**Instructions:**

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use 🗷 for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

**SECTION A. – APPLICANT, RETROACTIVE DATES & ACCREDITATION**

1. Legal name of the parent entity to be the first named insured exactly as it shall be shown on the policy. Include location information and requested retroactive date(s).

|  |  |
| --- | --- |
| First Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |
| Professional Liability Retroactive Date: | General Liability Retroactive Date: |

1. Applicant is:

|  |  |
| --- | --- |
| Individual  Partnership  Corporation  Joint Venture | Limited Liability company  Profit  Non-Profit |

1. List any subsidiary or affiliate to be insured exactly as it shall be shown on the policy. Include its relationship to the parent entity shown in item A.1. above, a description of operations and requested retroactive dates. If multiple entities are to be insured, attach a list providing the same information for each applicant.

|  |  |
| --- | --- |
| Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |
| Professional Liability Retroactive Date: | General Liability Retroactive Date: |
| Relationship to the parent entity shown in item A.1.: | |
| Description of Operations: | |

1. List all other entities or persons to be insured exactly as they shall be shown on the policy. Include their interest in the applicant and applicable coverage (e.g. CGL-Bodily Injury and Property Damage Liability, HPL, Managed Care Organizations’ Errors and Omissions Liability). If this space is inadequate, attach a list providing the same information for each applicant.

| Additional Insured | Interest in Applicant | Applicable Coverage |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. Is the applicant accredited by:

|  |  |
| --- | --- |
| The Joint Commission: | Yes  No |
| DNV: | |
| Commission on Accreditation of Rehabilitation Facilities: | Yes  No |
| Other(s) – describe: | Yes  No |

**SECTION B. – COVERAGE REQUESTED**

1. Requested coverage period. From:       To:
2. Type of coverage requested:
   1. Insurance  Reinsurance
   2. Primary Hospital or Facility Professional Liability – Claims-Made

Primary General Liability –  Claims-Made; or  Occurrence

Primary Managed Care Organizations’ Errors & Omissions Liability – Claims-Made

Primary Employee Benefits Liability – Claims-Made

Excess Liability – Claims-Made and Occurrence

**Attach detailed coverage specifications for Primary and/or Excess Liability being requested from Chubb. These specifications must provide information regarding coverage type and trigger, limits of liability, deductible or self-insured retention, treatment of claim expenses with respect to any deductible or self-insured retention, retroactive date(s), expiring premium, and insurer for both the current or expiring coverage and the prospective coverage requested from Chubb. If detailed coverage specifications are not available, complete an Chubb Coverage Specifications Supplement.**

**If multiple retroactive dates apply to the same coverage, show the earliest retroactive date in the detailed coverage specifications and note specific retroactive dates for each named insured in the applicant section.**

**For Excess Liability only, if different retroactive dates apply to various layers (limits) note specific retroactive dates for each layer of coverage.**

**SECTION C. – LOSS ADJUSTMENT**

1. Does the applicant settle or coordinate the settlement of Professional and/or General Liability claims?

Yes  No

If Yes, who handles the claims:  Self-Administered  Third Party Claim Administrator – Firm:

**SECTION D. – LOSS EXPERIENCE**

1. Professional, Managed Care Organizations’ Errors & Omissions, and General Liability Loss Experience & Corrective Action. Submit claim data, in an electronic format, as follows:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Historical Period: | | | 12 years (including the current or expiring year) arranged by year. | | | | | | | | | | |
| Type of Claims: | | | Hospital or Facility Professional Liability, Physicians’ Professional Liability, Managed Care Organizations’ Errors & Omissions Liability, and General Liability, if applicable. | | | | | | | | | | |
| Valuation Date: | | | Within 6 Months of the proposed coverage Effective Date. | | | | | | | | | | |
| Loss Descriptions: | | | For All Claims: | | | | | Description of loss. | | | | | |
|  | | | For Claims > $500,000 or 50% of the Underlying PL/GL Limit or Retention, whichever is greater: | | | | | Detailed description of loss and as respects claims paid or reserved in the past 5 years, what, if any, corrective action was taken to avoid or mitigate future losses. | | | | | |
| Format of Data: | | | | | | | | | | | | | |
| Dates | | | | Indemnity | | Expenses | |
| State | | Insured or Location | \*Coverage Type | | Claim ID | Occurrence Date | Report  Date | Settlement  Date | | Indemnity Paid | Indemnity Reserve | Expense Paid | Expense Reserve | Description | |

\*HPL, PPL, MCO E&O, GL

1. Are all claims ground-up and unlimited including all self-insured, insured and uninsured losses, and including the experience of all applicants?  Yes  No

If No, explain any exceptions:

1. All Other Loss Experience. Provide details of any claims > $500,000 during the last 10 years associated with any other coverage being applied for. Include the following information:

|  |  |  |  |
| --- | --- | --- | --- |
| Indemnity + Expenses | | Status | |
| Coverage Type | Occurrence Date | Indemnity + Expense Paid | Indemnity + Expense Reserve | Open | Closed | Detailed Description |

**SECTION E. - EXPOSURES**

1. Current/Expiring and Prospective Hospital/Facility Professional Liability Exposures. Provide census data separately by location as follows. If multiple locations are to be insured, attach a list providing the same information for each location.

| Separately By Location:       (location) | Projections for  Current or Expiring Year By Location | Projections for Requested Coverage Period By Location |
| --- | --- | --- |
| Type | (Annualized Data) | (Annualized Data) |
| Occupied Acute Care Beds |  |  |
| Occupied Long-Term Acute Care Beds |  |  |
| Occupied Sub-Acute Care Beds |  |  |
| Occupied Skilled Nursing Beds (LTC) |  |  |
| Occupied Intermediate Care Beds (LTC) |  |  |
| Occupied Assisted Living Units (LTC) |  |  |
| Occupied Personal Care Beds (LTC) |  |  |
| Occupied Independent Living Units (LTC) |  |  |
| Occupied Chemical Dependency Beds |  |  |
| Occupied Cribs & Bassinets |  |  |
| Occupied Behavioral Health Beds |  |  |
| Occupied Rehabilitation Beds |  |  |
| Occupied – Other Beds – describe: |  |  |
| Number of Vaginal Births/C-sections/VBACs |  |  |
| Number of Inpatient Surgeries |  |  |
| Number of Bariatric Surgeries |  |  |
| Number of Transplant Surgeries |  |  |
| Number of Outpatient Surgeries |  |  |
| Number of Emergency Department Visits |  |  |
| Number of Urgent Care Visits |  |  |
| Number of Outpatient Visits Excluding Home Health Care (1) |  |  |
| Number of Home Health Care Visits |  |  |

