



Hospital/Healthcare System Liability Protection Application New Business

Requested Effective Date _____

Instructions:

- Please print or type clearly all responses and answer all questions as instructed.
- If any questions do not apply, print N/A in the space.
- If more space is needed, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this application is completed and all required documents are provided.

Required Documents

In addition to this application, the following information is required:

- Separate application for each hospital location if multiple locations exist
- Individual applications for each employed physician, surgeon, dentist and oral surgeon
- Declarations page from current insurance carrier, including retroactive date if claims-made coverage
- List of all subsidiaries and other entities to be covered, including a copy of the latest ERM-14 and organizational chart
- List of all physicians, surgeons, interns and residents, including name, specialty and privileges
 - Include medical professional liability insurance information for all employed and contracted individuals, including name of insurance company, retroactive date, policy period and limits of liability
- Location schedule for general liability exposures
- Loss runs, dated within 60 days of submission, covering the past ten years including the current year via disk, CD or email
 - Include within loss runs a breakdown of total incurred losses (paid and outstanding for indemnity and expense) and complete details of allegations on all losses paid or outstanding in excess of \$100,000
- Current accrediting agency (JCAHO, AOA, CARF, etc.) report with recommendations and the Applicant's response to any contingencies
- Current audited financial statements if a deductible is being requested
- Risk management and quality improvement plan

A. AGENT INFORMATION

Agent Name:		Agency Name:		Address:	
City:	State:	Zip:	Telephone Number:	Fax Number:	

B. APPLICANT INFORMATION (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)

Hospital or Healthcare System Name: _____

Street Address (City, State, Zip, County): _____

Telephone:	Fax:	E-Mail Address:	Policy # (if renewal):
Tax I.D. Number:	License Number:	AHA Number:	Website Address:

Legal structure (Check all that apply): Sole Proprietorship Corporation Partnership Joint Venture
 For Profit Not for Profit Government Other (Specify): _____

C. FACILITY ADMINISTRATIVE TEAM

Name	Title	Phone Number	E-Mail Address
	CEO		
	CFO		
	Risk Management		
	CNO		
	QA/QI		

D. SUBSIDIARIES

List Below all Subsidiaries	Type and Legal Structure	Retro Date

Type of entities: general hospital, teaching hospital, psychiatric hospital, children's hospital, convalescent or nursing home, clinic, critical access hospital, governmental, operated for profit, not for profit, corporation, partnership, charitable, surgery center, home health care, urgicenter

Is coverage desired for all subsidiaries? If no, please explain in the Comments section. Yes No

E. GENERAL INFORMATION

- Is the Applicant accredited by the Joint Commission on Accreditation of Healthcare Organizations? Yes No
If yes, what is the date of the last survey? _____
Please specify the type of accreditation: Full Conditional
If the accreditation is conditional, have all recommendations been complied with? Yes No
- Has the Applicant entered into any joint ventures or limited partnerships? Yes No
If yes, please explain in the Comments section.
- Does the Applicant provide management services to other entities for a fee? Yes No
If yes, please provide entity name(s) managed by the Applicant and describe the services provided in the Comments section.
- Does the Applicant conduct research or experimental activities? Yes No
If yes, please explain in Comments section.
- Is the Applicant currently enrolled in a Patient's Compensation Fund (PCF)? Yes No
If yes, answer the following question and indicate the fund name.
Has the Applicant, at all times subsequent to the retroactive date, been continually qualified/covered by the state fund? Yes No
If no, use the Comments section to provide the exact dates of gaps in coverage and explanation.
 Kansas Healthcare Stabilization Fund Nebraska Excess Liability Fund Wisconsin Patients' Compensation Fund
 Other (specify):

F. CURRENT LIABILITY COVERAGE

Professional Liability Carrier:	General Liability Carrier:
Limit of Coverage:	Limit of Coverage:
Deductible/Retention:	Deductible/Retention:
Policy Period:	Policy Period:
Coverage is: <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence	Coverage is: <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
If claims made, what is the retroactive date?	If claims made, what is the retroactive date?
Has any insurer canceled or declined to issue any of the coverages being applied for under this application? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details in Comments section. *Missouri applicants do not answer this question.	

