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DATE:

HEALTHCARE FACILITY LIABILITY APPLICATION

Thank you for considering Berkley Medical Excess Underwriters as your hospital professional liability provider. The information gathered in this application will provide us with the basis for our underwriting review. We look forward to working with you on your professional liability program.

HEALTHCARE FACILITY LIABILITY APPLICATION

The following items are necessary for us to properly assess your insurance coverage:

Description of Operations	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Organizational Chart	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Most recent Annual Report	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Most recent 2 yrs audited Corporate Financial Statements including Management Discussion & Analysis	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Most recent Captive Financial Statement, if applicable	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Current Statement of Balance of any Self-Insured Trust Fund	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Trust or Captive Agreement, if applicable	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Most recent Actuarial Study, if applicable	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Risk Management Plan	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Patient Safety Plan	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Performance Improvement Plan	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Adverse Event Policy	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Claims Handling Guidelines	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
JCAHO report w/ grid scores and responses to Type 1 Rec's	<input type="radio"/> Attached	<input type="radio"/> Not Applicable
Medical Staff Rules and Regulations	<input type="radio"/> Attached	<input type="radio"/> Not Applicable

Please provide, preferable in an electronic format, 12 years of historical Professional and General Liability claim experience.

The following information must be identified:

- a. Insurance carrier or TPA, if self administered
- b. Losses valued within the past 90 days
- c. Accident Date and Report Date
- d. Indemnity paid and reserved
- e. Expenses paid and reserved
- f. Location of incident (if multiple hospital system)
- g. Brief description of loss or allegation code

For each loss exceeding \$100,000 (from the first dollar), include the following specific information:

- a. Claimant name or claim identification number
- b. Brief description of loss

Are the claim values submitted ground-up and unlimited including all self insured, insured, and uninsured losses?

If NO, please explain any exceptions. YES NO

INSURED ENTITY

1) Insured Contact Information

Hospital or Hospital System Name		
Street Address		
City	State	Zip
County		
Web Site Address		
Contact Name (primary contact for insurance selection)		
Title		
Phone Number	Fax Number	
E-mail Address		

2) Please state below the Named Insured(s) exactly as it should appear on the policy

Named Insured	City / County	Retroactive Date	% Owned	For-profit or Not-for-profit	Description of Operations

3) Type of organization

<input type="checkbox"/> Acute Care	<input type="checkbox"/> Children's Hospital	<input type="checkbox"/> Rehabilitation Hospital
<input type="checkbox"/> Teaching Hospital	<input type="checkbox"/> Psychiatric Hospital	<input type="checkbox"/> Geriatric Hospital
<input type="checkbox"/> Research Hospital	<input type="checkbox"/> Women's Hospital	<input type="checkbox"/> Other

4) Please attach a list of any entities with which the hospital has agreements that require the hospital to name such entities as additional insureds. Please identify the relationship to the hospital and whether hospital professional liability, general liability or both are required.

5) Please attach a list of any parent or subsidiary corporations, joint ventures, and limited partnerships, not listed above. For each such organization, please provide the percentage of hospital ownership, a list of the other owners, and a brief statement as to the corporate or partnership purpose of the organization.

INSURED ENTITY (Continued)

6) Please attach a list of any business operations outside of the United States of America, including its territories and possessions, Puerto Rico and Canada, not listed above. For each such organization, please provide the business relationship to the hospital.

7) Within the next 12-month period, does the applicant plan to obtain, divest, or merge with another healthcare or non-healthcare entity or make any significant changes to its operations?

YES NO

If YES, please explain:

8) Is the hospital managed by an independent hospital management group or similar entity?

YES NO

If YES, please explain:

BROKER OF RECORD

9) Broker of Record Information

Agency Name		
Street Address		
City	State	Zip
Web Site Address		
Contact Name (primary)		
Title		
Phone Number	Fax Number	
E-mail Address		
Contact Name (secondary)		
Title		
Phone Number	Fax Number	
E-mail Address		

COVERAGE

10) Coverage Effective Date Desired:

11) Current Policy Period Coverage

Coverage	Carrier	HPL Limit	Claims Made or Occurrence	Retroactive Date	Deductible / Self Insured Retention	Defense Expenses Limit <small>Inside or Outside the Limit</small>	Defense Expenses Retention <small>Pro-rata / Erodes</small>	Premium
HPL Primary								
GL Primary								
Lead Umbrella								
2 nd Layer Excess								
3 rd Layer Excess								