1. Outpatient Visits including but not limited to Chemical Dependency, Rehabilitation or Therapy, Behavioral Health, and Clinic but excluding Home Health Care (separate category applies to Home Health Care). Use visits rather than occasions of service. For example, a patient referred to the hospital by a physician for a laboratory test and an x-ray would be counted as one visit but two occasions of service. A visit is a threshold crossing which may involve multiple occasions of service from more than one clinical department.
2. Historical Hospital/Facility Professional Liability Exposures. Provide historical census data for years prior to the current or expiring coverage period by attaching an independent actuarial report or funding study for hospital or facility professional liability, if available. If an independent actuarial report or funding study is not available, provide historical census data by completion of a Chubb Historical Exposures Supplement.
3. Current/Expiring and Prospective Physician Exposures. Attach a list providing employed physician exposure data for each specialty and separately by location as follows. This information must be provided regardless of whether or not employed physicians are to be included for individual coverage.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | Full-Time Equivalent Employed Physician Projections (Annualized Data) | | | |
| By Location For Each ISO Code(1)/Specialty | | | Current of Expiring Year | | Requested Coverage Period | |
| Location: | ISO Code: | Specialty: | Other Than Residents: | Residents: | Other Than Residents: | Residents: |
| (1) See table following this application for ISO codes.  Not Applicable – No Employed Physicians   1. Historical Physician Exposures. Provide historical employed physician exposure data for years prior to the current or expiring coverage period by attaching an independent actuarial report or funding study for professional liability, if available. This information must be provided regardless of whether or not employed physicians are to be included for individual coverage. If an independent actuarial report or funding study is not available, provide historical physician data by completion of a Chubb Historical Exposures Supplement.   Not Applicable – No Employed Physicians   1. Are employed physicians to be included for individual professional liability coverage?  Yes  No 2. Are contracted physicians to be included for individual professional liability coverage?  Yes  No   If Yes, describe:   1. Do you have PGY-1 physicians, residents and/or fellows at your hospital?  Yes  No   If Yes, are PGY-1 physicians, residents and/or fellows enrolled in the applicant’s sponsored and controlled post- graduate training program(s) to be included for individual professional liability coverage?  Yes  No  If Yes, describe:   1. Provide a separate attachment with similar information (current/expiring and prospective coverage period projected FTE’s by location and by specialty) for any other physicians to be included for individual coverage and describe relationship to the parent entity shown in item A.1. 2. Current/Expiring and Prospective Other Employed Doctors & Allied Health Care Provider Exposures. Provide other employed doctor and allied health care provider exposure data separately by location as follows. This information must be provided regardless of whether or not these employees are to be included for individual coverage. If multiple locations have these exposures, attach a list providing the same information for each location.   Please provide the number of “Contracted” FTEs per category:   | Employed Doctors &  Employed Allied Health Care Providers Separately By Location:       (location) | Full-Time Equivalent Projections for Current or Expiring Year By Location | Full-Time Equivalent Projections for Prospective Coverage Period By Location | | --- | --- | --- | | Dentist |  |  | | Nurse Anesthetist |  |  | | Nurse Midwife Doulas |  |  | | Nurse Practitioner |  |  | | Oral Surgeon |  |  | | Physician Assistant |  |  | | Podiatrist |  |  | | RNs |  |  | | LPNs |  |  |   Not Applicable – No Such Employed Providers   1. Historical Other Employed Doctors & Allied Health Care Provider Exposures. Provide historical other employed doctor and allied health care provider exposure data for years prior to the current or expiring coverage period by attaching an independent actuarial report or funding study for professional liability, if available. This information must be provided regardless of whether or not these employees are to be included for individual coverage. If an independent actuarial report or funding study is not available, provide historical data by completion of a Chubb Historical Exposure Supplement.  Not Applicable – No Such Employed Providers 2. Should the providers listed in item E.9. above be included for individual professional liability coverage?   Yes  No  If Yes, describe:  General Liability. Provide the following information for each area owned, occupied, or leased by the applicant. If the space is inadequate, attach a list providing the same information for additional locations.   1. Patient Care Buildings:  | Location | Occupancy | Area (Square Footage) | Age | Type of Construction | Number of Floors | Type of Fire Protection (1) | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |   (1)Fire Protection Key: AS = Approved Sprinkler; H = Heat Detector; S = Smoke Detector; A = Automatic Alarm   1. Other Buildings:  | Location | Occupancy | Area (Square Footage) | Age | Type of Construction | Number of Floors | Type of Fire Protection (1) | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |   (1)Fire Protection Key: AS = Approved Sprinkler; H = Heat Detector; S = Smoke Detector; A = Automatic Alarm   1. Is the applicant planning any new construction or abatement for the prospective coverage period?   Yes  No  If Yes, explain:   1. Does the applicant provide bio-engineering services to third parties?  Yes  No   If Yes, describe and provide projected annual revenues for the prospective coverage period:   1. Does the organization conduct fire evacuation drills?  Yes  No   If "yes", which departments and how often?  Helipad Liability.   1. Does the applicant own or operate a secure heliport or helipad?  Yes  No   If No, disregard the remaining questions in this section.   1. Number of annual landings: 2. Is the helicopter landing pad FAA approved?  