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Healthcare Facility Application
Hospital—Renewal

ProAssurance
Treated Fairly

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

Expiring Policy No. _____

1. Introductory Information

Policyholder Name: _____

Address: _____

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

Telephone Number: _____ Fax Number: _____

Hospital Fiscal Year Begins: _____

Contact Name: _____ Contact Email: _____

Website Address: _____

Instructions:

1. Please review and complete this renewal 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. General Information

A. Has there been a change in facility ownership or management? ☐ Yes ☐ No

If *yes*, please explain: _____

_____

B. Provide details of any new start-up services or any services discontinued during the past fiscal year.

C. Has the facility's license been revoked, suspended or restricted during the past fiscal year? ☐ Yes ☐ No

If *yes*, please provide details: _____

_____

D. Has any accreditation program revoked, suspended or restricted the facility's accreditation status? ☐ Yes ☐ No

If *yes*, please provide details: _____

_____

E. Please provide a copy of the facility's latest fiscal year-end audited financial statement.

F. Please provide an updated schedule of locations and insured entities.

3. Self-Insured Retention Program (if applicable)

If this renewal is excess over a policyholder's formal Self-Insured Retention program, please provide:

1. The current limit of liability for the self-insured retention?

   Professional liability: _____ per claim _____ annual aggregate

   General liability: _____ per claim _____ annual aggregate

2. A copy of the annual independent actuarial study.
3. Verification of the account balance for the self-insured trust.

4. Professional Exposures

A. **Inpatient Beds**

Inpatient Beds	Licensed	Occupied	Annual 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):			

Annual Number of: Admissions: _____ Births: _____ Inpatient Surgeries: _____

B. **Non-Physician Personnel**

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*
 # Separate Application Required for New Personnel if not Previously Submitted

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

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

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

**Separate Application Required if new operation – Refer to Company*

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

5. 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.

PROASSURANCE.
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Important Notice About the Policy of Insurance for Which You Have Applied

This Document Affects Your Legal Rights

Read the Following Information Carefully

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

Applicant's Signature	Date	Time
Agent	Date	Time

Note: You will need to sign this notice to be considered for coverage.