G. REQUESTED LIABILITY COVERAGE

Retroactive Date:	
Professional Liability Limit: <input type="checkbox"/> \$1,000,000/\$3,000,000 <input type="checkbox"/> Other(specify):	
General Liability Limit: <input type="checkbox"/> \$1,000,000/\$3,000,000 <input type="checkbox"/> Other(specify):	
Employee Benefits Liability Limit: <input type="checkbox"/> \$1,000,000/\$3,000,000 <input type="checkbox"/> Other(specify):	
For limits above \$1,000,000/\$3,000,000, please complete the Healthcare Umbrella Liability section.	
Deductible: <input type="checkbox"/> None <input type="checkbox"/> \$25,000/\$125,000 <input type="checkbox"/> \$50,000/\$250,000 <input type="checkbox"/> Other(specify):	

NOTE: Limits and deductibles are expressed as each claim/aggregate. Professional and general liability deductible amounts should be the same.

H. HOSPITAL EXPOSURE INFORMATION

DIRECTIONS: Please provide the projected, current and previous 12 month exposure count for each classification.

Occupied Beds	Use the average number of occupied beds by dividing the total annual inpatient days by 365.
Licensed Beds	Total number of licensed beds.
Outpatient Visits	Count each appearance of an outpatient in a hospital unit, regardless of the number of procedures or treatments performed within each unit (AHA definition). Report visits to outpatient units, not occasions of service. Include visits made to a client's home when home healthcare is provided.
Receipts	Use annual gross revenues resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Freestanding Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed.

	Occupied Beds			Total Licensed Beds
	Projected Next 12 Months	Current 12 Months	Previous 12 Months	
HOSPITAL INPATIENT				
Acute Care Beds:				
Cribs and Bassinets:				
Psychiatric/Chemical Dependency/Rehab Beds:				
Extended Care Beds:				
Skilled Care Beds:				
Personal Care Beds:				
HOSPITAL INPATIENT - OTHER	Projected Next 12 Months	Current 12 Months	Previous 12 Months	
Total Number of Surgeries (inpatient only):				
Total Number of Births:				
HOSPITAL OUTPATIENT	Projected Next 12 Months	Current 12 Months	Previous 12 Months	
Clinic Visits:				
Outpatient Surgery Visits:				
Emergency Room Visits:				
Home Healthcare Visits:				
All other hospital based visits:				
HOSPITAL - OTHER EXPOSURES	Projected Next 12 Months	Current 12 Months	Previous 12 Months	
Durable Medical Equipment Receipts:				
X-Ray/Imaging Receipts:				
Physical Fitness Center Receipts:				
Retail Pharmacy Receipts (for non-patients):				
Other (specify):				
FREESTANDING OPERATIONS	Projected Next 12 Months	Current 12 Months	Previous 12 Months	
Urgent Care Center or Walk In Clinic Visits:				
SurgiCenter Visits:				
Birthing Center Number of Births:				
X-Ray/Imaging Center Visits:				
Other (specify):				

MISCELLANEOUS	Total Number
Total Number of Employees:	
Adult or Child Care Center Number of Individuals:	
HMO/PPO/IPA or other Managed Care Services Number of Members:	
Vacant Land Number of Acres:	
Pay Parking Areas Receipts:	

I. PHYSICIANS/SURGEONS AND OTHER MEDICAL PROFESSIONALS

1. Please indicate the number of physicians/surgeons in each of the following categories.

PHYSICIANS/SURGEONS	Employed	Contracted	Privileges
Physicians/Surgeons:			
Residents:			
Interns:			
Locum Tenens:			

2. Please indicate the number of other medical professionals in each of the following categories. Compute full-time equivalents (FTE) for all part-time employees using 40 hours per week as one full-time equivalent.

OTHER MEDICAL PROFESSIONALS	Employed FTE	Contracted FTE	OTHER MEDICAL PROFESSIONALS	Employed FTE	Contracted FTE
Chiropractors:			Oral Surgeons:		
Dentists:			Paramedics:		
Emergency Medical Technicians:			Paramedics-Ambulance Svc:		
Laboratory or X-Ray Technicians:			Physical Therapists:		
Licensed Practical Nurses (LPN):			Podiatrists:		
Nurse Anesthetists:			Physicians Assistants:		
Nurse Midwives (certified):			Psychologists:		
Nurse Practitioners:			Registered Nurses (RN):		
Optometrists:			Social Workers:		

J. STAFF PRIVILEGES

- Are credentials for full-time staff members checked and approved prior to granting staff privileges?
If yes, who approves credentials? Yes No
- How are the applicants' degree(s) and experience verified?
- Are privileges probationary for at least six months for all new staff members? Yes No
- Are there any staff members who are not licensed or who have restricted licenses or privileges?
If yes, please explain in Comments section. Yes No
- Are staff privileges reviewed each year?
If no, how often? Yes No
- Is the clinical work of all staff members during reappointment and the privileging process evaluated by department chairpersons? Yes No
- Are all staff members required to maintain medical professional liability insurance?
Is this requirement stated in the staff bylaws? Yes No
If yes, what limits of liability are required? Each incident: _____ Aggregate: _____
(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)
Are Certificates of Insurance required annually? Yes No
- Is history of previous employment verified? Yes No
- Have the privileges/credentials of any employed or contracted physician/surgeon ever been restricted or suspended?
If yes, please provide details in the Comment section. Yes No

10. Has the Applicant made reports to the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff in the last two years? Yes No

If yes, please provide details in the Comment section.

