

PHYSICIANS' RECIPROCAL INSURERS

**HOSPITAL
PROFESSIONAL LIABILITY INSURANCE
RENEWAL APPLICATION**

IMPORTANT

Processing of this application will be delayed if it is not completed in its entirety and the requisite attachments are not included.

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Telephone: (516) 365-6690 Fax: (516) 365-7522

**PHYSICIANS' RECIPROCAL INSURERS
HOSPITAL
PROFESSIONAL LIABILITY INSURANCE RENEWAL APPLICATION**

PART I - APPLICANT *(If more than one location, please list on separate sheet)*

Name of Hospital: _____

Street Address: _____

City/State/Zip: _____

Telephone Number: () _____ Number of Years at Present Location: _____

Mailing Address *(If different from above)*:

Contact Person: _____ Title: _____
Telephone Number: _____

List any Affiliates or Subdivisions to which this policy will apply:

PART II - LIABILITY LIMIT AND DEDUCTIBLE OPTIONS

If your Hospital wishes to change the type of coverage(s), please refer to the prior year's information and list changes below.

	<u>Current Coverages</u>	<u>Change(s)</u>	<u>Please Check</u>
<u>Coverage Type:</u>	_____	_____	<input type="checkbox"/> No Changes
<u>Limits:</u>	_____	_____	<input type="checkbox"/> No Changes
<u>Deductible:</u>	_____	_____	<input type="checkbox"/> No Changes
<u>Coverage Dates:</u>	_____	Retroactive Date, if applicable: _____	

PART III - GENERAL INFORMATION

1. Please list any newly approved programs or beds that were approved during the last year.

2. Please list any new clinical services that have been added during the last year.

3. Please provide full details if your Hospital has added to or deleted from its current residency and/or other type teaching programs during the last year.

4. Please list below any fines or sanctions the Hospital has received from regulatory agencies during the last year.

PART IV - HOSPITAL CENSUS FOR LAST YEAR

1.	<u>Hospital Beds By Specialty</u>	<u>Number</u>	<u>% Occupied</u>	<u>Projected Number</u>	<u>Projected % Occupied</u>
	# of Certified Beds	_____	_____	_____	_____
	Medical/Surgical	_____	_____	_____	_____
	ICU/CC	_____	_____	_____	_____
	Obstetrical	_____	_____	_____	_____
	Pediatric	_____	_____	_____	_____
	Psychiatric	_____	_____	_____	_____
	Rehabilitation	_____	_____	_____	_____
	Alcohol/Drugs	_____	_____	_____	_____
	Long Term Care	_____	_____	_____	_____
	• SNF	_____	_____	_____	_____
	• HRF	_____	_____	_____	_____
	TOTALS:	_____	_____	_____	_____

2. Please provide the number of procedures performed:

	<u>Current Year</u>	<u>Projected</u>
Non-Ambulatory Surgical:	_____	_____
Ambulatory Surgical:	_____	_____
Deliveries: C-Section:	_____	_____
Normal Vaginal Delivery:	_____	_____

3. Please provide the number of outpatient/ambulatory care visits:

	<u>Current Year</u>	<u>Projected</u>
Emergency Dept.	_____	_____
Ambulatory Care	_____	_____
Rehabilitation	_____	_____
Psychiatric	_____	_____
Home Healthcare	_____	_____
Other	_____	_____
Total	_____	_____

4. Please provide the number of ancillary procedures performed:

	<u>Current Year</u>	<u>Projected</u>
Radiology	_____	_____
Lab	_____	_____
Nuclear Medicine	_____	_____
Total	_____	_____

5. Please list other ancillary procedures performed not listed above:

<u>Department</u>	<u>Procedure</u>	<u>Current Year</u>	<u>Projected</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PART V - EMPLOYED MEDICAL AND PROFESSIONAL STAFF

1. Please indicate any changes in number of Employed Physicians, Podiatrists, Dentists.

	<u>Current Year</u>	<u>Change(s)</u>	<u>Please Check</u>
<u>Physicians:</u>	_____	_____	<input type="checkbox"/> No Changes
<u>Podiatrists:</u>	_____	_____	<input type="checkbox"/> No Changes
<u>Dentists:</u>	_____	_____	<input type="checkbox"/> No Changes

PART V - EMPLOYED MEDICAL AND PROFESSIONAL STAFF (continued)

	<u>Current Year</u>	<u>Change(s)</u>	<u>Please Check</u>
Residents:	_____	_____	<input type="checkbox"/> No Changes
Interns:	_____	_____	<input type="checkbox"/> No Changes

**Please attach a schedule of all physicians requiring coverage under this policy.
Please include name, specialty and FTE.**

2. Other Employed Professional Staff:

	<u>Current Year</u>	<u>Change(s)</u>	<u>Please Check</u>
RN's	_____	_____	<input type="checkbox"/> No Changes
CNM's	_____	_____	<input type="checkbox"/> No Changes
CRNA's	_____	_____	<input type="checkbox"/> No Changes
PA's	_____	_____	<input type="checkbox"/> No Changes
Resp. Therapists	_____	_____	<input type="checkbox"/> No Changes
Pharmacists	_____	_____	<input type="checkbox"/> No Changes
Radiology Technician	_____	_____	<input type="checkbox"/> No Changes
Lab Technician	_____	_____	<input type="checkbox"/> No Changes
Perfusionists	_____	_____	<input type="checkbox"/> No Changes
Paramedics	_____	_____	<input type="checkbox"/> No Changes
Dieticians	_____	_____	<input type="checkbox"/> No Changes

PART VI - CONTRACTED SERVICES

Please list below any additions/deletions in contracted clinical services.

<u>Service</u>	<u>Addition</u>	<u>Deletion</u>	<u>Date of Change</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____

PART VII - ADDITIONAL EXPOSURES

Please include below any additional exposures not already mentioned that will require malpractice coverage.

PART VIII - ADDITIONAL INFORMATION AND DOCUMENTS TO ACCOMPANY APPLICATION

- **Copy of current year's loss runs from prior carrier.**
- **Copy of current annual and financial reports.**
- **Copies of newly entered Hold Harmless/Indemnification Agreements and/or contracts with independent physician groups.**

If applicable, send updated copies of the following:

1. Current State license.
2. Actuarial review of the SIR
3. Updated information on excess professional liability coverage.
4. Recent inspections and/or surveys conducted by regulatory or accreditation agencies.
5. Hold Harmless/Indemnification Agreements.

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.

Contact/Title: _____

Telephone #: () _____

Date: _____