Yes  No   Aircraft Liability.   1. Does the applicant own, lease or operate any aircraft?  Yes  No   If Yes, describe:   1. Does any applicant have employees flying owned or non-owned aircraft?  Yes  No   If Yes, describe:   1. Are any fuel services provided for aircraft?  Yes  No   If Yes, describe:  Automobile Liability. If Excess Automobile Liability coverage is requested, provide the following information:   1. Does the applicant own or operate ambulances or provide emergency patient transport services?  Yes  No   If Yes, provide: Annual Number of Emergency Runs:       Annual Number of Non-Emergency Runs:   1. Does the applicant have a policy and procedures to secure motor vehicle records for all drivers who frequently use covered autos?  Yes  No   Comments:   1. Based upon the principal garaging location of the vehicle, indicate the number of vehicles by state, by category, and covered by the applicant’s primary automobile liability insurance:  | State | Private Passenger or Pickup | Truck-Tractor & Trailers (1) | Bus  9 to 20 seats | Bus  21 to 60 seats | Van Pool  9 to 20 seats (2) | Van Pool  21 to 60 seats | Ambulance – Emergency Services | Ambulance – No Emergency Services (3) | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |   (1) A motorized auto with or without body for carrying commodities or materials, equipped with a fifth-wheel coupling device for semi-trailers.  (2) Employer-furnished transportation for employees. This includes an auto of the bus or van type used to provide prearranged commuter transportation for employees to and from work and is not otherwise used to transport passengers for a charge.  (3) An ambulance that is used for non-emergency runs such as the transfer of patients who have been stabilized.   1. If other types of vehicles are covered by the applicant’s primary automobile liability insurance, describe and include principal garaging location:   Watercraft Liability.   1. Does any applicant own or lease watercraft?  Yes  No   If Yes, describe:  Employee Benefits Liability. Provide the following information if coverage is requested:   1. Number of employees: 2. Number of employees covered by employee benefit plans:   Employer’s Liability.   1. Has any applicant rejected a state Workers’ Compensation Act?  Yes  No   If Yes, indicate entity name and state:  **SECTION F. – CONTACT INFORMATION**   1. Provide the following contact information for the insurance buyer:  |  |  | | --- | --- | | Name: |  | | Title: |  | | Telephone Number: |  | | E-Mail Address: |  | | Mailing Address: |  |  1. Provide the following contact information for the person who coordinates the applicant’s risk management program:  |  |  | | --- | --- | | Name: |  | | Title: |  | | Telephone Number: |  | | E-Mail Address: |  | | Mailing Address: |  | | Years of Experience: |  | | Reports To: |  |  1. Provide the following contact information for the person responsible for reporting claims to Chubb:  |  |  | | --- | --- | | Name: |  | | Title: |  | | Firm: |  | | Telephone Number: |  | | E-Mail Address: |  | | Mailing Address: |  |  1. Provide the following contact information for the applicant’s broker or agent:  |  |  | | --- | --- | | Name: |  | | Title: |  | | Firm: |  | | Telephone Number: |  | | E-Mail Address: |  | | Mailing Address: |  |   **SECTION G. – TYPE OF FACILITY & SERVICES PROVIDED**   1. Select each facility type and all services that apply to the applicant’s operations:  | Type of Facility | Services Provided | Surgery | | --- | --- | --- | | Clinic – Describe services: | Ambulance or Emergency Patient Transport | Ambulatory | | Hospital – Behavioral Health | Blood Bank | Bariatric | | Hospital – Children | Day Care (Adult or Child or Both) | Cardiothoracic | | Hospital – Critical Access | Health & Fitness Center | Experimental | | Hospital – General | Managed Care (HMO/PPO) (2) | Gender-affirming | | Hospital – Other – describe: | NICU/ICU/CCU | General | | Hospital – Rehabilitation | Pharmacy – Other Than Patient Use Only | Neurosurgery | | Hospital – Teaching/Research | Research/Clinical Trials | Orthopedics | | Hospital – Birthing Center | Urgent Care | Plastic/Cosmetic | | Long-Term Care (1) | Trauma/Burn Care | Organ Transplantation | |  | Home Health Care |  | |  | Oncology/Radiation Therapy |  | |  | Pathology |  |   (1)A separate Chubb Long-Term Care Facilities Supplement is required for each stand-alone facility not contained within the hospital premises.  (2)A separate Chubb Managed Care Organizations’ Errors and Omissions Liability Supplement is required if this coverage is requested.  Research Services.   1. Does the applicant sponsor clinical trials?  Yes  No   If Yes, does the applicant draft protocols for these trials?  Yes  No   1. Does the applicant act as an investigator in the clinical trial process for the product of another party?   Yes  No  Comments:   1. Are clinical trials being conducted at the applicant’s facility?  Yes  No   If Yes, are these clinical trials approved by the applicant’s Institutional Review Board?  Yes  No  Comments:   1. Do any clinical trials involve the following test subjects:  |  |  |  |  | | --- | --- | --- | --- | | Children: | Yes  No | Expectant Women or Fetuses: | Yes  No |  1. For each clinical trial where the applicant is acting as a sponsor, attach a list providing the following information:  | Name of Clinical Trial | Protocol Number | # of Patients Involved in the Clinical Trial | | --- | --- | --- | |  |  |  |   Change in Services.   1. Will new services be provided in the next 12 months?  Yes  No   If Yes, explain:   1. Will any services be discontinued in the next 12 months?  Yes  No   If Yes, explain:   1. Have any services been discontinued in the last 24 months?  Yes  No   If Yes, explain:  Management Services.   1. Does the applicant have a contract or agreement to provide management services to a third party?   Yes  No  If Yes, provide a copy of the contract or agreement.   1. Does a third party provide management services to any applicant?  Yes  No   If Yes, provide a copy of the contact or agreement.  Artificial Intelligence.   1. Does the healthcare staff utilize machine learning or artificial intelligence algorithms to assist in the delivery of healthcare services, including diagnosis, treatment plans, or staffing requirements?  Yes  No   If Yes, explain the protocol for healthcare staff to override the algorithm’s recommendations?   