Premium Indication Request for Hospitals and Medical Centers

Please read carefully before completing:

This is a premium indication request only. It is not an application for medical malpractice insurance coverage and does not, in any way, bind coverage. The information contained in this request will be used to acquire premium indications from one or more insurance carriers as appropriate and will otherwise be held in the strictest confidence.

SIGNATURE
After completing the premium indication request, the signature of an authorized representative of the facility is required, along with the date. Please complete the request completely.

CLAIMS INFORMATION
If you have any claims, suits, or incidents alleging malpractice brought against you within the past ten (10) years, complete a claim information sheet for each claim. Each Claim Information Sheet must be completed, signed and dated.

RETROACTIVE ("NOSE") COVERAGE
If you wish to obtain nose coverage, a copy of your most recent declarations page from your current carrier indicating the original effective date of coverage and a current paid through date must be attached.

Tegner-Miller Insurance Brokers - CAMM
2001 Wilshire Boulevard Suite 101
Santa Monica, CA 90403
Phone: 800.775.8642
Fax: 310.453.7971
E-mail: insure@tmib.com

SECTION I – GENERAL INFORMATION

A. APPLICANT

1. Legal Name of Facility ______________________________

2. Address ______________________________

   City ____________________ State ____________ Zip ________

3. Telephone No. (____) ______________________________

4. How many years has the facility been in operation? ____________________

5. How many years has the facility been under present ownership? ____________________

6. List all affiliates and subsidiaries to which this insurance is to apply. Include a complete description of the operations of each affiliate/subsidiary and their relationship to the applicant. (Attach a separate sheet if necessary.)

____

____

____

____

____

____

B. GENERAL INFORMATION

14. Hospital Facility is: (Check all appropriate boxes)

- ☐ Children's Hospital
- ☐ Clinic(s)
- ☐ Corporation
- ☐ Delivery System Network
- ☐ For Profit
- ☐ Other Specialty (explain)
- ☐ General Hospital
- ☐ Governmental
- ☐ Not for Profit
- ☐ Psychiatric Hospital
- ☐ Rehabilitation Hospital
- ☐ Skilled or Extended Care Facility
- ☐ Teaching Hospital
- ☐ Tertiary Hospital

15. a. Is the hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations? ☐ Yes ☐ No

    Date of last accreditation: ______________________________

    Please attach a copy of the most recent survey.

    b. Is this facility licensed by the State? ☐ Yes ☐ No

    Please attach a copy of the most recent survey.

    c. Is this facility Medicare approved? ☐ Yes ☐ No

    If NO, please explain:

SECTION II – COVERAGE INFORMATION

A. COVERAGE

7. Current Liability Coverage:

   a. Carrier: ____________________

   b. Policy Period: ____________________

   c. Limits of Liability: ____________________

   d. Deductible: ____________________

   e. Present Coverage is:

   ☐ Occurrence
   ☐ Claims-made

   f. Premium for the Last Five Years:

YEAR	PREMIUM
________	________________
________	________________
________	________________
________	________________
________	________________

8. Past Coverage:
   Has any insurer canceled or declined to issue Professional Liability insurance for this hospital? If YES, please explain on a separate sheet of paper. ☐ Yes ☐ No

9. Loss History:
   Please attach loss history for past ten (10) years including current year and include breakdown of total incurred losses,paid losses, and outstanding losses separated by year for Professional Liability and General Liability.

   Additionally, please provide full details of any claim paid or outstanding during this period in excess of $100,000 (paid) and $50,000 (outstanding).

10. Proposed Quote: Requested total limits of liability: ____________________
    Per Claim

    DEDUCTIBLE SIZE (Please indicate deductible quotes you would like):

    a. **Shared Indemnity Only** (Per claim)

    ☐ $1,000 ☐ $25,200 ☐ $100,200
    ☐ $5,200 ☐ $50,200 ☐ $250,100
    ☐ $10,200 ☐ $75,200

    b. **Flat Indemnity and Expense** (Per claim)

    ☐ $25,000
    ☐ $50,000
    ☐ $100,000

    a. **Combined** (Per claim)

    ☐ $5,000 ☐ $50,000
    ☐ $10,000 ☐ $75,000
    ☐ $25,000 ☐ $100,000

    c. SIR: ____________________

    d. Desired Effective Date of Coverage: ____________________

    e. Retroactive Date: ____________________

    Please attach a current copy of proof of Insurance Coverage

11. Have all known claims and incidents which may give rise to future claims been reported to past or current insurers? ☐ Yes ☐ No

12. Has the facility conducted a recent review of incidents and other potential claims, and have all been forwarded to the facility's current insurer? ☐ Yes ☐ No

