Print Form

| IRONSHORE your safe harbour | IRONSHORE COMPANIES<br>175 Powder Forest Drive<br>Weatogue, CT 06089 | HEALTH CARE ORGANIZATION AND PROVIDER PROFESSIONAL LIABILITY APPLICATION |
|---|---|---|

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): | | | |
| | | | |
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| REQUESTED & CURRENT COVERAGE STRUCTURE: | | | |
|---|---|---|---|
| Requested Coverage: ☐ Primary ☐ Excess ☐ 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 | |

| Self Insured Retention: | | |
|---|---|---|
| | 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? | |

| Current Coverage | PL | GL | Excess | AL | EL | Helipad |
|---|---|---|---|---|---|---|
| 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)*

| | | |
|---|---|---|
| ☐ General Hospital | ☐ Teaching Hospital | ☐ For Profit |
| ☐ Critical Access Hospital | ☐ Research Hospital | ☐ Not for Profit |
| ☐ Long Term Acute Care Hospital | ☐ Government Hospital | ☐ Medicare Approved |
| ☐ Psychiatric Hospital | ☐ Nursing Home | ☐ Partnership |
| ☐ Children's Hospital | ☐ Clinic | ☐ Corporation |
| ☐ Other Specialty | | |

| | |
|---|---|
| Is this facility licensed by the State? | ☐ Yes ☐ No |
| Has the Applicant or other associated entity ever lost a license or been placed on probation by any governmental licensing agency? | ☐ Yes ☐ No |
| If "Yes", please explain: | |
| Has the Applicant entered into any joint ventures or limited partnerships? | ☐ Yes ☐ No |
| If "Yes", please explain. (Attach additional sheets of paper, if necessary) | |
| Is any part of the Applicant operated/leased by a management corporation? | ☐ Yes ☐ 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? | ☐ Yes ☐ No |
| If "Yes", please explain: | |
| Is the program hospital-sponsored? | ☐ Yes ☐ 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? | ☐ Yes ☐ 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: | | | | | | | | |
| Classification | FTE's | | Classification | FTE's | | Classification | FTE's | |
| 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<br>** Please provide additional information as required in Additional Information<br>(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 | ☐ Yes ☐ No | | | | | | | |
| Physician Assistant | ☐ Yes ☐ No | | | | | | | |
| Nurse Midwives | ☐ Yes ☐ No | | | | | | | |
| Employed Physicians & Surgeons | ☐ Yes ☐ No | | | | | | | |
| Residents | ☐ Yes ☐ No | | | | | | | |

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

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

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Extended Care | | | | | Hospice | | | |
| Skilled Nursing | | | | | Other | | | |

| INPATIENT SERVICES: | | | | | | |
|---|---|---|---|---|---|---|
| | Projected | Current Year | | | Projected | Current Year |
| 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: | ☐ Contracted Physicians<br>☐ Employed Physicians | ☐ Residents<br>☐ CRNA's |
| Are all physicians board certified? | ☐ Yes ☐ No | |
| If under contract, to who is staffing contracted? | | |
| Are contracted physicians required to carry professional liability insurance? | ☐ Yes ☐ No | |
| If "Yes", what limits are required? | | |
| If staffing is provided by CRNA's, are CRNA's: | ☐ Employed by Applicant<br>☐ Employed by the Surgeon | ☐ Employed by the Anesthesiologist<br>☐ Independent |
| Do CRNA's work under the direct supervision of an anesthesiologist? | ☐ Yes ☐ No | |

| RADIOLOGY SERVICES: | | |
|---|---|---|
| Staffing is contracted by: | ☐ Contracted Physicians | ☐ Employed Physicians |
| | ☐ Residents | ☐ CRNA's |
| Are all physicians board certified? | ☐ Yes ☐ No | |
| Are contract physicians required to carry professional liability insurance? | ☐ Yes ☐ No | |
| If "Yes", what limits are required? | | |

| OBSTETRICS: | |
|---|---|
| Is the Applicant a regional referral center for newborns requiring intensive care? | ☐ Yes ☐ No |
| If "No", does a written procedure exist for transferring all high risk mothers and/or babies? | ☐ Yes ☐ No |
| Does the Applicant have a separate birthing center? | ☐ Yes ☐ No |

| | |
|---|---|
| Can cesarean sections be performed within thirty (30) minutes at all times? | ☐ Yes ☐ No |
| Do CNM's practice at your hospital? | ☐ Yes ☐ No |
| If "Yes", are they supervised by OB physicians? | ☐ Yes ☐ No |
| If employed, do CNM's deliver babies at home? | ☐ Yes ☐ No |
| Do Family Physicians perform obstetrical services? | ☐ Yes ☐ No |
| Do Family Physicians or CNM's perform VBAC's or C-Sections? | ☐ Yes ☐ 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? | ☐ Yes ☐ No | |
| If "Yes", please answer the following questions: | | |
| Staffing is by: | ☐ Contracted Physicians | ☐ Employed Physicians |
| | ☐ Residents | ☐ Physician Assistants |
| Are all physicians board certified? | ☐ Yes ☐ No | |
| If under contract, to whom is staffing contracted? | | |
| Are contract physicians required to carry professional liability insurance? | ☐ Yes ☐ No | |
| If "Yes", what limits are required? | | |

| SURGERY: | |
|---|---|
| Are any of the following performed at your facility: | |
| ☐ Experimental Surgery | ☐ Neurosurgery |
| ☐ Open Heart Surgery | ☐ 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 days per week |
| | | Number of organ/tissue donations per year | | | On hospital premises? | ☐ Yes ☐ No |
| | | | | | Open to the public? | ☐ Yes ☐ No |

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

| RISK MANAGEMENT: | | |
|---|---|---|
| Is there a written, formalized risk management program? | | ☐ Yes ☐ 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? | | |
| ☐ Pathology | ☐ Laboratory | |
| ☐ Pharmacy | ☐ Other | |
| Does the Applicant require these contractors to provide evidence of insurance? | | ☐ Yes ☐ No |
| If "Yes", what limits of liability does the Applicant require? | | |
| Are there any other service contracts in effect? | | ☐ Yes ☐ No |
| If "Yes", please describe services: | | |
| Does the Applicant indemnify (hold harmless) the service provider? | | ☐ Yes ☐ 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-resistive, etc.) | | No. of Stories: | | Total Sq. Feet: | |
| | Use: | | Inpatient / Outpatient: | | | |
| | Address: | | | | Year Built: | |

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

| | | | | | |
|---|---|---|---|---|---|
| Address: | | | | Year Built: | |
| Construction (brick, fire-resistive, 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: | ☐ Employees ☐ Contractors |
| | Do guards carry guns? | ☐ Yes ☐ No |

## AUTO LIABILITY EXPOSURE:

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

| Vehicle Type | # | | Vehicle Type: | # |
|---|---|---|---|---|
| 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? ☐ Yes ☐ 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).<br>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.<br>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 COMPLEE 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 AN DWITH 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 APLICATION 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.

NOTICETO MENNESOTA, OHIO, AND ARKANSAS APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATION 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 AN DWITH 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 FAC TMATERIAL 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.