Healthcare Facility Application
Hospital—New Business

ProAssurance
Treated Fairly

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

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1. Introductory Information

Legal Entity Name: _____

Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Contact Name: _____

Contact Email: _____

Number of Years in Operation: _____

Telephone Number: _____ Fax Number: _____

Hospital Fiscal Year Begins: _____

Tax ID Number: _____ NPI Number: _____

Website Address: _____

Instructions:

1. Please review and complete this new business application.
2. When necessary, check all boxes that apply.
3. If you need more space for your responses, continue on a separate sheet indicating question number.

2. Application Addendum

Please attach the following:

A. Carrier Loss History:
   1. **Ten years** of historical PL and GL losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.
   2. Date of loss valuation must be within the past 90 days.
   3. Loss run must include carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL) and narrative of claim.
   4. Full details of allegations on all losses paid or outstanding in excess of $100,000 even if greater than 10 years old.

B. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or, if accrediting agency reports are unavailable, please submit the state licensure report with recommendations and the institution's response to any contingencies.

C. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.

D. Identity of each employed physician including name, specialty, date of hire, retro date, primary PL carrier, is primary coverage occurrence or claims-made and PL limits (if applicable).

E. Identity related entities or subsidiaries to be considered for coverage on the policy including a brief explanation of their relationship to the applicant, scope of operations and their retro date on Schedule A of application (if historically written on claims-made basis).

F. Copy of current risk management and quality improvement plan.

G. Recent actuarial review supporting the funding of any self-insured retention, applicable SIR Trust documents and balance of SIR Trust account.

H. Copy of current organizational chart (corporate and risk management).

I. Copy of claim management procedures.

J. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.

K. Copy of current PL and GL policies.

L. For Excess/Umbrella coverages, please provide copies of underlying policy declaration pages for all applicable coverages (auto, employers' liability, etc.).

M. If applicable, copy of underlying auto carrier's loss run for the past five years including the following information: carrier, date of loss, report date, total incurred, status (open or closed) and a narrative of claim. Date of loss valuation must be within the past 90 days.

N. Copy of state license.

The items requested above are **mandatory** before a quotation can be provided.

3. General Information

Applicant is: (check all applicable boxes)

A.
- ☐ Children's hospital
- ☐ Geriatric hospital
- ☐ General hospital
- ☐ Psychiatric hospital
- ☐ Rehabilitation hospital
- ☐ Teaching hospital
- ☐ Women's hospital
- ☐ Other: _____

B.
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Joint Venture
- ☐ Government

C.
- ☐ Profit
- ☐ Non-profit
- ☐ Charitable

D.
- ☐ Accredited by JCAHO
- ☐ Licensed by state
- ☐ Medicare approved
- ☐ Member of AHA

E. **Teaching Hospitals:**

1. Please identify the type of training program(s) offered and the number of trainees enrolled in each program in the past 12 months:

☐ Residency	# of trainees: _____	☐ Physical Therapy	# of trainees: _____
☐ Nursing	# of trainees: _____	☐ CRNA's	# of trainees: _____
☐ Physician Assistants	# of trainees: _____	☐ Other: _____	# of trainees: _____

2. The training program(s) is/are accredited by: _____

F. **Accreditation (if applicable):**

1. Accreditation decision:
   - ☐ Accredited
   - ☐ Provisional Accreditation
   - ☐ Conditional Accreditation
   - ☐ Preliminary Denial of Accreditation
   - ☐ Denial of Accreditation
   - ☐ Preliminary Accreditation

2. Requirements for improvement? ☐ Yes ☐ No
   If *yes*, please provide a list of standards scored as non-compliant: _____

3. Did the survey identify any life safety issues? ☐ Yes ☐ No
   If *yes*, please explain:

4. Were partially compliant standards identified in the supplemental findings? ☐ Yes ☐ No
   If *yes*, please explain:

G. **Current Insurance Program:**

Type	Carrier or Self-Insured	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible	Premium
Primary Prof. Liability							
Primary General Liability							
Excess PL							
Umbrella GL							
Auto Liability							
Employers' Liability							
Helipad/Aviation							
Other:							