1. Does the facility use machine learning or artificial intelligence algorithms for other purposes, e.g., billing services or health record generation?  Yes  No 2. **SECTION H. – ANESTHESIOLOGY SERVICES**The anesthesiology department is staffed by:  |  |  | | --- | --- | | Employed Physicians | Employed Nurse Anesthetists | | Independent Medical Staff Members | Contracted Physicians | | Contracted Nurse Anesthetists | |  1. Certificates of Insurance are furnished by each physician/nurse anesthetist: $     Each Professional Incident / $     Annual Aggregate 2. Is anesthesia equipment equipped with oxygen analyzers?  Yes  No 3. Can anesthesia equipment alarms be disconnected or inactivated?  Yes  No   If Yes, under what circumstances is this done?  **SECTION I. – EMERGENCY SERVICES**   1. The emergency department is staffed by:  |  |  | | --- | --- | | Employed Physicians | Independent Medical Staff Members | | Contracted Physicians | |  1. What percentage of these physicians are board eligible      % or board certified      % in emergency medicine? 2. For any contracted emergency services group, provide the minimum amount of Professional Liability insurance required by contract for each physician: $     Each Professional Incident / $     Annual Aggregate    1. What is the name of the group?    2. Are Certificates of Insurance furnished by contracted providers? 3. According to The Joint Commission standards, how is the emergency department classified:  |  |  | | --- | --- | | Level I (Tertiary) | Level III (Basic) | | Level II (Comprehensive) | None (Standby) | | Other – describe: | |  1. Are protocols in place for rapid treatment of high-risk presentations, e.g. chest pain, abdominal pain, children with high fever, trauma, and deliveries?  Yes  No   If No, explain:   1. Do all discharge instructions contain specific written contact information and time frame for follow-up visits?   Yes  No   1. Are all emergency department nurses required to be ACLS certified?  Yes  No 2. Does the emergency department have:   Staffed radiology rooms?  Yes  No  Dedicated triage area with staff?  Yes  No  Dedicated trauma room?  Yes  No  Dedicated lab personnel?  Yes  No  9. Do emergency department staff members routinely work more than a 16-hour shift?  Yes  No If Yes, explain:  Comments:  **SECTION J. – OBSTETRICAL SERVICES**   1. The obstetrics department is staffed by:  |  |  | | --- | --- | | Employed Physicians | Independent Medical Staff Members | | Contracted Physicians | |  1. Which of the following obstetrical service providers have privileges to deliver babies:  |  |  |  | | --- | --- | --- | | Obstetrician | | Family or General Practitioner | | Certified Nurse Midwife | | Physician Assistant | | Other - Describe: |  | |  1. What percentage of these physicians are board eligible      % or board certified      % in obstetrics-gynecology? 2. For any contracted obstetrical group, provide the minimum amount of Professional Liability insurance required by contract for each provider: $     Each Professional Incident / $     Annual Aggregate    1. What is the name of the group?    2. Are Certificates of Insurance furnished by contracted providers? 3. Do nurse midwives perform home deliveries?  Yes  No If Yes, does the organization have a written emergency transport policy and procedure in place?  Yes  No 4. Is the applicant a regional referral center for high-risk pregnancies or newborns requiring intensive care?   Yes  No  If No, does a written procedure exist for transferring all high-risk mothers and/or babies which the applicant is not equipped to treat?  Yes  No  If No, explain:   1. Indicate the level of Neonatal Services provided:  |  | | --- | | Level III/Tertiary (neonates < 24 weeks, long term ventilation, surgery capability) | | Level II+ (neonates < 30 weeks, short term ventilation, invasive monitoring) | | Level II (neonates < 32 weeks, IV fluids, gavage, non-invasive monitoring) | | Level I (neonates < 35 weeks, 24 hour resuscitation capability including intubation, ability to stabilize and transfer) | | Other – describe: |  1. Is continuous electronic fetal monitoring performed on all patients in active labor?  Yes  No   If No, explain:   1. Is labor inducing drugs administered only by an obstetrician?  Yes  No   If No, explain:   1. Induction rate:      % Type of inducing agents administered: 2. Are all emergency Caesarean Sections performed by a board-certified obstetrician within 30 minutes?   Yes  No  If No, explain:   1. Are bilirubin levels tested on all neonates prior to routine discharge?  Yes  No   If No, explain:  13. Is an obstetrician on premise 24 hours a day?  Yes  No  **SECTION K. – RADIOLOGY SERVICES**   1. The radiology department is staffed by:  |  |  | | --- | --- | | Employed Physicians | Independent Medical Staff Members | | Contracted Physicians | |  1. What percentage of these physicians are board eligible      % or board certified      % in radiology? 2. For any contracted radiology group, provide the minimum amount of Professional Liability insurance required by contract for each physician: $     Each Professional Incident / $     Annual Aggregate    1. What is the name of the group?    2. Are Certificates of Insurance furnished by contracted providers?   4. Is a radiologist on premise 24 hours a day?  Yes  No  **SECTION L. – PERIOPERATIVE – SURGICAL SERVICES**   1. Are patients/legal surrogates always involved in the marking of the proper surgical site?  Yes  No   If No, explain:   1. Is a final pre-op “time out” always performed with more than one surgical team member to confirm the correct patient, procedure, side, and site?  Yes  No   If No, explain:   1. Are sponge, needle and instrument counts performed in the course of a surgical procedure?  Yes  No   If No, explain:   1. Number and type of bariatric procedures performed in the past 12 months: 2. Number of years the applicant has specialized in the care and treatment of bariatric patients: 3. Are there a multidisciplinary team and unit dedicated to the care and treatment of bariatric patients?   Yes  No  If Yes, what disciplines are represented?   1. Does the applicant utilize a safe surgery checklist (e.g., The Joint Commission’s Universal Protocol, World Health Organization’s Surgical Safety Checklist)?  Yes  No 2. Does the surgical program adhere to the Core Elements of Antibiotic Stewardship, as articulated by the Centers for Disease Control and Prevention?  