K. RISK MANAGEMENT

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

2. Does the governing body periodically review the program for effectiveness and approve necessary changes? Yes No

3. Is there a designated risk manager?
If no, use the Comments to explain how these functions are monitored. Yes No

4. Is the risk manager accountable and responsible solely for risk management?
If no, describe other responsibilities: Yes No

5. Is the risk manager responsible for reviewing incident reports? Yes No

L. ANESTHESIA

1. Are anesthesia services provided? If no, please proceed to the next section.
If yes, please answer the following questions. Yes No

2. Do certified registered nurse anesthetists (CRNAs) provide anesthesia services? Yes No

3. Specify how the anesthesiology department is staffed: Hospital Employees Contract Group

4. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually? Yes No

If yes, what limits of liability are required? Each incident: _____ Aggregate: _____

(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)

M. BARIATRIC SURGERY

1. Are bariatric surgery services provided? If no, please proceed to the next section.
If yes, please answer the following questions. Yes No

2. How long has the Applicant been performing bariatric procedures?

3. Specify the number of procedures performed annually:

4. Does the Applicant have a bariatric services coordinator? Yes No

5. Does the Applicant have a call coverage team consisting of surgeons who are trained in or familiar with bariatrics? Yes No

6. Does the Applicant have an ICU with specialty services such as Pulmonology, Cardiology, Nephrology or Infectious Diseases with staff trained to handle bariatric patients? Yes No

7. Are surgical, ER, radiology and floor staff aware of and trained to respond to the types of bariatric surgery being performed, and are they educated regarding associated complications and issues related to bariatric surgery? Yes No

8. Are anesthesia and recovery room staff trained to work with bariatric surgery patients? Yes No

9. Does the Applicant have special equipment (operating tables, x-ray tables, retractors, stapling equipment, surgical instruments, hospital beds, commodes, wheelchairs, etc) to accommodate larger patients? Yes No

10. Does the Applicant advertise bariatric services? If yes, please provide copies of materials and website addresses utilized for advertising. Yes No

11. Does each patient undergo a complete evaluation before being accepted and scheduled for surgery? Yes No

12. What is the age range of patients undergoing bariatric surgery?

13. Does the Applicant perform bariatric surgery on adolescents? If yes, indicate the number of adolescent procedures done in the past 12 months:
Please submit your criteria for evaluating adolescents. Yes No

14. Do procedures for informed consent include a quiz type format, which allows a patient to answer specific questions regarding the procedure they are to undergo and risks that are being undertaken in their own handwriting? Yes No

15. Are you willing to refuse a procedure to any patient who fails the quiz or is not able to reflect an accurate understanding of the informed consent in his or her own handwriting? Yes No

16. On average, what percentage of procedures have complications? %

17. What percentage of procedures are laparoscopic? %

18. Please provide the following data regarding any major complications, adverse outcomes or deaths with any of your cases for the last three years:

Outcome	Total	% of Total	Outcome	Total	% of Total
Inpatient Mortality			Revisions		
30 Day Mortality			Transfers to Other Facilities		
90 Day Mortality			Number of Re-admissions in past 12 months		

19. Check those organizations whose guidelines you follow:

- American College of Surgeons
 Society of American Gastrointestinal Endoscopic Surgeons
 American Society of Bariatric Surgery
 American Society of Bariatric Surgeons
 Other (specify):

20. Are the credentialing guidelines of the Society of American Gastrointestinal Endoscopic Surgeons and The American Society of Bariatric Surgery being followed? Yes No

If no, please explain in the Comments section.

By separate attachment, provide a detailed description of your bariatric guidelines, policies and procedures. Include within the attachment the patient pre-screening/selection process, your post-surgery follow-up procedures and the medical professionals involved in the process, including types and responsibilities.

N. EMERGENCY ROOM

1. Are emergency room services provided? If no, please proceed to the next section. Yes No
If yes, please answer the following questions.