**Please specify by layer if more than one Retro Date applies.*

1. Self-Insured Retention Program (if applicable): Has an independent actuarial study been completed? ☐ Yes ☐ No
2. Do you participate in a Patient Compensation Fund or similar type program in the state in which you operate? ☐ Yes ☐ No
   If *yes*, what limit do you carry? _____

H. **Prior Insurance History**

1. Please list all general liability and hospital professional liability policies for the past ten years.

Policy Period	Carrier	PL Limits Per Occ/Agg Primary	GL Limits Per Occ/Agg Primary	Deductible	Claims-Made or Occurrence	Premium

2. Please list all excess/umbrella policies for the past five years.

Policy Period	Insurer	Limits	Retro Date (if applicable)	Premium

3. Has professional, general, excess/umbrella, automobile or employers' liability coverage ever been cancelled or non-renewed by a previous carrier? ☐ Yes ☐ No

If *yes*, please provide details:

I. **Insurance Coverage Desired:**

Primary:	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible
Professional Liability (PL)					
General Liability (GL)					
#Limited Pollution Liability					
Excess/Umbrella:					
Excess PL					
Umbrella GL					

**Please specify by layer if more than one Retro Date applies.*
#Separate Application Required – Refer to Company

Include the following as underlying coverages on the Excess/Umbrella (if applicable). Policy information must be indicated in Item G, "Current Insurance Program" section above. Provide policy declaration pages for all applicable coverages.

☐ Auto Liability ☐ Employers' Liability ☐ Helipad/Aviation ☐ Other: _____

For each selected Excess/Umbrella underlying line of insurance above, describe any claims in excess of $10,000.

4. Professional Exposures

A. **Other Services Provided by Insured**

☐ Assisted Living Facilities (Application Required)
☐ Dialysis
☐ Laundry
☐ Morgue
☐ Schools or Professional Training Programs (Nursing, EMT, CRNA, etc.) Provide details.
☐ Medical Mgmt. Services (mgmt. of non-owned entities) (separate application required)
☐ ACO/MCO/PHO (coverage cannot be provided)
☐ Nuclear Medicine
☐ Nuclear Therapy
☐ Open Heart Surgery
☐ Pathology
☐ Radiology
☐ Respiratory Therapy
☐ Social Services

1. Ambulances:
   a. Is excess/umbrella coverage desired for ambulance(s)? ☐ Yes ☐ No
   b. Are ambulances used as: ☐ First Responders ☐ Patient transport ☐ Both
   c. Number of ambulances in fleet: _____
   d. Service radius: _____ miles
   e. Number of emergency runs in the past 12 months: _____
2. Blood Banks:
   a. Please identify the screening test(s) utilized by the hospital: _____
   _____
   b. Accredited by:
      ☐ American Assn. of Blood Banks
      ☐ American Blood Centers
      ☐ American Red Cross
      ☐ College of American Pathologists
      ☐ JCAHO
      ☐ Other: _____
   c. Is any blood or blood product bought or obtained from outside the U.S.? ☐ Yes ☐ No
      If *yes*, please explain:

d. Does the blood bank outsource its blood testing? ☐ Yes ☐ No
If *yes*, please provide details:

e. Number of volunteered and paid donations in the past 12 months: _____
f. Number of pheresis procedures in the past 12 months: _____
g. Number of outpatient transfusions in the past 12 months: _____
h. Number of therapeutic plasma exchanges in the past 12 months: _____

3. Day Care (Child and/or Adult):
   a. Is the day care center on the hospital premises? Child: ☐ Yes ☐ No Adult: ☐ Yes ☐ No
   b. Is the day care center open to the public? Child: ☐ Yes ☐ No Adult: ☐ Yes ☐ No
   c. Number enrolled in the past 12 months: Child: _____ Adult: _____

4. Fitness Center/Health Club:
   a. Is the facility on the hospital premises? ☐ Yes ☐ No
   b. Is the facility open to the public? ☐ Yes ☐ No
   c. Number of members enrolled in the past 12 months: _____
   d. Annual Gross Sales: _____
   e. Types of programs provided:

5. Skilled Nursing/Extended Care:
   a. Long term care beds are located: ☐ Within the hospital ☐ In a stand-alone facility
   b. If a stand-alone facility:
      i. Is the stand-alone facility on the hospital premises? ☐ Yes ☐ No
      ii. Does the stand-alone facility fall under the hospital's risk management? ☐ Yes ☐ No
      iii. Does the stand-alone facility follow policies established by the hospital? ☐ Yes ☐ No