Yes  No 3. Is the surgical patient’s informed consent documented in the medical record?  Yes  No 4. Is there a surgeon on premise 24 hours a day?  Yes  No   If No, is travel time less than 30 minutes?  Yes  No   1. Is there a gender-affirming care program for adolescents, inclusive of gender-affirming medical and surgical interventions?  Yes  No 2. Does the gender-affirming care program follow evidence-based guidelines for the initiation of puberty blockers and hormone therapy in adolescents?  Yes  No 3. Are “top surgeries” - i.e., breast augmentation or a mastectomy to create a male-appearing chest - performed on patients less than 18 years old?  Yes  No 4. Are “bottom surgeries” - i.e., procedures on the genitals or reproductive organs - performed on patients less than 18 years old?  Yes  No   **SECTION M. - TRANSPLANTATION SERVICES**  1. Tissue donations: Past 12 months: Projected next 12 months:  2. Organ donations: Past 12 months: Projected next 12 months:  3. Accreditation(s):   * AOPO * AATB * EBAA * Other   4 Does the organization have a written protocol to ensure recipient compatibility? Yes No  5. Has the organization been involved in any tissue FDA recalls? Yes No If Yes, please explain  6. Has the organization initiated any voluntary tissue recalls in the past 5 years? Yes No If Yes, please explain  7. Are any tissues procured/recovered from outside the U.S.? Yes No  8. Does the organization accept "John Doe" donors? Yes No  9. Please check all transplant services offered:   * OPO Eye Procurement (“Gift of Life”) * Tissue Procurement (“Gift of Life”) * Tissue Labeling * Tissue Distribution * Tissue Storage * Tissue Processing * Lab Testing   **SECTION N. – STAFF PRIVILEGES**   1. Are credentials of staff physicians approved by the medical staff and/or hospital review board before privileges are granted?  Yes  No   If No, explain:   1. Are staff privileges probationary for at least six months for all physicians?  Yes  No   If No, explain:   1. Is history of previous employment verified and references checked?  Yes  No   If No, explain:   1. How frequently do staff members undergo peer review by medical staff and/or the hospital review board? 2. Do non-physician providers (Nurse Anesthetist, Certified Nurse Midwife, Physician Assistant, Nurse Practitioner, etc.) undergo the same credentialing process as physician medical staff?  Yes  No   If No, explain:   1. Medical Staff Disciplinary Action:  |  |  |  |  | | --- | --- | --- | --- | | In the past 5 years how many medical staff members have had their license: | | In the past 5 years how many medical staff appointments has the applicant: | | | Denied: |  | Denied: |  | | Restricted: |  | Restricted: |  | | Suspended: |  | Suspended: |  | | Revoked: |  | Revoked: |  |  1. Minimum Medical Professional Liability insurance requirements contained in your medical staff by-laws:  |  |  | | --- | --- | | Minimum Financial Rating of Their Insurer: | $      Each Professional Incident/$      Annual Aggregate | | Extended Reporting Period Must Be Purchased or Prior Acts Provided by New Carrier: | Yes  No |   **SECTION O. – PHARMACY SERVICES & MEDICATION ADMINISTRATION**   1. Does the applicant utilize the unit dose system of dispensing medicine?  Yes  No   If No, explain:   1. Do all unit dose packaging have barcodes?  Yes  No   If No, explain:   1. Do all high-alert drugs undergo an independent double check prior to administration?  Yes  No   If No, explain:   1. Do clinical pharmacists actively participate in clinical consultation with prescribers?  Yes  No   If No, explain:   1. Is a computerized physician order entry system utilized in all clinical settings?  Yes  No 2. Is the pharmacy staffed by a contract group?  Yes  No   Name of group:       Does the organization require the contract group to carry professional liability insurance?  Yes  No If "yes", what limits are required? $      per occurrence $      annual aggregate.   1. Is there a designated clinical leader responsible for the oversight of pain management and safe opioid prescribing, which includes monitoring the duration of opiate prescription and investigating potential misuse?  Yes  No 2. Are clinicians at all levels educated about safe opioid use, including pain assessment and management, risks associated with opioids, and potential risk of physical dependence and addiction?  Yes  No 3. Have guidelines been adopted for safe prescribing of opioids for postoperative and chronic pain patients?  Yes  No   **SECTION P. – BLOOD BANK SERVICES**   1. Identify the blood screening test(s) utilized by the organization: 2. Is blood testing outsourced?  Yes  No If "yes", provide details: 3. Number of volunteer and paid donations in the past 12 months: 4. Is blood or any blood components bought or obtained from outside the U.S.?  Yes  No  If "yes", explain: 5. Accreditation(s):   AABB  ARC  ABC  CAP  TJC   1. Other: Is the applicant selling or distributing blood or blood components (plasma, red cells, or PRB) to third parties? Yes  No   If Yes, explain:   1. Is the applicant collecting blood or blood components (plasma, red cells, or PRB) and using it other than in the treatment and care of their own patients?  Yes  No   If Yes, explain:  If Yes applies to either question above, provide the following information:   |  |  | | --- | --- | | Annual Number of Units Sold or Distributed: |  | | Annual Receipts from Units Sold: | $ | | Last AABB Accreditation Date: |  | | FDA Licensed: | Yes  No |   **SECTION Q. – DAY CARE SERVICES**   1. Are day care services provided on the premises?  Yes  No 2. Is the day care center open to the public?  Yes  No 3. Are day care staff members required to be certified?  Yes  No 4. Does the organization provide for dementia patient safety?  Yes  No 5. Does the applicant own, operate or provide day care services?  Yes  No   If No, disregard the remaining questions in this section.   1. Average daily attendance – children:       Average daily attendance – adults: 2. Does the applicant conduct a background check for criminal history and abuse or neglect, at a minimum, on all day care staff?  Yes  No   Comments:  **SECTION R. - TELEMEDICINE**   1. Is the applicant a telemedicine site?  Yes  No If Yes, is it an originating site or distant site?  Yes  No 2. Are there telemedical services provided outside of the U.S.?  Yes  No If Yes, explain: 3. Are there written agreements in place for all telemedical service arrangements?  