2. What level of service is provided based upon the American College of Surgeons' definition?

- Level I - 24 hour in-house emergency room physician and physician specialists
 Level II - 24 hour in-house emergency room physician with physician specialists within 30 minutes
 Level III - 24 hour on-call physician available within 30 minutes
 Level IV - Assessment, lifesaving first aid and appropriate referral

3. Specify how the emergency room physicians are staffed: Hospital Employees Contract Group

4. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually? Yes No

If yes, what limits of liability are required? Each incident: _____ Aggregate: _____

(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)

5. Is the Applicant a designated trauma center or advertised as one? Yes No

6. Specify the number of emergency room physicians:

7. Do you staff with non-board certified emergency room physicians? Yes No

8. Specify the number of nurse practitioners and physicians assistants:

9. Is the emergency room staffed by a physician on a 24-hour basis? Yes No

O. OBSTETRICS

1. Are obstetrical services provided? If no, please proceed to the next section. Yes No
If yes, please answer the following questions.

2. Specify the number of obstetricians on staff:

3. Specify the following information on an annual basis:

Number of births:	Number of OB/GYN deliveries:
Number of multiple births:	Number of family practice physician deliveries:
Number of c-sections:	Number of midwife deliveries:
Number of VBACs:	Number of all other healthcare professional deliveries:

4. If VBACs are performed, is c-section immediately available with MD qualified to perform c-sections in house during labor? Yes No

5. Is the Applicant a regional referral center for high-risk pregnancies or newborns? Yes No

P. PHARMACY

1. Are pharmacy services provided? If no, please proceed to the next section. Yes No
If yes, please answer the following questions.

2. Specify how the pharmacy is staffed: Hospital Employees Contract Group

3. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually? Yes No
If yes, what limits of liability are required? Each incident: _____ Aggregate: _____

(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)

4. Does the pharmacy dispense medicine to non-patients? Yes No

5. Does the facility use the bar coding system for dispensing medicine? Yes No

6. Is the pharmacy staffed 24-hours a day? Yes No

If not, how are medications accessed when the pharmacy is closed?

Q. RADIOLOGY

1. Are radiology services provided? If no, please proceed to the next section. Yes No
If yes, please answer the following questions.

2. Specify how radiology is staffed: Hospital Employees Contract Group Staff Physicians

3. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually? Yes No
If yes, what limits of liability are required? Each incident: _____ Aggregate: _____

(MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)

4. Does the Applicant or contract group (if used) use teleradiology? Yes No

5. Are any radiologists (including radiologists of the contract group) located out of state? Yes No
If yes, specify states:

6. Are any radiologists (including radiologists of the contract group) providing services to patients out of state? Yes No
If yes, specify states:

7. Are all radiographs over-read by the radiologist? Yes No
If no, please explain.

R. SURGERY

1. Are surgery services provided? If no, please proceed to the next section. Yes No
If yes, please answer the following questions.

2. Specify the number of surgeries performed in the previous 12 months for the following categories:

Abdominal:	Cardiac:	Cardiovascular:	Colon & Rectal:
Dermatology:	Endocrinology:	Foot & Ankle:	Gastroenterology:
General:	Geriatrics:	Gynecology:	Hand:
Head & Neck:	Lap choles:	Laryngology:	Neonatal:
Nephrology:	Neurosurgery:	Obstetrics/Gynecology:	Ophthalmology:
Orthopedic surgery:	Otorhinolaryngology:	Plastic:	Thoracic:
Transplant:	Traumatic:	Urological:	Vascular:

S. OTHER SERVICES

1. Does the Applicant sell or rent any equipment to others? Yes No
If yes, please provide a description:

2. Does the Applicant participate in any teaching programs? Yes No
If yes, check each that apply and specify the number of students and faculty:

	Number of Students	Number of Faculty
<input type="checkbox"/> Medical		
<input type="checkbox"/> Nursing		
<input type="checkbox"/> Radiology		
<input type="checkbox"/> Laboratory		
<input type="checkbox"/> Pharmacy		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

3. Does the Applicant operate a blood bank? Yes No
 If yes, indicate which services are provided: Procuring of blood Testing of blood Distributing blood
 Does the Applicant test for the West Nile Virus, HIV, and Hepatitis C? Yes No

T. PREMISES AND OPERATIONS

1. List all premises owned, rented, leased, occupied or used by you. Attach a separate sheet, if necessary.

Address	Use	Year Built	Constr. Type Number*	Fire Class	# of Stories	Sprinkler System Y/N	Total Area

*Construction Type Number: 1 = Frame, 2 = Joisted Masonry, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive

2. Does each location meet applicable NFPA building codes? Yes No
 3. Does the Applicant have a written emergency evacuation plan? Yes No
 If yes, please attach a copy of the plan.
 4. If an inpatient care facility location is older than 15 years old, when was the last qualified inspection of electric, heating and plumbing?
 5. List any planned major fund raising activities or sporting events which will be sponsored by the Applicant during the next year.