12) Desired Coverage for Upcoming Policy Period

Coverage	HPL Limit	Claims Made or Occurrence	Retroactive Date	Deductible / Self Insured Retention	Defense Expenses <small>Inside or Outside the Limit</small>	Defense Expenses <small>Pro-rata / Erodes</small>
HPL						
GL						
Umbrella						
Umbrella						

13) Schedule of Underlying for Excess Coverages

Other Coverage	Carrier	Limit	Effective Date
Auto			
Ambulance			
Employers Liability			
Helipad			
Non-owned Aviation			
Employee Benefit Liability			
Other (describe)			
Other			

14) Historical Coverage

Policy Period	Carrier	HPL Deductible / Self Insured Retention	Primary or Excess Coverage	HPL Limit	Claims Made or Occurrence	Retroactive Date	Premium

ACCREDITATION

15) Is the hospital currently accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)?

YES NO

If Yes, Date: _____

16) Is the hospital currently accredited by the Department of Health?

YES NO

If Yes, Date: _____

SERVICES PROVIDED

17) Services provided by or under the jurisdiction of the facility (please check the following that apply)

<input type="checkbox"/> Abortion	<input type="checkbox"/> Dental	<input type="checkbox"/> Orthopedics
<input type="checkbox"/> AIDS Unit	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Osteopathic
<input type="checkbox"/> Alcohol Addiction	<input type="checkbox"/> Dietary	<input type="checkbox"/> Outpatient Clinics / Physician Offices
<input type="checkbox"/> Ambulance	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Pathology
<input type="checkbox"/> Ambulatory Surgery Center	<input type="checkbox"/> Emergency Services	<input type="checkbox"/> Pediatrics
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Genetics	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Bariatrics	<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Gynecology	<input type="checkbox"/> Podiatry
<input type="checkbox"/> Birthing Center	<input type="checkbox"/> Home Health	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Blood Bank	<input type="checkbox"/> Infertility	<input type="checkbox"/> Radiology
<input type="checkbox"/> Burn Treatment	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Research
<input type="checkbox"/> Cancer Center	<input type="checkbox"/> Medical Products Mfg	<input type="checkbox"/> Skilled Nursing
<input type="checkbox"/> Cardiac	<input type="checkbox"/> Neonatal ICU	<input type="checkbox"/> Surgery Centers
<input type="checkbox"/> CCU / ICU	<input type="checkbox"/> Neurology	<input type="checkbox"/> Trauma
<input type="checkbox"/> Clinical Trials	<input type="checkbox"/> Nursery	<input type="checkbox"/> Urology
<input type="checkbox"/> Clinics for Underserved	<input type="checkbox"/> Obstetrical	<input type="checkbox"/> Other
<input type="checkbox"/> Day Care - Adult	<input type="checkbox"/> Oncology	<input type="checkbox"/> Other
<input type="checkbox"/> Day Care - Child	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Other

18) Please check the following surgeries that apply:

<input type="checkbox"/> General	<input type="checkbox"/> Plastic	<input type="checkbox"/> Thoracic
<input type="checkbox"/> Vascular	<input type="checkbox"/> Experimental	<input type="checkbox"/> Bariatric
<input type="checkbox"/> Transplant (specify)		
<input type="checkbox"/> Other (specify)		

19) Occupancy Data

Please provide occupancy data for the three most recent 12-month periods available, as well as estimates for the upcoming 12-month period.

Period Reported:

Policy Year Calendar Year Fiscal Year

SERVICES PROVIDED (Continued)

Period Description:				
Type of Beds	Licensed	Estimated Next Year (Occupied)	Current Year (Occupied)	Last Year (Occupied)
Acute Care				
Substance Abuse				
Cribs & Bassinets				
Psychiatric Care				
Rehabilitation				
Other				
Long Term Care				
Skilled Nursing Facility				
Intermediate Care Facility				
Residential Living Facility				
Assisted Living Facility				

Visits / Other	Estimated Next Year	Current Year	Last Year
Emergency Room			
Home Health Care			
Inpatient Surgeries			
Outpatient Surgeries			
Psychiatric			
Rehabilitation			
Substance Abuse			
Clinical Visits			
Live Vaginal Deliveries (excluding VBACs)			
Live VBACs			
Live Caesarean sections			
Still Births (Vaginal & C-section)			
Other			

20) Does the hospital intend to begin or eliminate any services during the next 12 months? YES NO

If YES, please explain:

21) Is the hospital a recognized regional referral center for certain types of patients, services, or care? YES NO

If YES, please explain:

SERVICES PROVIDED (Continued)

22) Blood Bank
 Does the hospital operate a blood bank that procures, tests, or distributes blood by-products? YES NO

If YES, how many units annually?