Yes  No 4. Are there written protocols for credentialing, privileging and reappointing medical staff members involved in telemedical care?  Yes  No 5. Do telemedical providers meet all applicable state statutory requirements for telemedicine licensure?   Yes  No   1. Are there written policies and procedures that outline the criteria for telemedicine activities and scope of practice parameters?  Yes  No 2. Are documentation standards for telemedical and telehealth services the same as in-person care?  Yes  No 3. Does the quality improvement and peer review programs adequately protect shared data between originating and distant sites?  Yes  No 4. Does the applicant conduct annual cyber risk assessments of its telemedicine program?  Yes  No 5. Is there a compliance plan that addresses billing practices and regulatory noncompliance?  Yes  No   **SECTION S. – EMERGENCY MANAGEMENT & HEALTH CARE FACILITY EVACUATION PLANS**   1. Does the applicant have a written Emergency Readiness and Response Plan?  Yes  No   Is the plan tested annually?  Yes  No   1. If accredited by The Joint Commission has there ever been Environment of Care deficiencies?  Yes  No   If Yes, explain and provide information on corrective action:   1. Is there a person designated to determine when to initiate the plan and provide ongoing direction and management?  Yes  No   If Yes, whom (title):   1. Does the applicant have an isolation/containment procedure for patients potentially exposed to biological or chemical agents in each of the following areas:  |  |  |  | | --- | --- | --- | | Clinics: | Yes  No | Comment: | | Emergency Department: | Yes  No | Comment: | | Inpatient Units: | Yes  No | Comment: |  1. Does the applicant have appropriate and sufficient personal protective equipment for staff in order to prevent or mitigate exposure to biological and chemical agents?  Yes  No   If Yes, has the applicant trained staff on selection and use of personal protective equipment?  Yes  No   1. Is staff aware of responsibilities to notify appropriate internal and external persons and agencies in case of an emergency or disaster?  Yes  No 2. Has the applicant identified alternative care sites if patients or residents must be transferred or directed elsewhere during an emergency or disaster, or if the emergency department becomes contaminated with a biological or chemical agent?  Yes  No 3. Has the applicant identified and developed back-up systems for the loss of electronic medical records, essential utilities, and water and dietary needs?  Yes  No   If No, explain:   1. Does the applicant have a strategic plan for supply chain emergencies, including critical access to medications, vaccinations, medical equipment, and other life-sustaining items in times of crisis?  Yes  No   If No, explain:   1. Are patient evacuation and shelter-in-place plans drafted and ready for implementation should the scenario arise for either emergency response?  Yes  No 2. Does the applicant have a written business continuity plan that is aligned with the organization’s enterprise risk management program?  Yes  No 3. Does the applicant have a Crisis Communication Plan for communicating with patients, families, and media sources in the event of an emergency?  Yes  No     **SECTION T. – WORKPLACE VIOLENCE PREVENTION**   1. Is a Violence Prevention Plan (VPP) in writing, and does it clearly define various types of violent and abusive acts?  Yes  No 2. Are written policies in place for reporting, investigating, and documenting acts of workplace violence against staff members and patients?  Yes  No 3. Is there a multidisciplinary team responsible for implementing and monitoring the VPP?  Yes  No 4. Is there a rapid response protocol for violent crisis situations, including an armed intruder?  Yes  No 5. Does a trained emergency response team deploy when a violent crisis situation arises?  Yes  No 6. Do local law enforcement and community watch organizations participate in VP-related training sessions and mock drills for staff members?  Yes  No 7. Are comprehensive post-incident evaluations conducted and findings acted upon?  Yes  No 8. Has the applicant had an incident that resulted in an allegation of workplace violence?  Yes  No 9. When was the last time a facility wide assessment was conducted?   **SECTION U. – SEXUAL HARRASSMENT AND MISCONDUCT**   1. Does the applicant have a written, zero-tolerance policy regarding Sexual Harassment and Misconduct (SHM)?  Yes  No 2. Is a copy of the SHM policy provided to all medical staff and employees, as well as volunteers?  Yes  No 3. How often is training on the prevention of SHM provided to medical staff and employees after their formal orientation? 4. Does the applicant require a criminal and sexual-offender background check on all medical staff/new employees/volunteers?  Yes  No 5. Does written policy outline clinical tasks that are generally consider sensitive in nature – e.g., treatment involving the genitalia, rectum or breasts – along with provider expectations?  Yes  No 6. Does the applicant have written policies and procedures for reporting and investigating allegations of SHM?   Yes  No 7. Have any SHM claims been made against the applicant or its employees?  Yes  No If Yes, explain:   **SECTION V. – RISK MANAGEMENT**   1. Who is responsible for the risk management program? Name   Certifications       Contact Information   1. Does the risk manager have responsibilities other than risk management?  Yes  No   If Yes, describe:   1. Does the risk manager have access to legal counsel for legal advice not directly related to claim activities?   Yes  No If Yes, describe:   1. Does the risk manager report results of quality improvement activities to the hospital board?  Yes  No 2. Risk Management Plan:  |  |  | | --- | --- | | Does the Risk Management Plan reflect Enterprise Risk Management principles? | Yes  No | | When was the Risk Management Plan last revised? |  | | Is the plan approved by the Board? | Yes  No | | Is the plan reviewed annually? | Yes  No |  1. Occurrence Reporting:  |  |  | | --- | --- | | How many sentinel events were reported to the Joint Commission in the last 2 years? |  | | Is occurrence reporting non-punitive in nature? | Yes  No | | Has the applicant adopted a formal Just Culture program regarding safety and quality inquiries? | Yes  No | | Is there an electronic process for reporting incidents? | Yes  No If Yes, what system is in place? |  1. Patient Safety:  |  |  | | --- | --- | | Briefly describe how the applicant’s risk management program interfaces with patient safety and performance improvement initiatives. |  |  1. Do all contracts for clinical services include mutual hold harmless and indemnification agreements?   