6. Does the Applicant have a heliport/helipad? Yes No
 If yes, please provide a description:
 Does the Applicant have a written maintenance plan for the pad or port? If yes, please attach a copy. Yes No
 7. Does the Applicant own or operate fixed-wing air ambulance? Yes No
 8. Are there any construction projects planned for the next year? Yes No
 If yes, provide a description of the project(s) in the Comments section, including the estimated cost and duration of the project.

U. CONTRACTUAL AGREEMENTS

1. Specify any contracted professional services performed:
 Laboratory Physical/Occupational Therapy Social Work
 Pathology Housekeeping Biomedical
 Home Health Care Laundry
 2. Does the Applicant require these contractors to provide evidence of insurance? Yes No
 If yes, what limits of liability are required? Each incident: _____ Aggregate: _____
 (MMIC recommends the limits of liability be equal to or greater than your own limits of liability.)
 3. Are there any service contracts in effect? Yes No
 If yes, please describe services:
 Does the Applicant indemnify (hold harmless) the owner for liability? Yes No
 4. Does the Applicant have an attorney review all contracts before signing? Yes No

V. HEALTHCARE UMBRELLA LIABILITY COVERAGE

1. Is Excess/Umbrella coverage desired? Yes No
 If yes, please complete this section.
 2. For Nebraska and Wisconsin hospitals only, is coverage desired for: General Liability Professional Liability Both
 3. Requested Limit of Liability: \$ _____

NOTE: All underlying carriers need to have an AM Best Rating of "A-" or better. The following minimum limits apply to underlying coverage:

- Auto minimum limits of \$1,000,000 CSL
- Employers liability minimum limits of \$500,000/\$500,000/\$500,000
- Non-owned aircraft limits of \$5,000,000/helipad limits of \$1,000,000

4. Please complete **Underlying Insurance** information.

Coverage Type	Carrier	Policy Number	Policy Period	Limits of Liability	Annual Premium
Auto Liability:					
Employers Liability:					
Helipad Liability:					
Non-Owned Aircraft Liability:					
Other:					
Other:					

*All Wisconsin Applicants must complete the Wisconsin UM/UIM Supplement.

5. Please list all vehicles below:

Type	# Owned	# Non-Owned	# Leased	Property Hauled	0-50 Miles	50-200 Miles	Over 200 Miles
Private Passenger							
Trucks	Light						
	Medium						
	Heavy						
	Ex Heavy						
Trucks/ Tractors	Heavy						
	Ex Heavy						
Buses							

For question 6 through 15, please explain all "yes" answers in the Comments section.

6. Are explosives, caustics, flammables or other dangerous cargo hauled? Yes No
7. Are passengers carried for a fee? Yes No
8. Are any units not insured by underlying policies? Yes No
9. Are any vehicles leased or rented to others? Yes No
10. Are hired and non-owned coverages provided? Yes No
11. Is auto symbol 1 (any auto) used on the underlying coverage? Yes No

Aircraft & Watercraft Liability:

12. Does the Applicant own, lease or operate any aircraft? Yes No
13. Does the Applicant own or lease watercraft? Yes No
- If yes, provide # owned, length and horsepower:

Employers Liability:

14. Is the Applicant self-insured in any state? Yes No
15. Is the Applicant subject to any of the following: Jones Act FELA STOP GAP OTHER:

Loss History:

16. Does the loss history provided with underlying coverages include umbrella loss history? Yes No
- If no, please provide detailed loss history for all umbrella losses in the Comments section or by attachment.

Exposure Analysis:

17. Indicate if any of the following exposures apply to your business.

<input type="checkbox"/> Aircraft Liability	<input type="checkbox"/> Care, Custody, Control	<input type="checkbox"/> Garagekeepers Liability	<input type="checkbox"/> Professional Liability (E&O)
<input type="checkbox"/> Aircraft Passenger Liability	<input type="checkbox"/> Employee Benefit Liability	<input type="checkbox"/> Liquor Liability	<input type="checkbox"/> Vendors Liability
<input type="checkbox"/> Additional Interests	<input type="checkbox"/> Foreign Liability/Travel	<input type="checkbox"/> Pollution Liability	<input type="checkbox"/> Watercraft Liability