6. Heliport:
   a. Does the hospital have a heliport? ☐ Yes ☐ No
   If *yes*, please provide the number of landings in the past 12 months: _____
   b. Does the hospital obtain a certificate of insurance from the helicopter service? ☐ Yes ☐ No
   c. Is the hospital named as an additional insured on the helicopter service's policy? ☐ Yes ☐ No

7. Transplant:
   a. Number of tissue donations: _____ Past 12 months _____ Projected next 12 months
   b. Number of organ donations: _____ Past 12 months _____ Projected next 12 months
   c. Accredited by:
      ☐ Assn. of Organ Procurement Organization ☐ Eye Bank Assn. of America
      ☐ American Assn. of Tissue Banks ☐ Other: _____
   d. Does the hospital have a formal policy regarding the informed consent process? ☐ Yes ☐ No
   e. Has the hospital been involved in any tissue FDA recalls? ☐ Yes ☐ No
   If *yes*, please explain: _____
   f. Has the hospital initiated any voluntary tissue recalls in the past 5 years? ☐ Yes ☐ No
   If *yes*, please explain: _____
   g. Are any tissues procured/recovered from outside the U.S.? ☐ Yes ☐ No
   If *yes*, please explain: _____
   h. Are any non-human tissues used in any way at the hospital? ☐ Yes ☐ No
   If *yes*, please explain: _____
   i. Do you accept "John Doe" donors? ☐ Yes ☐ No
   j. Do you participate in a living donor program? ☐ Yes ☐ No

k. Does the hospital place all organs through United Network for Organ Sharing? ☐ Yes ☐ No
If *no*, do you have a protocol for ensuring compatibility? ☐ Yes ☐ No

l. Please indicate all of the transplant operations at the hospital:

☐ Eye Procurement	☐ Tissue Processing	☐ Organ Procurement Operations
☐ Lab Testing	☐ Tissue Procurement	☐ Other: _____
☐ Tissue Storage	☐ Tissue Distribution	☐ Other: _____
☐ Tissue Labeling	☐ OR for Procurement	☐ Other: _____

8. Please list research programs conducted:

9. Are there any new services or operations scheduled to begin during the next fiscal year? ☐ Yes ☐ No
If *yes*, please explain:

B. **Inpatient Beds:**

	Annual Licensed	Occupied	Inpatient Days
General/Acute Care			
Psychiatric – Do you accept involuntary admissions? ☐ Yes ☐ No			
Intensive Care			
Coronary Care			
Drug & Alcohol			
Rehabilitation			
Pediatrics			
*Hospice			
*Nursing Home (coverage may not be available)			
*Extended Care			
*Assisted Living			
Maternity			
Bassinets (Standard)			
Bassinets (Staff Enhanced Electronic Fetal Monitoring Training)			
Total Hospital Beds (including Bassinets):			

**Separate Application Required – Refer to Company*

Number of Annual Admissions: _____

C. **Hospital Based or Free Standing Outpatient Utilization and Services** – For requested visit classifications, complete number of annual visits and *not* number of procedures. For example, if someone came in and had more than one type lab work done, or maybe lab work and then x-ray, that would be just one visit and *not* the total number of procedures. For requested procedure classifications, provide the actual number of annual procedures.

