Healthcare Facility Application
Non-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: _____

2. Facility/Corporate Organization

Type of Entity: ☐ Government ☐ Non-Profit ☐ Profit ☐ Other: _____
☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture

Type of Facility: _____

Do you have a Physician Medical Director? ☐ Yes ☐ No

Does the Medical Director provide any patient care as part of the Medical Director duties? ☐ Yes ☐ No

Please attach the following:

A. Carrier Loss History:

   i. **Ten years** of historical professional liability (PL) and general liability (GL) losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.

   ii. Date of loss valuation must be within the past 90 days.

   iii. 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.

   iv. 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 (if historically written on claims-made basis).

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

G. Copy of state license.

H. List of all stockholders and their percent of ownership and identify any medical designations held by any stockholder.

I. Copy of your facility accreditation.

3. Current Insurance/Claim Information

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

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

A. 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? _____

B. Have any claims ever been made or suits brought against you or any of your employees in the last five years because of any alleged malpractice, error or mistake, or from any premise accident arising in any manner out of your operations? ☐ Yes ☐ No

If *yes*, attach a separate sheet listing date of occurrence, circumstances of claim and amount paid or amount reserved.

C. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future? ☐ Yes ☐ No

If *yes*, please provide details: _____

_____

4. 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 the "Current Insurance" section above. Provide policy declaration pages for all applicable coverages.

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

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

5. General Exposure Data

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 Lab	_____ Annual Receipts
	_____ Annual Visits	Mental Health Counseling	_____ Occupied Beds
*Bariatric Surgery	_____ Ann. Procedures		_____ Annual Visits
Birthing Center	_____ Occupied Beds	Municipal Health Department	_____ Annual Visits
	_____ Annual Visits	Ocular Lab	_____ Annual Receipts
Blood or Plasma Bank	_____ Ann. Donations	Oncology Cancer Center	_____ Occupied Beds
Cardiac Rehabilitation	_____ Occupied Beds	- Radiation	_____ Ann. Procedures
	_____ Annual Visits	- Chemotherapy	_____ Ann. Procedures
College/University Health Center	_____ Occupied Beds	Optical Establishment	_____ Annual Receipts
	_____ Annual Visits	Organ Bank-Direct Processing	_____ Annual Receipts
Community Health Center	_____ Occupied Beds	Organ Bank-No Direct Processing	_____ Annual Receipts
	_____ Annual Visits	Pathology Lab	_____ Annual Receipts
Crises Stabilization Center	_____ Occupied Beds	Pharmacy	_____ Annual Receipts
	_____ Annual Visits	Physical/Occup./Speech Rehab.	_____ Occupied Beds
Dental Lab	_____ Annual Receipts		_____ Annual Visits
Developmental Disability Rehab.	_____ Occupied Beds	Quality Control/Reference Lab	_____ Annual Receipts
	_____ Annual Visits	Substance Abuse-Counseling	_____ Occupied Beds
Developmental Health Counseling	_____ Annual Visits		_____ Annual Visits
Dialysis Center	_____ Annual Visits	Substance Abuse-Skilled Medical	_____ Occupied Beds
Emergicenter	_____ Occupied Beds		_____ Annual Visits
	_____ Annual Visits	*Surgery Center	_____ Occupied Beds
Fitness Center/Health Club	_____ Annual Members		_____ Ann. Procedures
	_____ Ann. Gross Sales	Trauma Rehab.-Skilled Medical	_____ Occupied Beds
Home Care-Durable Equipment	_____ Annual Receipts		_____ Annual Visits
Home Care-Intravenous Therapy	_____ Annual Visits	Trauma Rehabilitation-Therapy	_____ Occupied Beds
Home Care-Personal Care	_____ Annual Visits		_____ Annual Visits
Home Care-Rehabilitation	_____ Annual Visits	Trauma Rehab.-Transitional Living	_____ Occupied Beds
Home Care-Respiratory Therapy	_____ Annual Visits		_____ Annual Visits
Home Care-Skilled Care	_____ Annual Visits	Urgent Care	_____ Occupied Beds
Hospice Care	_____ Occupied Beds		_____ Annual Visits
	_____ Annual Visits	Weight Loss Center	_____ Occupied Beds
Medical/Hosp./Surg. Equip. Rental	_____ Ann. Gross Sales		_____ Annual Visits
Medical/Hosp./Surg. Equip. Sales	_____ Ann. Gross Sales	X-ray/Imaging Center	_____ Annual Receipts

**Separate Application Required – Refer to Company*

Are any procedures performed on persons rendered unconscious through anesthesia? ☐ Yes ☐ No

If *yes*, give detailed description of how anesthesia is provided, including minimum patient age and number of overnight beds on premises or affiliated. _____

_____

6. Personnel

A. Physicians providing health care services at this entity:

Name	Specialty	Board Certified	Limits	C=Contracted E=Employed O=Owner	Current Insurance Carrier

Please attach additional sheets if necessary.

B. Do you require certification of Professional Liability Coverage? ☐ Yes ☐ No

If *yes*, how much? _____

Non-Physician Personnel	No. Employed	No. Contracted
Anesthesiology Assistant		
Audiologists		
*Chiropractors		
*Dentists		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
*Nurse Anesthetists - Are they supervised by an anesthesiologist? ☐ Yes ☐ No		
*Nurse Midwives		
*Nurse Practitioners/Clinical Nurse Specialists		
Occupational/Physical Therapists		
Opticians		
*Optometrists		
*Oral Surgeons		
Paramedics or EMT's		
*Perfusionists		
Pharmacists		
Pharmacy Technicians		
*Physician Assistants		
Physiotherapists		
*Podiatrists		
*Psychologists/Psychotherapists		
RNs		
Social Workers		
Speech Therapists		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe):		

**Separate Application Required – Refer to Company*

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. Does the facility have a day care center? Child: ☐ Yes ☐ No Adult: ☐ Yes ☐ No
Is it open to the public? Child: ☐ Yes ☐ No Adult: ☐ Yes ☐ No
Number enrolled in the past 12 months: Child: _____ Adult: _____

G. Does the facility have a Fitness Center/Health Club? ☐ Yes ☐ No
Number of members enrolled in the past 12 months: _____
Annual Gross Sales: _____

H. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

I. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

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 #**