

 IRONSHORE A Liberty Mutual Company	IRONSHORE COMPANIES 175 Powder Forest Drive Weatogue, CT 06089	HEALTH CARE ORGANIZATION AND PROVIDER PROFESSIONAL LIABILITY APPLICATION
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NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE.

APPLICANT			
Legal Name:	Telephone No:		() -
Address:			
City:	County:	State:	ZIP:
Years in Operation:		Years Under Present Ownership:	
Website: www.			
Please list all affiliates and subsidiaries to which this insurance is to apply. Please include a complete description of the operations of each affiliate / subsidiary and the relationship to the Applicant. (Attach a separate sheet if necessary):			

REQUESTED & CURRENT COVERAGE STRUCTURE:			
Requested Coverage:	<input type="checkbox"/> Primary	<input type="checkbox"/> Excess	<input type="checkbox"/> Both
Effective Date:		Retroactive Date:	
Option 1:		Option 2:	
Per Claim Limit		Per Claim Limit:	
Aggregate Limit:		Aggregate Limit:	
Per Claim Deductible/Retention		Per Claim Deductible / Retention	
Aggregate Deductible/Retention		Aggregate Deductible / Retention	
<u>Self Insured Retention:</u>	What coverage(s) does the SIR contemplate?		
	Limits of coverage provided by the SIR?		
	Do defense expenses erode the limit?		
	Is there a dedicated trust?		
	Who handles claims within the SIR?		
	Is there a dedicated trust?		

	Which law firm provides defense coverage?	
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<u>Current Coverage</u>	<u>PL</u>	<u>GL</u>	<u>Excess</u>	<u>AL</u>	<u>EL</u>	<u>Helipad</u>
Carrier						
Policy Period						
Limits						
Deductible or Retention						
Claims Made or Occurrence						
Retroactive Date						
# Years Insured by Current Carrier						

* On a separate sheet of paper, please provide the information requested above for all other medical professional liability coverage(s) Applicant has had in the past five years.

GENERAL INFORMATION: (check all that apply)		
<input type="checkbox"/> General Hospital	<input type="checkbox"/> Teaching Hospital	<input type="checkbox"/> For Profit
<input type="checkbox"/> Critical Access Hospital	<input type="checkbox"/> Research Hospital	<input type="checkbox"/> Not for Profit
<input type="checkbox"/> Long Term Acute Care Hospital	<input type="checkbox"/> Government Hospital	<input type="checkbox"/> Medicare Approved
<input type="checkbox"/> Psychiatric Hospital	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Partnership
<input type="checkbox"/> Children's Hospital	<input type="checkbox"/> Clinic	<input type="checkbox"/> Corporation
<input type="checkbox"/> Other Specialty		
Is this facility licensed by the State?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please explain:		
Has the Applicant entered into any joint ventures or limited partnerships?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please explain. (Attach additional sheets of paper, if necessary)		
Is any part of the Applicant operated/leased by a management corporation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please give the name of the corporation and details of structure. Please attach a separate sheet of paper if necessary.		
Does the Applicant participate in any teaching programs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please explain:		
Is the program hospital-sponsored?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please provide the name of the sponsoring institution:		
Does the Applicant anticipate any facility expansions (increase in licensed beds) within the next year?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please explain:		

PERSONNEL:					
Indicate the number of persons employed by or working under the control of the Applicant in each of the following classifications:					
<u>Classification</u>	<u>FTE's</u>		<u>Classification</u>	<u>FTE's</u>	
Physicians & Surgeons **			Nurse Practitioner *		Nurses Aides
Residents *			Midwives *		Paramedics
Dentists			Pharmacists		Emergency Medical Technicians
CRNA *			Registered Nurses		Respiratory Therapists
Physician Assistant *			Licensed Vocational/Practical Nurses		Laboratory or X-Ray Technicians
* Please provide additional information as required in Additional Information ** Please provide additional information as required in Additional Information (A separate application may be required for each Physician or Surgeon prior to commencement of coverage)					
If coverage is requested for the following, please indicate:					
	CRNA	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	Physician Assistant	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	Nurse Midwives	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	Employed Physicians & Surgeons	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	Residents	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