Description	Number		Description	Number	
Abortion Clinic	_____	Occupied Beds	Medical/Hosp./Surg. Equipment Rental	_____	Annual Gross Sales
	_____	Annual Visits	Medical/Hosp./Surg. Equipment Sales	_____	Annual Gross Sales
*Bariatric Surgery	_____	Annual Procedures	Medical Lab	_____	Annual Receipts
Birthing Center	_____	Occupied Beds	Mental Health Counseling	_____	Occupied Beds
	_____	Annual Visits		_____	Annual Visits
Blood or Plasma Bank	_____	Annual Donations	Municipal Health Department	_____	Annual Visits
Cardiac Rehab	_____	Occupied Beds	Ocular Lab	_____	Annual Receipts
	_____	Annual Visits	Oncology Cancer Center	_____	Occupied Beds
College/University Health Center	_____	Occupied Beds	- Radiation	_____	Annual Procedures
	_____	Annual Visits	- Chemotherapy	_____	Annual Procedures
Community Health Center	_____	Occupied Beds	Optical Establishment	_____	Annual Receipts
	_____	Annual Visits	Organ Bank-Direct Processing	_____	Annual Receipts
Crises Stabilization Center	_____	Occupied Beds	Organ Bank-No Direct Processing	_____	Annual Receipts
	_____	Annual Visits	Pathology Lab	_____	Annual Receipts
Dental Lab	_____	Annual Receipts	Pharmacy (excluding inpatient)	_____	Annual Receipts
Developmental Disability Rehab.	_____	Occupied Beds	Physical/Occupational/Speech Rehab.	_____	Occupied Beds
	_____	Annual Visits		_____	Annual Visits
Developmental Health Counseling	_____	Annual Visits	Quality Control/Reference Lab	_____	Annual Receipts
Dialysis Center	_____	Annual Visits	Substance Abuse-Counseling	_____	Occupied Beds
Emergency Room (hospital)	_____	Annual Visits		_____	Annual Visits
Emergicenter (free standing)	_____	Occupied Beds	Substance Abuse-Skilled Medical	_____	Occupied Beds
	_____	Annual Visits		_____	Annual Visits
Home Care - Durable Equipment	_____	Annual Receipts	*Surgery Center (free standing)	_____	Occupied Beds
Home Care - Intravenous Therapy	_____	Annual Visits		_____	Annual Procedures
Home Care - Personal Care	_____	Annual Visits	Trauma Rehabilitation - Skilled Medical	_____	Occupied Beds
Home Care - Rehabilitation	_____	Annual Visits		_____	Annual Visits
Home Care - Respiratory Therapy	_____	Annual Visits	Trauma Rehabilitation - Therapy	_____	Occupied Beds
Home Care - Skilled Care	_____	Annual Visits		_____	Annual Visits
Hospice Care	_____	Occupied Beds	Trauma Rehab. - Transitional Living	_____	Occupied Beds
	_____	Annual Visits		_____	Annual Visits
Hospital Clinics, Dispensaries or Infirmaries	_____	Annual Visits	Urgent Care (free standing)	_____	Occupied Beds
				_____	Annual Visits
#Hospital Other Outpatient Services	_____	Annual Visits	Weight Loss Center	_____	Occupied Beds
Hospital Outpatient/One-day Surgery	_____	Annual Procedures		_____	Annual Visits
Hospital Psychiatric Outpatient	_____	Annual Visits	X-ray/Imaging Center	_____	Annual Receipts

**Separate Application Required – Refer to Company*

#*Referred for lab, x-ray, other diagnostic test, etc.*

D. **Non-Physician Personnel**

	No. Employed	No. Contracted
Aids or Orderlies		
Anesthesiology Assistants		
*Chiropractors		
*Dentists		
Inhalation / Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
Nuclear Medicine Technicians		
*Nurse Anesthetists - Are they supervised by anesthesiologists? ☐ Yes ☐ No		
*Nurse Midwives		
*Nurse Practitioners / Clinical Nurse Specialists		
Occupational / Physical Therapists		
*Optometrists		
Paramedics or EMT's		
*Perfusionists		
Pharmacists		
*Physician Assistants		
Physiotherapists		
*Podiatrists		
*Psychologists / Psychotherapists		
RNs		
Social Workers		
*Surgical Assistants (Certified or Licensed)		
Other (describe)		

** Separate Application Required – Refer to Company*

_____ Total number of all employees including professional, clerical, executive, and maintenance.

_____ Number of Leased Employees. Provide a list of positions where utilized.

E. **Physicians/Medical Staff – Employed and Contracted (include Residents and Interns):**

1. Are credentials of staff physicians checked and approved prior to the granting of privileges? ☐ Yes ☐ No
2. Are staff physician privileges and overall performances evaluated periodically? ☐ Yes ☐ No
3. Are there procedures in place to restrict or suspend any staff physician's privileges? ☐ Yes ☐ No
4. Has there been any requirement to notify the National Practitioners Data Bank of any suspension, peer review action or liability payment involving any member of the medical or dental staff? ☐ Yes ☐ No
   If *yes*, please explain:
5. Are all privileges granted to staff physicians detailed in writing? ☐ Yes ☐ No
6. Do the hospital by-laws and/or the medical staff by-laws specify that staff physicians maintain malpractice insurance for themselves and their employees who may work in the institution? ☐ Yes ☐ No
   If *yes*, what limits are required:
7. If coverage is desired for physicians, Physician Applications must be completed, returned and approved.
8. Number of Physicians with admitting privileges: _____