If YES, when: ____________________

By whom: ____________________

13. a. List below all other primary Liability and Compensation policies written by other companies and for which you are not applying to us for coverage at this time. ☐ None

TYPE OF INSURANCE	POLICY NUMBER	INSURANCE COMPANY	POLICY PERIOD	LIMITS	PREMIUM
Auto	______	______	______	______	
WC	______	______	______	______	
______	______	______	______	______	
______	______	______	______	______	

b. Do you lease or rent any (real or other) property, with estimated combined value beyond $10,000 at a single location for which you are liable for damages? ☐ Yes ☐ No

If YES, use the comment page to describe:

i. The property by address location;

ii. estimated value;

iii. perils for which you are liable, and

iv. existing property damage insurance that covers these assumed liabilities.

c. Do you own, lease or charter any aircraft? ☐ Yes ☐ No

d. If your automobile liability coverage is provided elsewhere and you are not applying to us for coverage at this time, does your policy cover all owned, leased, non-owned or rental automobiles? ☐ Yes ☐ No

e. Indicate the number of:

	OWNED	LEASED		OWNED	LEASED
Private Passenger Cars	______	______	Light Trucks	______	______
Ambulances	______	______	Other	______	______

f. List any liability claims or suits during the last five (5) years. ☐ None

DATE OF LOSS	CAUSE OF LOSS	CHECK STATUS: OPEN	CLOSED	AMOUNT OF LOSS OR RESERVE
______	______	____	____	______
______	______	____	____	______
______	______	____	____	______

16. Has the facility or other associated entity ever lost a license or been placed on probation by any governmental licensing agency? ☐ Yes ☐ No
    If YES, please explain on a separate sheet of paper.

17. Has the facility entered into any joint ventures or limited partnerships? ☐ Yes ☐ No
    If YES, please explain on a separate sheet of paper.

18. a. Does the facility participate in any teaching programs? ☐ Yes ☐ No
    If YES, please give the type of program, describe the relationship, and who supervises the students: ______________________________

    ____

    b. Is the program sponsored? ☐ Yes ☐ No
    If YES, please provide the name of sponsoring the institution:

    ____

19. Do you anticipate an expansion of your facility within the next year? ☐ Yes ☐ No

20. Does your facility manage any non-owned entities? ☐ Yes ☐ No
    If YES, please explain: ______________________________

    ____

21. Are any of the hospital's units or facilities managed by a third party? ☐ Yes ☐ No
    If YES, please explain and provide a copy of the agreement:

    ____

    ____

22. Does the facility rent or lease any equipment from other (medical equipment, computers, beds, etc.)? ☐ Yes ☐ No
    If YES, please describe and indicate the value of the items:

    ____

    ____

C. PHYSICAL PREMISES

23. List below all buildings you own, control or occupy. Where fixed features exist for a building, list wings, floors or areas separately. Attach a separate schedule if more space is needed.

a. Address: ____________________

City: ____________ State: ____________ Zip:

Year Built: ______ No. of Stories: ______ Area (total square feet): ____________

Construction (Brick, Fire Resistive, etc.): ____________________

Use: ____________________

Altered to Comply with Earthquake Requirements? ☐ Yes ☐ No If YES, Year: ______

Complete Sprinkler System? ☐ Yes ☐ No

Smoke Detectors? ☐ Yes ☐ No

Emergency Electrical System? ☐ Yes ☐ No

Facility Meets NFPA Building Codes? ☐ Yes ☐ No

b. Address: ____________________

City: ____________ State: ____________ Zip:

Year Built: ______ No. of Stories: ______ Area (total square feet): ____________

Construction (Brick, Fire Resistive, etc.): ____________________

Use: ____________________

Altered to Comply with Earthquake Requirements? ☐ Yes ☐ No If YES, Year: ______

Complete Sprinkler System? ☐ Yes ☐ No

Smoke Detectors? ☐ Yes ☐ No

Emergency Electrical System? ☐ Yes ☐ No

Facility Meets NFPA Building Codes? ☐ Yes ☐ No

c. Address: ____________________

City: ____________ State: ____________ Zip:

Year Built: ______ No. of Stories: ______ Area (total square feet): ____________

Construction (Brick, Fire Resistive, etc.): ____________________

Use: ____________________

Altered to Comply with Earthquake Requirements? ☐ Yes ☐ No If YES, Year: ______

Complete Sprinkler System? ☐ Yes ☐ No

Smoke Detectors? ☐ Yes ☐ No

Emergency Electrical System? ☐ Yes ☐ No

Facility Meets NFPA Building Codes? ☐ Yes ☐ No

d. Address: ____________________

City: ____________ State: ____________ Zip:

Year Built: ________ No. of Stories: ________ Area (total square feet): ____________

Construction (Brick, Fire Resistive, etc.): ____________________

Use: ____________________

Altered to Comply with Earthquake Requirements? ☐ Yes ☐ No If YES, Year: ________
Complete Sprinkler System? ☐ Yes ☐ No
Smoke Detectors? ☐ Yes ☐ No
Emergency Electrical System? ☐ Yes ☐ No
Facility Meets NFPA Building Codes? ☐ Yes ☐ No

e. Address: ____________________

City: ____________ State: ____________ Zip:

Year Built: ________ No. of Stories: ________ Area (total square feet): ____________

Construction (Brick, Fire Resistive, etc.): ____________________

Use: ____________________

Altered to Comply with Earthquake Requirements? ☐ Yes ☐ No If YES, Year: ________
Complete Sprinkler System? ☐ Yes ☐ No
Smoke Detectors? ☐ Yes ☐ No
Emergency Electrical System? ☐ Yes ☐ No
Facility Meets NFPA Building Codes? ☐ Yes ☐ No

24. Does the facility have a heliport/helipad? ☐ Yes ☐ No

If YES, where is the pad located (e.g., parking lot, top of building, etc.)?

____

How far from the facility? ____________________

Dimensions of helipad? ____________________

Type of construction: ____________________

Number of landings per month: ____________________

25. Is any new contraction or renovation to existing structure planned during the next twelve (12) months? ☐ Yes ☐ No
If YES, provide an estimated costs and briefly describe the construction planned:

____

____

26. Do you provide and charge for parking for visitors? ☐ Yes ☐ No
If YES, annual revenues: ______________________________

27. Do you provide valet parking? ☐ Yes ☐ No

28. Do you transport patients or employees? ☐ Yes ☐ No
If YES, please explain: ______________________________

____

29. OCCUPANCY (If Prior Acts Coverage is requested, complete current year and five previous years)

	CURRENT YEAR Estimated Average Annual Occupancy/Visits	PRIOR YEARS 1	2	3	4	5
a. **Beds**						
Total Licensed Beds	______	____	_____	____	_____	____
Total Average Annual Occupancy	______	____	_____	____	_____	____
b. **Breakdown**						
Acute Care Beds, Cribs, Bassinets: Daily Average Number Occupied	______	____	_____	____	_____	____
Extended Care Beds: Daily Average Number Occupied	______	____	_____	____	_____	____
Acute Psychiatric Care Beds: Daily Average Number Occupied	______	____	_____	____	_____	____
Chem Dep/Phys Rehab Beds: Daily Average Number Occupied	______	____	_____	____	_____	____
Emergency Room Physicians Number of Patients	______	____	_____	____	_____	____
Emergency Visits: Total Number of Visits	______	____	_____	____	_____	____
Other Outpatient Visits: Total Number of Visits	______	____	_____	____	_____	____
Counseling: Total Number of Visits	______	____	_____	____	_____	____
Reference Lab Total Number	______	____	_____	____	_____	____
Home Health Care Total Number	______	____	_____	____	_____	____
Surgeries: Outpatient	______	____	_____	____	_____	____
Surgeries: Inpatient	______	____	_____	____	_____	____
Deliveries: Total Number	______	____	_____	____	_____	____

SECTION III – PRACTICE INFORMATION

A. PERSONNEL

30. Indicate the number of persons employed by the hospital in each of the following classifications:

______ Certified Registered Nurse Anesthetists**	______ Paramedics
______ Dentists*	______ Registered Nurses
______ Emergency Medical Technicians	______ Respiratory Therapists
______ Laboratory or X-ray Technicians	______ Pharmacists
______ Licensed Vocational/Practical Nurses	______ Physician Assistants*
______ Nurse's Aides	______ Physicians & Surgeons**
______ Nurse Midwives**	______ Residents
______ Nurse Practitioners*	______ Interns/First Year Residents

______ Other (explain) ____

* Please provide separate listings of names and specialties (and contract, if applicable) for each.

