yes," include a brief description of the program: sponsors, number of students, faculty, etc..

24. Is the facility or any part of it operated or leased by a management company? Yes☐ No☐

SECTION 4 - INSURANCE HISTORY

Year	Insurance Company	Limits of Liability	Occur-rence or Claims Made	Policy Period	Retro Date	Deductibles or Retention
Current Year:						
1st year prior:						
2nd year prior:						
3rd year prior:						
4th year prior:						
5th year prior:						

SECTION 5 – UNDERWRITING

1. Check the boxes that best describe your practice:

☐ Surgery Center ☐ Dialysis Center ☐ Cancer Center
☐ Blood Bank ☐ Hospital ☐ Laboratory (diagnostic)
☐ Radiology (diagnostic) ☐ Urgi/Emergency Center ☐ Other ______________

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

____
____
____

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

☐ CRNA: _______________ ☐ Chiropractors: _________ ☐ LPN: __________________
☐ Midwife: ______________ ☐ Nurse Practitioner: _____ ☐ Physician: ______________
☐ Physician Assistant: _____ ☐ Physical Therapist: _____ ☐ Podiatrist: ______________
☐ RN: __________________ ☐ Surgeon: ______________ ☐ Other: ________________

Technicians:

☐ EEG/EKG: _____________ ☐ Medical/Lab.: __________ ☐ Operating Room: _________
☐ Perfusionist: ____________ ☐ Physical therapist: ______ ☐ Phlebotomist: ____________
☐ Radiology: _____________ ☐ Radiation: ____________ ☐ Respiratory therapist: ______
☐ X-ray: _________________ ☐ Orthotist/Prosthetist: ____
☐ Other: ____________________

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

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

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

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

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

8. Do you require that all medical staff maintain professional liability? Yes☐ No☐
If "Yes", what limits are required? ______________

9. Has any member of the medical staff brought any complaints or suits against the facility? Yes☐ No☐
If "Yes", provide details on Section 11.

10. 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? ___________________________

11. Does the facility have a formalized Quality Assurance Program? Yes☐ No☐

12. Does the facility have Medical Directors? If “Yes”, please indicate their names and departments.	Yes☐ No☐
13. 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 11. Does the contract include an indemnity (hold harmless) agreement?	Yes☐ No☐ Yes☐ No☐
14. Estimated percentage of practice that involves PPO or HMO patients: _________________________	
15. Does the facility have written job descriptions for all medical personnel?	Yes☐ No☐

SECTION 6 – EXPOSURES

Indicate below total annual exposures starting with projected exposures for the upcoming policy period:

EXPOSURES	UPCOMING YEAR	CURRENT YEAR	FIRST PRIOR YEAR	SECOND PRIOR YEAR	THIRD PRIOR YEAR
Total number of Employees					
BEDS					
Acute Care					
NICU					
Sub-Acute Care					
Psychiatry/Chemical Dependency					
Physicial Rehabilitiation					
Extended Care/Skilled					
Extended Care/Intermediate					
Extended Care/Assisted Living					
Visits or Procedures					
Emergency					
Clinic/Diagnostic					
Outpatient Surgeries					
Inpatient Surgeries					
Urgi-centers					
Home Health Care					
Mental/Psychiatric Care					
Physical Rehabilitation					
Births					
Blood/Plasma Bank					
Dialysis					
Fertility Clinic					
Organ Bank					
Other					

Indicate total receipts					

SECTION 7 – 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? Yes☐ No☐
   If "Yes", by whom? ____
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? Yes☐ No☐
   If "Yes", are these evaluations done in writing? 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? Yes☐ No☐
    If "Yes", provide details on Section 11.
13. Do you have a written, formalized Risk Management program? Yes☐ No☐
    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?
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)? Yes☐ No☐
    If "Yes", provide details and the status of such action(s) in detail on Section 11.
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? Yes☐ No☐
    If yes, provide details and the status of such action(s) in detail on Section 11.
17. Do you have any on-site dumps, landfills or to other disposal areas? Yes☐ No☐
    If "Yes", is the site currently utilized?

18. Do you own, rent, or lease any biomedical or other equipment used for diagnosis, monitoring, or treatment purposes? Yes☐ No☐
If "Yes", who is responsible for inspection wand maintenance of the equipment?
_____ Employees _____ Independent contractor
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 11.

SECTION 8 – 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 11.

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 10 - 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______________________

APPLICABLE IN ARKANSAS

WARNING: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

APPLICABLE IN OKLAHOMA

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 11 – 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 #