

**HOSPITAL
PROFESSIONAL LIABILITY INSURANCE 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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Manhasset, New York 11030
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**PHYSICIANS' RECIPROCAL INSURERS
HOSPITAL
PROFESSIONAL LIABILITY INSURANCE 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: _____

Facility Tax I.D. Number _____

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

PART II - LIABILITY LIMIT AND DEDUCTIBLE OPTIONS

Claims-Made Coverage Period _____ Retroactive Date _____

Occurrence Coverage Period _____

Primary Limits: _____ Deductible _____

Excess Limits: _____

PART III - GENERAL INFORMATION

1. **TYPE OF HOSPITAL**

- General Hospital
- Childrens' Hospital
- Psychiatric Hospital
- Specialty Hospital
 (Specify) _____
- Other (Specify)

2. **TYPE OF OWNERSHIP**

- General Hospital
- For Profit Corporation
- Not-for-Profit Corporation
- Partnership
- Sole Proprietorship

3. **OUTPATIENT/AMBULATORY CARE VISITS** Please provide number of visits.

<u>Department</u>	Current Year	1 Year Prior	2 Years Prior
Emergency Dept.	_____	_____	_____
Ambulatory Care	_____	_____	_____
Rehabilitation	_____	_____	_____
Psychiatric	_____	_____	_____
Home Healthcare	_____	_____	_____
Other	_____	_____	_____

4. **ANCILLARY PROCEDURES** Please provide number of procedures.

<u>Department</u>	Current Year	1 Year Prior	2 Years Prior
Radiology	_____	_____	_____
Lab	_____	_____	_____
Nuclear Medicine	_____	_____	_____

PART V – EMPLOYED MEDICAL AND PROFESSIONAL STAFF

PROFESSIONAL STAFF

	<u>Number</u>	<u>F/T</u>	<u>P/T</u>
M.D.'s	_____	_____	_____
Podiatrists	_____	_____	_____
Dentists	_____	_____	_____
Residents	_____	_____	_____
Interns	_____	_____	_____
RN's	_____	_____	_____
Nurse Midwives	_____	_____	_____
CRNA's	_____	_____	_____
PA's	_____	_____	_____
CNM's	_____	_____	_____
Resp. Therapists	_____	_____	_____
Pharmacists	_____	_____	_____
Radiology Technician	_____	_____	_____
Lab Technician	_____	_____	_____
Perfusionists	_____	_____	_____
Dietician	_____	_____	_____
Other: _____	_____	_____	_____

Please attach a schedule of all physicians to be covered under this policy. Please include name, specialty and FTE.

PART VI – CONTRACTED SERVICES

Please list below all services that are contracted for.

Are Hold Harmless/Indemnification Agreements in place? Yes No

PART VII – ADDITIONAL EXPOSURES

Are there additional exposures not already indicated that will require malpractice coverage?

Yes No If "yes", please indicate below.

PART VIII - INSURANCE PROFILE (FIVE YEARS)

1. PRIMARY PROFESSIONAL LIABILITY COVERAGE

	Current Year	1 Year Prior	2 Years Prior	3 Years Prior	4 Years Prior	5 Years Prior
Year						
Carrier						
Limits						
Premium						
Policy Type/Form	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made

Is there a self-insurance trust fund? If "Yes", please indicate limits: _____

2. EXCESS PROFESSIONAL LIABILITY COVERAGE

	Current Year	1 Year Prior	2 Years Prior	3 Years Prior	4 Years Prior	5 Years Prior
Year						
Carrier						
Limits						
Premium						
Policy Type/Form	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made

Is there a self-insurance trust fund? If "Yes", please indicate limits: _____

PART IX - ADDITIONAL INFORMATION AND DOCUMENTS TO ACCOMPANY APPLICATION

1. Most recent State Health Department Annual Survey and Plan of Correction.
2. Most recent JCAHO report with recommendations and status of recommendations.
3. Most recent AHA Survey.
4. Copy of current State license.
5. Current annual and financial reports.
6. Risk Management Department job descriptions, copy of Risk Manager's CV, copy of facility's Risk Management Plan, administrative Table of Organization.
7. Copies of hold harmless/indemnification agreements.
8. Actuarial review of the SIR (if applicable).
9. Trust agreement for the SIR (if applicable).
10. Any claims audit or actuarial audit which has been completed in the past ten years.
11. Public relations materials, brochures, etc.
12. Copies of all contracts with independent physicians' groups.
13. Copies of all agreements between hospital and any training programs.
14. List any acquisitions and divestitures for the past ten years.
15. Copy of most recent FDA and CAP inspections of the Blood Bank.
16. Copy of most recently valued loss run.

NOTICE

Applicants considering claims-made coverage must take note of the following:

A claims-made policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy.

The policy covers claims actually made against the insured and incidents reported while the policy remains in effect and all coverage under the policy ceases upon the termination of the policy, except for the mandatory automatic extended reporting period of sixty (60) days, unless the insured purchases additional extended reporting period coverage which will provide coverage for an unlimited time period without any gap in coverage.

The rates for extended reporting period coverage will be based on the rates in effect at the time of termination of coverage and such rate may be subject to substantial increase over the rates currently in effect. The average statewide percentage changes, and the effective dates, of each rate revision which PRI has implemented in this State during the five (5) year period immediately preceding the effective date of the policy will be provided upon the written request of the insured. Such past changes may or may not be indicative of future rate changes.

Unless the insured purchases extended reporting period coverage in addition to the mandated automatic extended reporting period of sixty (60) days, there will be no coverage provided for claims-made or incidents reported after such period of sixty (60) days.

During the first few years of coverage on a claims-made basis, the annual rate is comparatively lower than occurrence rates, however, such annual rate increases significantly, independent of overall rate level increases, until the claims-made relationship reaches maturity.

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.

Signature: _____

Name (please print): _____

Title: _____

Date: _____