31. Please indicate the number of independent allied staff:

______ Midwives	______ Physician Assistants
______ Nurse Anesthetists	______ Therapists
______ Nurse Practitioners	

B. SERVICES

32a. Please indicate if your facility presently provides, plans to provide, or presently operates any of the following:

- ☐ Abortion Clinic
- ☐ Acute Rehabilitation
- ☐ Ambulance Service
- ☐ Blood Bank
- ☐ Burn Units
- ☐ Cardiac Catheterization Centers
- ☐ Coronary Care Unit
- ☐ Day Care
- ☐ Dental Services
- ☐ Dialysis
- ☐ Emergency Room
- ☐ Extended Care
- ☐ Other (explain)
- ☐ Fitness Wellness Center
- ☐ Health Maintenance Organizations
- ☐ Home Health Care
- ☐ Hospice
- ☐ Hospital Foundation
- ☐ Inhalation Therapy
- ☐ Intensive Care Unit
- ☐ Mobile Unit (bloodmobiles, mammography, cat scan units, etc.)
- ☐ Nursery
- ☐ Neonatal
- ☐ OB/GYN
- ☐ Off Premises Clinics
- ☐ Off Premises Food Services
- ☐ Off Premises Labs
- ☐ Oncology
- ☐ Open Heart Surgery
- ☐ Organ Bank
- ☐ Organ Transplants
- ☐ Outpatient Surgi-Centers
- ☐ Pharmacy
- ☐ Physician Hospital Organization or IPA
- ☐ Psychiatric/ Chemical Dependency
- ☐ Skilled Nursing Care
- ☐ Surgery
- ☐ Transportation services (other than ambulance)
- ☐ Trauma Surgery
- ☐ Urgent Care

32b. Are any of these services contracted? ☐ Yes ☐ No
If YES, which ones? ____

C. STAFF PRIVILEGES

33. a. Are credentials for new staff members checked and approved prior to granting staff privileges? ☐ Yes ☐ No

    By whom: ____________________

    ____

    b. How are the applicant's degree(s) and experience verified: ____________________

    ____

    ____

34. Are privileges probationary for at least six months for all new staff members? ☐ Yes ☐ No

35. Do you have any staff members who are not licensed or who have restricted licenses or privileges? ☐ Yes ☐ No

    If YES, explain on the comment page.

36. a. Do department heads evaluate the work of their staff members? ☐ Yes ☐ No

    b. Are these evaluations done in writing? ☐ Yes ☐ No

    c. Is an ongoing medical audit maintained on all staff members' clinical work? ☐ Yes ☐ No

37. Are all staff privileges reviewed each year? ☐ Yes ☐ No

38. Do you require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? ☐ Yes ☐ No

39. Staff members malpractice insurance

    a. Are all staff members required to maintain malpractice insurance? ☐ Yes ☐ No

    b. Is this requirement stated in the staff bylaws? ☐ Yes ☐ No

    c. What limits are required? ____________________

    d. What evidence of compliance is required? ____________________

    Please explain any NO answers on the comment page.

40. Number of staff physicians in each category:

    _______ Active _______ Consulting _______ Emeritus

    _______ Assistant _______ Courtesy _______ Probationary

D. CONTRACT SERVICES

41. Identify any contracted professional services performed at the hospital:

    ☐ Anesthesia Services ☐ Nursing Services ☐ Pathology/Laboratory ☐ Radiology

    ☐ ER Services ☐ Other Services: ____________________

    Please submit a copy of each such contract.

42. Are there any other (professional) service contracts in effect? ☐ Yes ☐ No

    Describe services: ____________________

    Do you indemnify (hold harmless) the service provider? ☐ Yes ☐ No

    If YES, submit a copy of the contract.

43. Are there any other source contracts in effect? ☐ Yes ☐ No

Please explain: ____

44. Are contract providers required to carry professional liability insurance? ☐ Yes ☐ No

Limits: ____

E. RISK MANAGEMENT

45. Is there a written, formalized Risk Management Program? ☐ Yes ☐ No

If YES, please provide a copy of the program: ______________________________

____

____

F. EMPLOYEES

46. Are licenses certifications for new (licensed/certified) employees checked prior to hire? ☐ Yes ☐ No

47. Are employees credentials verified in writing? ☐ Yes ☐ No

48. Are probationary and regular performance evaluations done in writing? ☐ Yes ☐ No

If YES, please explain: ____

____

49. Does every employee receive a copy of their job descriptions and personnel handbook? ☐ Yes ☐ No

If NO, please explain: ____

50. Are employees cross trained to other units prior to assignment to another unit? ☐ Yes ☐ No

Please explain: ____

____

51. What percentage of employee shifts are float, per diem or agency assignments over the period of a week? _______ %

52. Are employees trained in the procedure to follow if medical orders are questioned? ☐ Yes ☐ No

53. Is there an employee relations program? ☐ Yes ☐ No

SECTION IV – SIGNATURE

REPRESENTATIONS AND AUTHORIZATIONS

I represent that the above statements and facts are true and that no material facts have been suppressed or misstated. Completion of this premium indication request does not bind coverage.

NOTICE:

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.

____
(Print Exact Name of Facility)

____
(Signature of Authorized Officer)

____
(Title)

____
(Date)