OPERATIONS:					
SERVICES (Please indicate if the Applicant presently provides, plans to provide, or presently operates any of the following):					
<input type="checkbox"/> Abortion Clinic	<input type="checkbox"/> Oncology	<input type="checkbox"/> Inhalation Therapy			
<input type="checkbox"/> Ambulance Service	<input type="checkbox"/> Open Heart Surgery	<input type="checkbox"/> Intensive Care Unit			
<input type="checkbox"/> Base Hospital	<input type="checkbox"/> Off – Premises Clinic	<input type="checkbox"/> Organ Bank			
<input type="checkbox"/> Blood Bank	<input type="checkbox"/> Day Care	<input type="checkbox"/> Organ Transplants			
<input type="checkbox"/> Burn Units	<input type="checkbox"/> Outpatient SurgiCenters	<input type="checkbox"/> Dental Services			
<input type="checkbox"/> Cardiac Cather Centers	<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Lifeline			
<input type="checkbox"/> Coronary Care Unit	<input type="checkbox"/> Home Health Care	<input type="checkbox"/> Nursery			
<input type="checkbox"/> Dialysis	<input type="checkbox"/> Hospice	<input type="checkbox"/> Neonatal			
<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Hospital Foundation	<input type="checkbox"/> Pharmacy			
<input type="checkbox"/> HMO	<input type="checkbox"/> Off Premises Labs				
<input type="checkbox"/> Transportation Services	<input type="checkbox"/> Mobile Unit (bloodmobiles, mammography, CAT scan, etc.)				

OCCUPANCY: (Provide average number of occupied beds in each category)							
BEDS:							
	<u>Licensed</u>	<u>Projected</u>	<u>Current Year</u>		<u>Licensed</u>	<u>Projected</u>	<u>Current Year</u>
Acute / ICU				Psychiatric			
Cribs / Bassinets				Rehabilitation			
Long Term Acute Care				Chemical Dependency			

Extended Care				Hospice			
Skilled Nursing				Other			

INPATIENT SERVICES:

	<u>Projected</u>	<u>Current Year</u>		<u>Projected</u>	<u>Current Year</u>
Inpatient Surgery			Cesarean Sections		
Deliveries (excluding C-Sections and VBAC's)			VBAC's		

OUTPATIENT SERVICES:

Emergency Room			Rehabilitation		
Outpatient Surgery			Home Health Care		
Other Outpatient Visits (Patient Per Registration Day)			Clinic Visits		
Psychiatric Visits			Physician Visits		
Alcohol / Drug Abuse			Reference Labs		

ANESTHESIA SERVICES:

Staffing is by:	<input type="checkbox"/> Contracted Physicians <input type="checkbox"/> Employed Physicians	<input type="checkbox"/> Residents <input type="checkbox"/> CRNA's
Are all physicians board certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If under contract, to who is staffing contracted?		
Are contracted physicians required to carry professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", what limits are required?		
If staffing is provided by CRNA's, are CRNA's:	<input type="checkbox"/> Employed by Applicant <input type="checkbox"/> Employed by the Surgeon	<input type="checkbox"/> Employed by the Anesthesiologist <input type="checkbox"/> Independent
Do CRNA's work under the direct supervision of an anesthesiologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

RADIOLOGY SERVICES:

Staffing is contracted by:	<input type="checkbox"/> Contracted Physicians <input type="checkbox"/> Residents	<input type="checkbox"/> Employed Physicians <input type="checkbox"/> CRNA's
Are all physicians board certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are contract physicians required to carry professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", what limits are required?		

OBSTETRICS:

Is the Applicant a regional referral center for newborns requiring intensive care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No", does a written procedure exist for transferring all high risk mothers and/or babies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Applicant have a separate birthing center?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Can cesarean sections be performed within thirty (30) minutes at all times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do CNM's practice at your hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", are they supervised by OB physicians?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If employed, do CNM's deliver babies at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do Family Physicians perform obstetrical services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do Family Physicians or CNM's perform VBAC's or C-Sections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the Applicant has a neonatal intensive care unit (NICU), state:	
Total number of neonates admitted to NICU in the past twelve (12) months:	
Total number of neonates admitted to NICU who were transferred from other facilities:	
Whether full-time attending neonatologists on-site in NICU twenty-four (24) hours per day:	
If the Applicant does not have a NICU, please state the total number of neonates transferred from the institution to other facilities in the past twelve (12) months:	

EMERGENCY ROOM:	
Does the Applicant provide emergency room (ER) service?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please answer the following questions:	
Staffing is by:	<input type="checkbox"/> Contracted Physicians <input type="checkbox"/> Employed Physicians
	<input type="checkbox"/> Residents <input type="checkbox"/> Physician Assistants
Are all physicians board certified?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If under contract, to whom is staffing contracted?	
Are contract physicians required to carry professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", what limits are required?	

