Healthcare Facility Professional Liability Insurance General Application

This application must be completed in full and submitted along with the required attachments and/or application supplements requested. In order to expedite the underwriting process, please write legibly and ensure that all questions have been fully answered.

Contact your insurance agent if you have any questions concerning this application or the coverage for which this application applies.

REQUIRED ATTACHMENTS:

- ❒ Copy of current Insurance Policy declarations page.
- ❒ Most recent state inspection report, licensure report or accreditation report, as applicable.
- ❒ Most recent annual financial statement.
- ❒ Copies of all current advertising materials such as: Brochures; Yellow Pages, Newspaper, and/or magazine advertisements. Also include copies of scripts for voice and/or film media.
- ❒ Currently dated formal loss runs from all prior insurance companies for the past 10 years.
- ❒ A ***Claim / Incident / Suit Supplement Form*** (see last page of the application) must be completed for each claim, incident and/or suit in which you have ever been involved, either directly or indirectly. You must also complete this form for any precautionary incident report you have ever submitted to your present or past professional liability insurance carrier(s).
- ❒ "Yes" responses to some questions require you to provide an explanation **via separate attachment**. Sometimes the explanation can be provided by you in a narrative form which should be on your letterhead and signed and dated by you. Other "yes" responses require you to attach copies of certain legal documents.

SECTION 1 – INSURANCE AGENT INFORMATION

Agent Name: Paul Graham License # A102086

Agency Name: Physician Protection Phone # 904-200-1232

SECTION 2 - APPLICANT INFORMATION

Facility Name: ______________________________

FEIN/Tax ID Number: ____________________ Tax Status For Profit Not for Profit

License Number: ____________________

Legal Structure: Individual Partnership LLC

Corporation Joint Venture Other ____________________

Ownership: PLEASE COMPLETE THE OWNERSHIP INFORMATION FORM

This facility has been: in operation for __________years

owned by present owners for _____________ years

managed by present management for _____________ years

Facility Address

____

Number Street City State Zip

____

Telephone # Fax # Website Address

Billing Address same as Facility Address

____

Number Street City State Zip

____

Telephone # Fax # Billing Contact Name

Accreditations held by facility (include a copy of the most recent accreditation report or inspection report):

State Licensure	Date of last inspection
Medicare Certification	Date of last certification
Accredited by JCAHO	Date accreditation expires
Accredited by AAAHC	Date accreditation expires
Accredited by AAAASF	Date accreditation expires
Accredited by CARF	Date accreditation expires
Accredited by COLA	Date accreditation expires
Accredited by ICAEL	Date accreditation expires
Approved by CLIA	Date approval expires
Other (describe):	

SECTION 3 – COVERAGE INFORMATION

1. Requested Coverage effective date: ______________________________ (at 12:01 a.m.)

2. Prior Acts

   If the facility's expiring policy is on a Claim-Made basis, an extended reporting period endorsement "tail" is generally available as an option of your expiring Claims-Made policy.

   a. Is the facility exercising this option? YES NO

   b. If **NO**, do you want us to provide coverage for prior acts (claims or incidents which may have occurred but, as yet, no indication has been made to the facility)? YES NO

   If Yes, please attach a copy of your current Declarations page and indicate retroactive date below.

   Requested Retroactive date of: ______________________________ (at 12:01 a.m.)

   c. Indicate reason for termination of latest policy: ____

   Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier.

3. Requested Limits of Liability (Please check at least one):

   $250,000 per claim/$750,000 aggregate per single policy year (MINIMUM LEVEL)
   $500,000 per claim/$1,500,000 aggregate per single policy year
   $1,000,000 per claim/$3,000,000 aggregate per single policy year
   Other (please list): ____

4. Requested Deductible (Please check at least one):

   None
   $5,000 per claim/$25,000 aggregate per single policy year
   $10,000 per claim/$50,000 aggregate per single policy year
   $25,000 per claim/$75,000 aggregate per single policy year
   $50,000 per claim/$150,000 aggregate per single policy year (letter of credit required)
   $100,000 per claim/$300,000 aggregate per single policy year (letter of credit required)
   Other (please list) ____

Limit of Liability and Deductible options offered will be determined at the sole discretion of the Company. If a letter of credit is required as indicated above, the amount will be determined by the Company.

SECTION 4 – INSURANCE INFORMATION

1. Insurance history for the previous ten (10) years

Coverage Period From / To	Insurance Carrier	Policy Number	Type of Policy (CM/OCC)	Retroactive Date

a. Has the facility **ever** operated without insurance or allowed a claims-made policy to lapse without the purchase of tail or nose coverage? YES NO

b. Has the facility **ever** had professional liability insurance refused, declined, non-renewed cancelled, or accepted on special terms? YES NO

c. Has the facility **ever** been required to pay a premium surcharge or been involved in an appeal concerning the imposition of such a surcharge? YES NO

If **Yes** to a, b or c, please explain in "Remarks" section.