5. Medical Service Departments

A. **Emergency Department:**

1. Is the emergency department staffed and operational 24 hours a day? ☐ Yes ☐ No
   If *no*, please explain:

2. Is emergency department staffed by:
   ☐ Employed physicians ☐ Contract group ☐ Rotating Staff

3. a. If under contract, name of group: _____
   b. If contract group, are certificates of insurance required? ☐ Yes ☐ No
   If *yes*, what minimum limits are required: _____ Per Claim _____ Aggregate

4. a. Are all physicians Board Certified or eligible in Emergency Medicine? ☐ Yes ☐ No
   b. Are the emergency physicians required to respond to Cardiac/Respiratory arrests or other medical emergencies occurring in the institution? ☐ Yes ☐ No

5. Is the emergency room equipped with the following:
   a. Is Emergency Resuscitation cart equipped with defibrillator? ☐ Yes ☐ No
   b. Electrocardiograph machine? ☐ Yes ☐ No
   c. Staffed radiology room(s)? ☐ Yes ☐ No
   d. Dedicated triage area and staff? ☐ Yes ☐ No
   e. Dedicated trauma room(s)? ☐ Yes ☐ No
   f. Dedicated laboratory personnel? ☐ Yes ☐ No

6. Do any of the emergency department staff routinely work more than a 12-hour shift? ☐ Yes ☐ No
   If *yes*, please explain:

7. Are all emergency room patients seen by a physician before discharge? ☐ Yes ☐ No

B. **Anesthesiology:**

1. Is anesthesiology department staffed by:
   ☐ Employed physicians ☐ Contract group ☐ Employed CRNA's ☐ Staff physicians

2. a. If under contract, name of group: _____
   b. If contract group, are certificates of insurance required? ☐ Yes ☐ No
   If *yes*, what minimum limits are required: _____ Per Claim _____ Aggregate

3. Are all anesthesiologists required to be Board Certified or eligible in Anesthesiology? ☐ Yes ☐ No

4. Is the anesthesia care performed by CRNA's supervised and reviewed by the anesthesiologists? ☐ Yes ☐ No
   If *no*, please explain: _____

5. Do any of the anesthesia services staff routinely work more than a 12-hour shift? ☐ Yes ☐ No
   If *yes*, please explain:

6. Is there an anesthesiologist or CRNA on the premises 24 hours a day? ☐ Yes ☐ No

7. Are CRNA's to be provided coverage on the hospital's policy? ☐ Yes ☐ No

C. **Radiology:**

1. Is radiology department staffed by:
   ☐ Employed physicians ☐ Contract group ☐ Staff physicians

2. a. If under contract, name of group: _____
   b. If contract group, are certificates of insurance required? ☐ Yes ☐ No
   If *yes*, what minimum limits are required: _____ Per Claim _____ Aggregate

3. Are all radiologists required to be Board Certified or eligible in Radiology and/or Nuclear Medicine? ☐ Yes ☐ No

4. Is there a radiologist on the premises 24 hours a day? ☐ Yes ☐ No

5. Are teleradiology services provided or utilized by the hospital? ☐ Yes ☐ No
   If *yes*, does the radiologist hold all necessary valid licenses? ☐ Yes ☐ No

D. **Obstetrics:**

1. a. Is the facility a regional referral center for newborns requiring intensive care or high risk pregnancies? ☐ Yes ☐ No
   b. If *no*, does a written procedure exist for transferring all high risk mothers and/or babies who the hospital is not qualified to treat? ☐ Yes ☐ No

2. How many births at your facility: (previous 12 months)? _____

3. a. How many cesarean sections: (previous 12 months)? _____
   b. Are all C-sections performed by obstetricians? ☐ Yes ☐ No
      If *no*, what other specialties perform C-sections: _____
   c. How many vaginal births after C-section: (previous 12 months)? _____