23) Does the Applicant operate any managed care plans? YES NO

If YES,

Number of Enrollees:

Premium Revenues Generated:

Types and Description of Plans:

If coverage is desired, attach supplemental managed care questionnaire.

MEDICAL STAFF

24) Please complete the following chart to indicate the number of employed health care professionals and employed allied professionals on the medical staff.

Specialty	Total # of FTE's	# Covered in Excess Program?	Specialty	Total # of FTE's	# Covered in Excess Program?
Anesthesiologists			CRNAs		
Chiropractors			Nurse Anesthetists		
Dentists			Midwives		
Emergency Medicine			Physician Assistants		
ENT			Nurse Practitioners		
General Medicine			Registered Nurses		
Hospitalists			LPNs		
Intensivists					
Internal Medicine					
Neurologists					
OB/GYN					
Optometrists					
Orthopedics					
Podiatrists					
Psychiatrist					
Radiology					
Registered Pharmacists					
Social Workers					
Surgeons					
Technicians					
Therapists					
All other Physicians					
Other (please specify)					

MEDICAL STAFF (Continued)

25) Please attach a list to indicate the physicians, health care professionals and allied professionals on the medical staff (FTE's) that you desire to be covered under the hospital professional liability program. Please indicate name, specialty, and board certification status.

26) Is the hospital affiliated with any university or medical school? YES NO

If YES, please explain:

27) Residents or Fellows

If the hospital has a formal residency training program that obligates the hospital to provide physician's professional liability insurance to residents or fellows, please attach a list with the names of the residents or fellows and their specialties.

Effective date of list:

28) Medical Staff Professional Liability Coverage Requirements
Are all medical staff members required to maintain professional liability insurance? YES NO

Is this requirement stated in the medical staff bylaws? YES NO

What limits are required?

What evidence of compliance is required?

29) Do Bylaws require coverage be purchased from a carrier with minimum A.M. Best Rating of A-? YES NO

If NO, please explain:

CONTRACTED

30) Anesthesia

A. Is anesthesia provided by:
Staff Doctors YES NO
Hospital Employees YES NO
Contracted Group YES NO

(if contracted, complete chart below)

B. Are CRNA's
Hospital Employees YES NO
Contracted Group YES NO

(if contracted, complete chart below)

C. Are CRNA's supervised by an anesthesiologist? YES NO

CONTRACTED (Continued)

31) Emergency Services

A. Are emergency room services provided? YES NO

If YES, please indicate how your ED is classified according to JCAHO standard.

Standby Basic Comprehensive Trauma

B. Are emergency room physician services provided by

Staff Doctors YES NO

Hospital Employees YES NO

Contracted Group YES NO (if contracted, complete chart below)

C. Are all ED physicians board certified? YES NO

If not, what percentage of ED physicians are board certified?

D. Are all ED nurses required to have ACLS certification? YES NO

E. Do ED physicians have in-house responsibilities? YES NO

F. Does the hospital operate an emergency ambulance service? YES NO

G. Are ambulance services provided by hospital or by an independent group under contract?

Hospital Independent Group under Contract

(If contracted, complete chart below)

32) Radiology Services

A. Is the Radiology Department staffed by:

Staff Doctors YES NO

Hospital Employees YES NO

Contracted Group YES NO (if contracted, complete chart below)

For all contracted services, please provide the following information:

Service	Service Provider	No. of Years Contracted	Limits Carried	Insurance Carrier
Ambulance				
Anesthesia				
Blood Bank				
ED				
Obstetrics				
Radiology				
Other (specify)				

33) Obstetrical Services

A. Is the institution a regional referral center for high-risk pregnancies? YES NO

B. Is the institution a regional referral center for newborns requiring intensive care? YES NO

C. Does the institution have a prenatal clinic? YES NO

D. Does a written procedure exist for transferring all high-risk mothers and/or babies that the hospital is not qualified to treat? YES NO

CONTRACTED (Continued)

- E. Do family practitioners have OB privileges? YES NO
- F. Are mid-wives performing deliveries?
If YES, are they hospital employees? YES NO
- G. Are OB nurses certified in neonatal resuscitation? YES NO
- H. Does the hospital have a placental retention program YES NO

CONTRACTUAL LIABILITY

34) Contractual Liability

- A. Does the hospital indemnify, hold harmless, or extend coverage to a third party for any professional liability loss judgment, settlement, legal fees, or cost of investigation? YES NO
- B. Who reviews and approves all contracts before they are executed?