2. Do you conduct any business over the internet? YES NO

If yes, please attach a detailed description of your services.

3. Have you sold, discontinued or acquired any operations in the past 5 years? YES NO

If Yes, please describe: ______________________________

____

____

4. Do you plan to add any new procedures, products, services or operations in the upcoming year? YES NO

If Yes, please describe: ______________________________

____

____

5. Describe the referral source(s) by which patients are directed to your facility. ______________________________

____

____

6. Special Activities N/A

Clinical Research
Experimental Drug Administration
Clinical site for students
Animal Research
Pharmacy
Biomedical Device research and development

Other (describe): ______________________________

____

____

SECTION 5 – HEALTHCARE PROFESSIONAL INFORMATION

1. Do you employ any of the following healthcare professionals listed below?
   a. Physicians / Surgeons — YES NO

      *If **Yes**, please complete the EMPLOYED PHYSICIAN/SURGEON INFORMATION FORM

   b. Nurse Anesthetist, Nurse Practitioner, Physicians Assistant, Nurse Midwife, Optometrist, Chiropractor, Podiatrist — YES NO

      *If **Yes**, please complete the EMPLOYED PROFESSIONALS INFORMATION FORM

2. STAFF PHYSICIANS
   a. Please indicate the number of staff physicians in each of the following categories:

      Active _________ Consulting ________ Emeritus ________ Provisional ________

      Associate _________ Courtesy ________ Probationary ________

   b. Is the credentialing and privileges process for employed, contract and staff physicians formalized and documented? — YES NO
   c. Is new technology included in the delineation of privileges? — YES NO
   d. How often are physicians with privileges at the facility re-credentialed? _______________
   e. Has there been any review by a state medical board, or other entity of any physician with privileges at the facility? — YES NO
   f. Has the license of any physician with privileges at the facility ever been suspended, revoked or voluntarily surrendered? — YES NO
   g. Have there been any limitations placed on any physician with privileges at the facility? — YES NO

3. For the following healthcare professionals, indicate if individual professional liability insurance is required and, if so, what are the minimum limits?

	Required?		Minimum Limits
Employed Phys / Surg *	YES	NO	$____________________ / ____________________
* Physicians / Surgeons who are employed by the facility			
Contracted Phys / Surg **	YES	NO	$____________________ / ____________________
** Physicians / Surgeons under contract with the facility			
Staff Phys / Surg ***	YES	NO	$____________________ / ____________________
*** Physicians / Surgeons not employed or contracted, but who have privileges at the facility			
Nurse Anesthetists	YES	NO	$____________________ / ____________________
Nurse Practitioners	YES	NO	$____________________ / ____________________
Physicians Assistants	YES	NO	$____________________ / ____________________
Nurse Midwives	YES	NO	$____________________ / ____________________
All Other Professionals	YES	NO	$____________________ / ____________________

How often are professional liability limits verified? ____

Comments: ____

____

____

SECTION 6 – RATING INFORMATION

This information, plus that requested on any supplement, will be used for rating purposes. The data provided should be projected for the 12 months to be covered under the policy.

1. Annual Revenue (past 2 calendar years)

	Projected	Current Year through (mm/dd/yy) ____________	1st Prior Year ____________	2nd Prior Year ____________
Gross Revenue	$	$	$	$
Number of Visits**	#	#	#	#

** Visits – Number of patients entering or visiting (not the number of departments visited or procedures performed during one visit)

2. Description of Services

Ambulatory Surgery Center	Complete the Ambulatory Surgery Center Supplement
X-ray / Imaging Center	Complete the Imaging Center Supplement
Laboratory (Medical / Pathology)	Complete the Medical / Pathology Laboratory Supplement

Other - describe, in detail, the services provided at the facility: ____

____

____

____

____

____

____

SECTION 7 – RISK MANAGEMENT INFORMATION

1. Risk Management / Patient Safety

	Name	Telephone Number
Risk Management Coordinator		
Patient Safety Officer		
Medical Director		

a. Do you have an established risk management / patient safety program? YES NO
(A copy of may be requested).

b. Is the risk manager accountable and solely responsible for risk management? YES NO

c. Is the risk manager responsible for reviewing incident reports? YES NO

d. Does the medical director provide direct patient care? YES NO

SECTION 7 – RISK MANAGEMENT INFORMATION - continued

2. Medical / Surgical Equipment

   a. Owned Equipment - Briefly describe your preventative maintenance program:

   ____

   ____

   If you use a vendor, what limits of liability do you require? ____________________

   b. Leased Equipment – Do you rent or lease any equipment from others? YES NO

   If so, do you have a hold harmless / indemnity agreement in place with each vendor? YES NO

3. Contracts & Services

   a. Does legal counsel review all contractual agreements? YES NO

   b. Have you agreed to hold harmless or indemnify others under contract? YES NO

   c. If not an ambulatory surgery center, how are anesthesia services provided? N/A

   On premises By Written Agreement By whom ____________________

   d. If not a medical / pathology laboratory, how are laboratory services provided? N/A

   On premises By Written Agreement By whom ____________________

   e. If not an imaging center, how are radiological services provided? N/A

   On premises By Written Agreement By whom ____________________

   f. Describe any contracted services provided BY YOU TO OTHER ENTITIES ____________________

   ____

   ____

   g. Describe any other contracted services provided TO YOU BY OTHER ENTITIES____________________

   ____

   ____

4. Policies / Procedures

   a. Are all policies and procedures reviewed at least annually? YES NO

   b. Is there an admission policy in place? YES NO

   c. Are consent forms used for each type of procedure performed? YES NO

   d. Is the physician/surgeon required to discuss the procedure / consent form with the patient prior to performing the procedure? YES NO

   e. Is there a medical records policy in place? YES NO

      i. Do you utilize electronic medical recordkeeping software? YES NO

      ii. If not, how long are medical records maintained? ____________

   f. Is there a formal written policy and process for tracking diagnostic testing and review by the ordering physician, physician assistant, nurse practitioner, etc. YES NO

   g. Is there a discharge policy in place, including written post operative instructions and/or instructions on how to seek medical attention after hours? YES NO

SECTION 7 – RISK MANAGEMENT INFORMATION – continued

5. Describe the patient screening process for allergies, pregnancy, pace makers, artificial valves, etc…

___

___

___

6. Describe your procedures for dealing with Latex sensitive patients.

___

___

___

7. Hiring / Screening / Training Procedures for Employees, Contractors and Volunteers

   a. Does screening / hiring include the following:

• Educational Background	YES	NO
• Previous employers/employment history	YES	NO
• Personal references	YES	NO
• Hospital privileges	YES	NO
• Pending license suspensions or revocations	YES	NO
• Pending disciplinary actions by other facilities	YES	NO
• Criminal background check	YES	NO
• Medical professional claims history	YES	NO
• Drug/Alcohol abuse screening	YES	NO

   Comments: ___

   ___

   ___

   b. If the individual has had a previous claim, license suspension or revocation, how does that impact your procedure for hiring that person? Are any additional criteria applied?

   ___

   ___

   ___

   c. Are each of the above procedures followed and documented? YES NO

   d. What training is provided for new staff (aides, volunteers, technicians)?

   ___

   ___

   ___

   e. Are written job descriptions established for all employees and volunteers? YES NO

   f. Percentage of turnover for: Licensed Staff ___% Non-licensed Staff ___%

   g. Before staff can provide care, is a competency-based checklist used to assess and document their skills? YES NO

SECTION 8 – CLAIM / INVESTIGATION INFORMATION

1. Is the facility **currently** involved in malpractice litigation? YES NO

2. Has the facility **ever** been involved in a malpractice claim or suit, including any expression of an intent (e.g. closed records requests, incident reports and Notices of Intent, even if suit was never filed)? YES NO

3. Does the facility know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that **any** of the following circumstances might reasonably lead to a claim or suit being brought against the facility, even if it is believed that the claim or suit would be without merit:

   a. A request for records from a patient and/or attorney related to an adverse outcome? YES NO

   b. A letter or communication from a patient, patient's representative, friend, relative or attorney regarding the medical treatment of a patient? YES NO

   c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? YES NO

4. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?

   a. Death YES NO

   b. Brian / Spinal Damage YES NO

   c. Permanent Disfigurement YES NO

   d. Fracture / Dislocation of bone or joints YES NO

   e. Neurological, physical or sensory limitations continuing after discharge YES NO

   f. Condition requiring transfer of patient to hospital YES NO

   g. Surgery – wrong procedure, wrong patient, wrong site YES NO

   h. Surgery – repair damage from planned procedure but damage was not recognized as a risk that was disclosed during informed consent process YES NO

   i. Surgery – removal of unplanned foreign objects remaining from previous procedure YES NO

5. Does the facility know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? YES NO

6. Does the facility know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits **(EVEN IF IT IS BELIEVED THE OUTSTANDING CLAIM OR SUIT WOULD BE WITHOUT MERIT)** that have not been reported to your current OR prior professional liability carrier? YES NO

7. Has the facility **ever:**

   a. been investigated or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility? YES NO

   b. had its license to practice medicine or permit to dispense or prescribe drugs limited, suspended, revoked, placed on probation or been voluntarily surrendered? YES NO

   c. been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature? YES NO

   d. had Medicare/Medicaid fraud charges filed against it ? YES NO

If you answered Yes to any question above, please provide full details in "Remarks" section and attach any additional documentation. An Incident/Claim Information Form must be completed for each incident, potential claim, claim or suit.