4. Is continuous electronic fetal monitoring performed on all patients in active labor? ☐ Yes ☐ No
   If *no*, please explain:

5. Do nurse midwives practice at your hospital? ☐ Yes ☐ No

6. Do you perform Water Births? ☐ Yes ☐ No

E. **Surgery:**

1. Indicate the total number of surgical procedures performed in the last year: _____
   a. Number of inpatient surgeries: _____
   b. Number of outpatient/one-day surgeries: _____

2. Does the facility have a surgical site identification procedure in place? ☐ Yes ☐ No

3. Are sponge, needle and instrument counts performed in the course of a surgical procedure? ☐ Yes ☐ No
   If *yes*, at what intervals of the operation: _____

4. Are any of the following performed at your facility?

Open Heart Surgery	☐ Yes ☐ No	Neurosurgery	☐ Yes ☐ No
Experimental Surgery	☐ Yes ☐ No	Gender Reassignment Operations	☐ Yes ☐ No
Weight Reduction Surgery	☐ Yes ☐ No	Laser Assisted Surgery	☐ Yes ☐ No

6. Hospital Administration and Management

A. Are operations managed by employees of the hospital? ☐ Yes ☐ No

B. Are operations managed and operated by a contract Management Company? ☐ Yes ☐ No

1. Name of Management Company: _____

2. What operational positions are occupied by contracted Management Company employees?

3. Is the Management Company required to maintain the following policies of insurance:
   a. Commercial General Liability ☐ Yes ☐ No
   b. Directors & Officers including Errors and Omissions ☐ Yes ☐ No
   c. Fiduciary & Crime ☐ Yes ☐ No

C. **Hospital Corporate Organization**

If coverage is to be considered for any "additional insureds" please provide a schedule of entities. Additional insureds are entities extended vicarious liability coverage subject to policy provisions, as a result of the actions of the policyholder or the actions of the policyholder's scheduled entities and subsidiaries. See Schedule A attached.

D. **Risk Management**

1. Who coordinates your risk management program?
   Name: _____ Title: _____
   Telephone number: _____
2. Is there a written risk management program that has been approved by the governing body? ☐ Yes ☐ No
3. Does the governing body review the effectiveness of the program and approve necessary changes? ☐ Yes ☐ No
4. Is the risk manager accountable and solely responsible for risk management? ☐ Yes ☐ No
   If *no*, explain other responsibilities:
5. Does the risk management program include the following:
   a. Occurrence reporting ☐ Yes ☐ No
   b. Claim management ☐ Yes ☐ No
   c. Formal link to quality management ☐ Yes ☐ No
   d. Contract review and evaluation ☐ Yes ☐ No
   e. Review and participation in medical staff committees ☐ Yes ☐ No
   f. Safety program and safety committee ☐ Yes ☐ No

7. Premises and Operations

A. Are there any construction plans for the next twelve months? ☐ Yes ☐ No
   If *yes*, please provide cost of project: _____
B. Total square footage of Parking Lots or Decks: _____
C. Total number of swimming pools: _____
D. Total number of lakes: _____
E. Total number of fountains: _____
F. Other retail operations provided to the public:

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____

Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):			
Agent:		Phone:	
Agency:		Fax:	
Address:		Email:	
		License No.:	
Signature:			

Insured Entities and D/B/A's
Schedule A

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Please attach additional sheets if necessary.

HEALTH CARE FACILITY APPLICATION ADDENDUM

PCF SCHEDULE OF ENTITIES AND D/B/A'S

NOTE: In compliance with the Indiana Patient Compensation Fund Guidelines all eligible entities and business names (D/B/A's) operating under the hospital's license must be scheduled on the Patient Compensation Fund Certificate, and remit the applicable surcharge to be extended coverage by the Patient Compensation Fund. Rating exposures (including but not limited to outpatient visits, one day surgery procedures, home health visits, inpatient days, etc.) of scheduled entities and operations are to be included on the Health Care Facility Application.

Other hospital owned or controlled eligible entities and D/B/A's operating under separate licensure must make separate PCF application, pay applicable surcharge, and meet underlying primary coverage requirements. Failure of the hospital to comply with PCF requirements could result in a declination of coverage by the Patient Compensation Fund.

Name:	**Tax ID #**	**Health Dept License #**