SURGERY:	
Are any of the following performed at your facility:	
<input type="checkbox"/> Experimental Surgery	<input type="checkbox"/> Neurosurgery
<input type="checkbox"/> Open Heart Surgery	<input type="checkbox"/> Weight Reduction Surgery

SPECIAL SERVICES:						
Ambulance		Number of Vehicles		Blood Banks		Number of donors (pints)
		Number of runs per year				Number of pints purchased from others
Organ Tissue Bank		Number of donors		Day Care		Number of children per day
		Number of organ/tissue donations per year				Number of days per week
					On hospital premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
					Open to the public?	<input type="checkbox"/> Yes <input type="checkbox"/> No

STAFF PRIVILEGES:	
Are credentials for new staff members checked and approved prior to granting staff privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No", please explain:	
Does the Applicant have any staff members who have restricted licenses or privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please explain:	
Are all staff privileges reviewed at least every two (2) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Applicant require all foreign school graduates to be certified by the Educational Council for Foreign Medical School graduates?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are all staff members required to maintain professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No

RISK MANAGEMENT:	
Is there a written, formalized risk management program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Who is in charge of implementing this program and any changes?	Name:
	Title:
	Phone:
	Fax:
	Email:
To whom does the Risk Manager or Director of Risk Management report?	

CONTRACTUAL AGREEMENTS:	
Are any of the following services performed at the hospital by contract professionals?	
<input type="checkbox"/> Pathology	<input type="checkbox"/> Laboratory
<input type="checkbox"/> Pharmacy	<input type="checkbox"/> Other
Does the Applicant require these contractors to provide evidence of insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", what limits of liability does the Applicant require?	
Are there any other service contracts in effect?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", please describe services:	
Does the Applicant indemnify (hold harmless) the service provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PHYSICAL PREMISES:						
Please indicate below all the buildings the Applicant owns, controls or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. Please attach a separate schedule if more space is needed.						
	Address:				Year Built:	
	Construction (brick, fire-resistant, etc.)		No. of Stories:		Total Sq. Feet:	
	Use:			Inpatient / Outpatient:		
	Address:				Year Built:	

Construction (brick, fire-resistant, etc.)		No. of Stories:		Total Sq. Feet:	
Use:		Inpatient / Outpatient:			

Address:				Year Built:	
Construction (brick, fire-resistant, etc.)		No. of Stories:		Total Sq. Feet:	
Use:		Inpatient / Outpatient:			

Does the Applicant use security guards? Yes No

If "Yes", complete the following questions:	Services are provided by:	<input type="checkbox"/> Employees <input type="checkbox"/> Contractors
	Do guards carry guns?	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTO LIABILITY EXPOSURE:

Indicate the number of vehicles in each of the following categories that the Applicant owns or operates:

<u>Vehicle Type</u>	<u>#</u>	<u>Vehicle Type:</u>	<u>#</u>
Private Passenger		Patient Transport	
Service		Ambulance	
Other (describe):			

HELIPAD EXPOSURE:

Does the Applicant have a heliport / helipad? Yes No

If "Yes", please complete the following:

	Where is it located (e.g. parking lot, top of building, etc.)	
	How far is it from the Applicant?	
	Please list the dimensions:	
	Please describe the type of construction:	
	Estimated number of landings per year:	

COVERAGE: (MISSOURI RESIDENTS DO NOT ANSWER)

Past coverage:	Has any insurer canceled or declined to renew professional liability coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Claims / Incidents:	Please attach a loss run describing all claims/incidents during the past 7 years made against the Applicant or any individual or entity proposed for coverage hereunder that would fall within the scope of the proposed insurance. (Attach additional sheets, if necessary). If answer is "none", so state:

Neither the Applicant nor any individual or entity proposed for coverage, is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows.

If answer is "none", so
state:

ADDITIONAL INFORMATION:

Please disclose any information material to the risk which has not otherwise been addressed in this application (please attach additional sheets of paper if necessary).

Please provide the following information:

1. Loss history for the last seven (7) years, including any claim paid or outstanding. Detailed losses should be provided including any paid or reserved amounts. Losses should be valued no earlier than ninety (90) days prior to the proposed effective date.
2. Employed Physician Schedule, including the name, specialty and retro date for each employed physician.
3. The Applicant's most recent annual report
4. A copy of the most recent JCAHO report and response to any contingencies
5. The Applicant's most recent financial statements
6. Copy of expiring Medical Professional Liability insurance policy
7. Current balance of the self-insured trust fund*
8. Trust Agreement*
9. Recent actuarial study supporting the funding of the self-insured trust*

* These items apply if Applicant has set up a self-insured trust fund

THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER'S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE OR ISSUE A POLICY.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO MINNESOTA, OHIO, AND ARKANSAS APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

Applicant (signature):		
By (CEO/President – Print Name)	Title:	Date:

NOTE: This Application must be signed by the Chief Executive Officer or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.