REMARKS

Section / Question #

Please make additional copies of this page, as necessary

SUPPLEMENTAL WAIVER AND RELEASE

As authorized representative for the facility, I hereby acknowledge that the foregoing information constitutes the application for insurance with Florida Doctors Insurance Company (FLDIC). All statements are the facility's own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences or circumstances related to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of FLDIC in considering this application for professional liability insurance.

If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. If it is determined that I failed or refused to disclose any relevant fact or information or misled, defrauded or lied to FLDIC, I understand that the policy shall be null and void. However, unintentional errors or omissions do not affect my rights under the policy, if issued. I understand that no insurance will be afforded unless and until this application is accepted by FLDIC and the facility is notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of the facility's background, competence and qualifications, which may involve underwriting and/or claims matters, may be conducted by FLDIC. I consent to any investigation or inquiry and authorize release and exchange of information related to the facility, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Resource Network, individuals and FLDIC. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if the facility is insured by FLDIC, re-verification of its credentials will be periodically required. Therefore, this authorization shall remain valid for so long as the facility maintains a business relationship with FLDIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FLDIC that this authorization is currently valid. This authorization may be canceled at any time, upon written notice to FLDIC.

______________________________	______________________________
Signature of Authorized Representative	Date
______________________________	______________________________
Printed Name of Authorized Representative	Title of Authorized Representative

This application form duly completed together with any supplementary information must be signed in ink by an authorized representative of the applicant. A signature on the form does not bind the applicant or FLDIC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

We do not sell or rent your information to unaffiliated third parties. However, from time to time, we may share your contact information with our affiliates (either subsidiaries or the trading partners listed on our website). If you do not want us to share your information with those affiliates, please check here. Do not share my information

Fraud Statement
Section 817.234(1)(b), Florida Statutes

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

Insurance coverage is subject to underwriting review and approval and premium payment No coverage exists until an initial premium deposit is received and a Binder or Coverage Summary Page, together with any applicable endorsements, has been issued by FLDIC to the policyholder.

FLORIDA DOCTORS INSURANCE COMPANY
4655 Salisbury Road, Suite 110
Jacksonville, Florida 32256
Phone: 800-FLA-DOCS (352-3627) FAX: 904-296-1013
www.FLDIC.com

OWNERSHIP INTEREST INFORMATION FORM –

Provide the names of the shareholders or partners of the facility, listing the majority owner(s) first.

Entity / Individual Name	Is this person a physician? (Yes/No)	If Yes, do they provide patient care at the facility?

EMPLOYED PHYSICIANS/SURGEONS INFORMATION FORM NONE

Name	Retroactive Date	American Board Certified or Eligible (Y/N)?	Specialty

EMPLOYED PROFESSIONALS INFORMATION FORM

NONE

Name	Retroactive Date	Specialty

FLORIDA DOCTORS INSURANCE COMPANY
INCIDENT/CLAIM INFORMATION

All incidents/claims reported to current and prior carriers should be reported on this form

NO CLAIMS TO REPORT – "NO" answered to all questions in Section 8 (on Page 9)

Name of patient: ______________________________ Age: __________

Your relationship to patient: ______________________________

____

Details of allegation(s): ______________________________

Date of incident ______________________________ Report date: ______________________________

Insurance carrier ______________________________

Name of defense attorney ______________________________

Other defendants: ______________________________

Present status of claim **(check applicable answer and fill in amounts where needed)**

CLAIM IS OPEN

Precautionary/Incident report only

Suit threatened, no action taken

Notice of intent filed, no suit filed

Suit filed

Reserve Amount $ ____________________

CLAIM IS CLOSED

Dropped by claimant

Settled

Summary judgment _____ Claimant's Favor _____ Your Favor

Court trial _____ Claimant's Favor _____ Your Favor

Date Paid ____________________ Amount Paid $ ____________________

Location of incident: ______________________________

Condition and diagnosis at time of incident: ______________________________

Dates and description of treatment rendered: ______________________________

____

____

Condition of patient subsequent to treatment (and DATES OF FOLLOW-UP TREATMENT) ______________________________

____

____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

______________________________ ______________________________

Signature of Authorized Representative Date

______________________________ ______________________________

Printed Name of Authorized Representative Title of Authorized Representative