



Hospital/Healthcare System Liability Protection Renewal Application

Name of Applicant: _____ **Policy Number:** _____
 (Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

A. General Information

1. Please use the Comments section to advise us of any changes to the contact information we have for you including the following:

- Address Phone/Fax Number Email Address Contact Person

2. Please use the Comments section to advise us of any desired changes to your insurance program including the following:

- Deductible Limits Umbrella Coverage Physician Coverage Other

For the following questions, please explain all "yes" answers in the Comments section.

3. Have there been any changes to the Applicant's operation within the past 12 months related to the following?

- Obtaining another operation/entity? Yes No
- Selling or discontinuing any operation/entity? Yes No
- Adding or reducing the number of employees? Yes No
- Adding or reducing the number of locations? Yes No
- Adding or reducing current services? Yes No
- Operating in new states? Yes No
- Entering into any joint ventures or limited partnerships? Yes No
- New construction or renovation projects? Yes No

4. Are future operational changes anticipated related to the items listed in question #3? Yes No

5. Have there been any changes to the Applicant's additional named insureds? Yes No

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

7. Does the Applicant sell or rent any equipment to others? Yes No

8. Are all staff members required to maintain medical professional liability insurance? Yes No
 Is this requirement stated in the staff bylaws? Yes No

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

9. Has the Applicant employed any new physicians in the past 12 months that are not currently listed on the schedule? If yes, please complete an individual application for each person. 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

Please attach a listing of locations or a copy of your statement of values.

B. Obstetrics

Are obstetrical services provided? Yes No If yes, please answer the following questions based on annualized data:

- | | |
|---|-----------------------------|
| Number of OB/GYN Deliveries: _____ | Number of Births: _____ |
| Deliveries by Family Practice Physicians: _____ | Number of C-Sections: _____ |
| Deliveries by Nurse Midwives: _____ | Number of VBACs: _____ |
| Other Deliveries: _____ | |

C. 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: | | | | |
| Long Term Care Beds: | | | | |
| Residential (Assisted) Care Beds: | | | | |
| Independent Living 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: | | | | |
| 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: | | |
| Gross Revenues: | Most Current 12 Months: | Projected 12 Months: |

D. 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 | Contract ed 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: | | |

E. 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 I (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 |

F. HOSPITAL ADMINISTRATIVE TEAM

| Named | Title | Phone Number | Email Address |
|-------|-----------------|--------------|---------------|
| | CEO | | |
| | CFO | | |
| | Risk Management | | |
| | CNO | | |
| | QA/QI | | |

G. COMMENTS

Notice Concerning Policyholder Rights In An
Insolvency Under The Minnesota Insurance Guaranty Association Law

The financial strength of your insurer is one of the most important things for you to consider when determining from whom to purchase a property or liability insurance policy. It is your best assurance that you will receive the protection for which you purchased the policy. If your insurer becomes insolvent, you may have protection from the Minnesota Insurance Guaranty Association as described below but to the extent that your policy is not protected by the Minnesota Insurance Guaranty Association or if it exceeds the guaranty association's limits, you will only have the assets, if any, of the insolvent insurer to satisfy your claim.

Residents of Minnesota who purchase property and casualty or liability insurance from insurance companies licensed to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes insolvent. This protection is provided by the Minnesota Insurance Guaranty Association.

Minnesota Insurance Guaranty Association
4640 West 77th Street, Suite 342
Edina, Minnesota 55436
(952) 831-1908

The maximum amount that the Minnesota Insurance Guaranty Association will pay in regard to a claim under all policies issued by the same insurer is limited to \$300,000. This limit does not apply to workers' compensation insurance. Protection by the guaranty association is subject to other substantial limitations and exclusions. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds from the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell property and casualty or liability insurance in Minnesota after the insolvency occurs. Claims are paid from the assessment.

THE PROTECTION PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON PROTECTION BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF PROPERTY AND CASUALTY OR LIABILITY INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL PROPERTY AND CASUALTY INSURANCE OR LIABILITY POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.