Yes  No  If No, describe the contracted services where these provisions do not exist:   1. Do all contracts for clinical services contain minimum Professional Liability insurance requirements for the other party?  Yes  No   If Yes, what is the minimum amount required? $     Each Professional Incident / $     Annual Aggregate  If No, describe the contracted services where this provision does not exist:   1. Is an electronic medical record system implemented in all clinical settings?  Yes  No   **SECTION W. – PREVIOUS INSURANCE**  **MISSOURI APPLICANTS SKIP THIS QUESTION**   1. Has any primary or excess liability insurer refused, canceled, or non-renewed insurance for any applicant in the past?  Yes  No   If Yes, explain:  **SECTION X. – PRIOR ACTS WARRANTY**   1. If this application is for new Claims-Made coverage including prior acts with Chubb, will all current Primary and Excess Claims-Made policies accept claims for: (a) a written notice, demand, or service of suit against any applicant, and (b) specific circumstances reasonably likely to give rise to a written notice, demand or service of suit against any applicant?  Yes  No   If Yes, does the applicant have a process to identify claims and specific circumstances regarding loss events reasonably likely to give rise to a written notice, demand or service of suit, for purposes of timely reporting to the applicant’s Claims-Made insurers before expiration?  Yes  No   1. Have all such claims or specific circumstances reasonably likely to give rise to a claim been made under all the applicant’s current Claims-Made policies and accepted by all current insurers for coverage there under?   Yes  No  If No, explain:  ***Note: Written notice, demand, service of suit, and specific circumstances reasonably likely to give rise to a written notice, demand or service of suit, known to the applicant or any insurer prior to the requested effective date of coverage for any applicant will be excluded.***  **SECTION Y. – SUPPLEMENTAL MATERIALS AS ATTACHMENTS**  The most current versions of the following documents must be submitted, if applicable:   |  |  | | --- | --- | | Audited Captive Financial Statements | Included  Not Applicable | | Audited Corporate Financial Statements | Included | | Bank Balance Statement of Trust Funds for Self-Insured Obligations | Included  Not Applicable | | Bariatric Surgery Supplement | Included  Not Applicable | | Biography of Corporate Risk Management Leader | Included | | Biography of Lead Adjuster of Self-Insured Losses | Included  Not Applicable | | Claim Handling Procedures for Self-Insured Losses | Included  Not Applicable | | Clinical Trials Where Applicant is Sponsor | Included  Not Applicable | | Coverage Specifications (1) | Included | | Current/Expiring and Prospective Hospital/Facility Exposures By Location – Multi Location Applicants Only | Included  Not Applicable | | Current/Expiring and Prospective Employed Physician Exposures – By Specialty and By Location | Included  Not Applicable | | Current/Expiring and Prospective Other Physician Exposures to be Insured – By Specialty and By Location | Included  Not Applicable | | Current/Expiring and Prospective Employed Dentists & Podiatrists and Other Employed Allied Health Care Providers By Location – Multi Location Applicants Only | Included  Not Applicable | | General Liability Exposures – Area Owned, Occupied or Leased by the Applicant – List of Additional Locations | Included  Not Applicable | | Historical Exposures Application Supplement (2) | Included  Not Applicable | | Independent Actuarial Report (Funding Study) (2) | Included  Not Applicable | | List of Subsidiaries or Affiliates to be Insured | Included  Not Applicable | | List of Additional Insureds to be Covered | Included  Not Applicable | | Long-Term Care Facilities Application Supplement (3) | Included  Not Applicable | | Loss Experience | Included | | Managed Care Organizations’ Errors & Omissions Liability Application Supplement (4) | Included  Not Applicable | | Management Services Contract(s) | Included  Not Applicable | | Organizational Chart | Included | | Risk Management Plan, Performance Improvement Plan & Safety Plan | Included  Not Applicable | | Trust Fund Agreement for Self-Insured Coverages | Included  Not Applicable |  1. Detailed coverage specifications must be submitted. If not otherwise available, a Chubb Coverage Specifications Supplement must be submitted. 2. An Independent Actuarial Report or Funding Study for professional liability must be submitted, or if not applicable, a Chubb Historical Exposures Supplement. 3. A Chubb Long-Term Care Facilities Supplement must be submitted for all stand-alone facilities that are not contained within hospital premises. 4. A Chubb Managed Care Organizations’ Errors and Omissions Liability Supplement is required if primary and/or excess coverage is requested.   **SECTION Z. – FRAUD WARNING, DECLARATION & CERTIFICATION, AND SIGNATURE**  **NOTICE TO ARKANSAS APPLICANTS**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.  **NOTICE TO CALIFORNIA APPLICANTS**: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.  **NOTICE TO COLORADO APPLICANTS**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.  **NOTICE TO DISTRICT OF COLUMBIA APPLICANTS**: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.  **NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application (or any supplemental application, questionnaire or similar document) containing any false, incomplete or misleading information is guilty of a felony of the third degree.  **NOTICE TO KANSAS APPLICANTS:** Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines and confinement in prison. A fraudulent insurance act means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer or insurance agent or broker, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for insurance, or the rating of an insurance policy, or a claim for payment or other benefit under an insurance policy, which such person knows to contain materially false information concerning any material fact thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.  **NOTICE TO KENTUCKY APPLICANTS**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.  **NOTICE TO LOUISIANA APPLICANTS**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.  **NOTICE TO MAINE APPLICANTS**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.  **NOTICE TO MARYLAND APPLICANTS**: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.  **NOTICE TO NEW JERSEY APPLICANTS**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.  **NOTICE TO NEW MEXICO APPLICANTS**: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.  **NOTICE TO NEW YORK APPLICANTS**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, 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.  **NOTICE TO OHIO APPLICANTS**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.  **NOTICE TO OKLAHOMA APPLICANTS**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.  **NOTICE TO OREGON APPLICANTS**: Any person who knowingly and with intent to defraud any insurance company or another person, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.  **NOTICE TO PENNSYLVANIA APPLICANTS**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.  **NOTICE TO RHODE ISLAND APPLICANTS**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.  **NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.  **NOTICE TO WEST VIRGINIA APPLICANTS**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.  **NOTICE TO ALL OTHER APPLICANTS**:  **ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON, FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION FOR THE PURPOSE OF MISLEADING, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.**  **DECLARATION AND CERTIFICATION**  **For the purposes of this Application, the undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and any attachments or information submitted with this Application, are true and complete. The undersigned agree that this Application and its attachments shall be the basis of a contract should a policy providing the requested coverage be issued. The Insurer will have relied upon this Application, its attachments, and such other information submitted therewith in issuing any policy.**  **The information requested in this Application is for underwriting purposes only and does not constitute notice to the Insurer under any policy of a Claim or potential Claim.**  **This Application must be signed by the risk manager or a senior officer of the Named Insured, acting as the authorized representative of the person(s) and entity(ies) proposed for this insurance.**  **BY SIGNING THIS APPLICATION, THE APPLICANT WARRANTS TO THE COMPANY THAT ALL STATEMENTS MADE IN THIS APPLICATION AND ANY SUPPLEMENTS AND ATTACHMENTS HERETO ABOUT THE APPLICANT AND ITS OPERATIONS ARE TRUE AND COMPLETE, AND THAT NO MATERIAL FACTS HAVE BEEN MISSTATED OR MISREPRESENTED IN THIS APPLICATION OR HAVE BEEN SUPPRESSED OR CONCEALED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE.**  **THE APPLICANT AGREES THAT IF AFTER THE DATE OF THIS APPLICATION, ANY INCIDENT, OCCURRENCE, EVENT OR OTHER CIRCUMSTANCE SHOULD RENDER ANY OF THE INFORMATION CONTAINED IN THIS APPLICATION OR ANY OTHER DOCUMENTS SUBMITTED IN CONNECTION WITH THE UNDERWRITING OF THIS APPLICATION INACCURATE OR INCOMPLETE, THEN THE APPLICANT SHALL NOTIFY THE COMPANY OF SUCH INCIDENT, OCCURRENCE, EVENT OR CIRCUMSTANCE AND SHALL PROVIDE THE COMPANY WITH INFORMATION THAT WOULD COMPLETE, UPDATE OR CORRECT SUCH INFORMATION. ANY OUTSTANDING QUOTATIONS OR BINDERS MAY BE MODIFIED OR WITHDRAWN AT THE SOLE DISCRETION OF THE COMPANY.**  **COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. THE APPLICANT’S ACCEPTANCE OF THE COMPANY’S QUOTATION IS REQUIRED BEFORE THE APPLICANT MAY BE BOUND AND A POLICY ISSUED. THE APPLICANT AGREES THAT THIS APPLICATION, IF THE INSURANCE COVERAGE APPLIED FOR IS WRITTEN, SHALL BE THE BASIS OF THE CONTRACT WITH THE INSURANCE COMPANY, AND BE DEEMED TO BE A PART OF THE POLICY TO BE ISSUED AS IF PHYSICALLY ATTACHED THERETO. THE APPLICANT HEREBY AUTHORIZES THE RELEASE OF CLAIMS INFORMATION FROM ANY PRIOR INSURERS TO THE COMPANY.**  **THE APPLICANT AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE APPLICANT UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.** | | | | | | | | |
| |  |  |  | | --- | --- | --- | |  |  |  | | Signature of Applicant |  | Signature of Agent/Broker | |  |  |  | | Title |  | Date | |  |  |  | | Date |  | Signed by Licensed Resident Agent | |  |  | (Where Required By Law) | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | ISO Code | Specialty | ISO Code | Specialty | | 80254 | Allergy | 80474 | Neonatology/Perinatology – Major Pediatric Surgery | | 80151 | Anesthesiology | 80293 | Neonatology/Perinatology – Minor Pediatric Surgery | | 80422 | Angio/Arterio/Catheterization | 80287 | Nephrology | | 80150 | Cardiovascular Surgery | 80261 | Neurology – No Surgery | | 80115 | Colon & Rectal Surgery | 80152 | Neurosurgery | | 80282 | Dermatology - Invasive Procedures | 80153 | Obstetrics/OB-GYN | | 80256 | Dermatology - No Surgery | 80233 | Occupational/Industrial Medicine | | 80271 | Diabetes - Minor Surgery | 80263 | Ophthalmology – No Surgery/Laser | | 80237 | Diabetes - No Surgery | 80114 | Ophthalmology - With Surgery/Laser | | 80253 | Diagnostic Radiology | 80154 | Orthopedic Surgery | | 80157 | Emergency Medicine | 80265 | Otolaryngology – No Surgery | | 80272 | Endocrinology - Minor Surgery | 80159 | Otolaryngology – No Elective Plastic | | 80420 | Family/General Practice - No Surgery/OB | 80155 | Otolaryngology – With Elective Plastic | | 80117 | Family/General Practice (With OB) | 80266 | Pathology | | 80421 | Family/General Practice - Minor Surgery/ No OB | 80267 | Pediatrics – No Surgery | | 80240 | Forensic/Legal Medicine | 80235 | Physical Medicine/Rehabilitation | | 80274 | Gastroenterology - Minor Surgery | 80156 | Plastic Surgery | | 80143 | General Surgery | PGY-1 | Post-Graduate Year-1 | | 80243 | Geriatrics | 80249 | Psychiatry | | 80277 | Gynecology - Minor Surgery | 80236 | Public Health | | 80167 | Gynecology – Surgery | 80269 | Pulmonary Medicine | | 80169 | Hand Surgery | 80280 | Radiation/Oncology | | 80278 | Hematology/Oncology | 80252 | Rheumatology | | 80222 | Hospitalist | 80144 | Thoracic Surgery | | 80279 | Infectious Disease | 80171 | Trauma Surgery | | 80283 | Intensive Care Medicine | 80145 | Urology – No Implants | | 80284 | Internal Medicine – Invasive Procedures | 80146 | Vascular Surgery | | 80257 | Internal Medicine – No Surgery |  |  | | | | | | | | | |  | |  |