RISK MANAGEMENT

- 35) Does the hospital employ a full-time Risk Manager? YES NO
- 36) Risk Management Contact
- A. Risk Management representative to contact for an assessment of your operations:

Name	Title/Position	Phone Number
Fax Number	E-mail address	

- 37) How many FTE's are in the Risk Management Department?
- 38) Who does Risk Management report to?
- 39) Does the Risk Manager have other responsibilities?
If YES, please describe: YES NO
- 40) Is there a written formalized risk management program? YES NO
- If YES, how frequently is the program reviewed for effectiveness and the necessary changes implemented?
- 41) Does the hospital have an organized patient representative program or ombudsman? YES NO
- 42) Are patient satisfaction surveys conducted? YES NO
- If YES, how often are the surveys reviewed to identify problems?
 Monthly Quarterly Other

CLAIMS MANAGEMENT

43) Claims Management

A. Who handles HPL claims? In-house YES NO
TPA YES NO

B. What law firms are utilized to defend claims?

C. Who is the hospital contact for claims?

Name	Title/Position	Phone Number
Fax Number	E-mail address	

D. Is there a designated person/department for receipt of lawsuits? YES NO

E. Who is responsible for reviewing incident reports and notifying insurer of potential claims?

F. Attach a brief description of how the complaint or grievance process is made known to the patient and how those complaints are handled.

44)

Are you, as of this date, aware of any claims against you that have not been reported to your present or prior insurance carrier? YES NO

If YES, please explain:

45)

Are you, as of this date aware of any conduct, circumstances, or incidents that occurred during the past five years that could reasonably be expected to result in a claim and that have not been reported to your present or prior insurance carrier? YES NO

OTHER COVERAGES

Please only complete sections that apply for excess coverage.

Commercial General Liability

46) Please attach a list of all buildings the hospital owns, controls, or occupies. Please include location and use or occupancy.

47) Is any new construction planned for the next 12 months? YES NO

If YES, please provide the following:

Purpose of the project:	<input style="width: 100%; height: 15px;" type="text"/>
Estimated Cost:	<input style="width: 100%; height: 15px;" type="text"/>
Estimated Completion Date:	<input style="width: 100%; height: 15px;" type="text"/>

OTHER COVERAGES (Continued)

Heliport

48) Is there a heliport on the hospital premises? YES NO

If YES, please provide the following:

Is heliport FAA approved? YES NO

Average number of landings per month: _____

If NO, what arrangements exist to provide patient transport by air?

Aviation / Watercraft

49) Does the hospital own, lease, or charter any aircraft? YES NO

If YES, please attach details and describe the frequency of use.

50) Does the hospital own, lease, or charter any watercraft? YES NO

If YES, please attach details and describe the frequency of use.

Auto / Ambulance

51) Please complete the following chart to indicate the number of Autos/Ambulances owned by the hospital.

Auto/Ambulances	Number Owned
Private Passenger	_____
Light Trucks	_____
Vans/Medium Trucks/Buses	_____
Ambulance/Heavy Trucks	_____

A. Do employees/volunteers use their personal vehicles for company business? YES NO

If YES, how many trips per year?

B. Are these employees/volunteers required to show proof of current auto insurance? YES NO

If YES, do you require minimum limits of auto insurance? YES NO

If YES, what are the minimum limits? _____

Other

52) Does the hospital host/sponsor any special events/fundraisers during the year? YES NO

If YES, provide details:

53) Is there a day care center for elderly adults? YES NO

If YES,

Is the center on premises? YES NO

Average number of enrollees: _____

54) Is there a day care center for children? YES NO

If YES,

Is the center on premises? YES NO

Is the center for employee's children only? YES NO

Average number of enrollees: _____

55) Does the hospital operate a retail pharmacy? YES NO

If YES, annual receipts (total): _____

