APPLICATION FOR
HOSPITAL PROFESSIONAL AND/OR GENERAL LIABILITY INSURANCE
PRIMARY AND UMBRELLA
(Claims-Made Basis)

OHA INSURANCE SOLUTIONS (OHAIS)

155 EAST BROAD STREET, FLOOR 2
COLUMBUS, OHIO 43215
PH. (614) 255-4840 * FAX (614) 255-4839

Applicant Instructions

1. Answer all questions; if a question is not applicable, state NOT APPLICABLE.
2. If answer is identical to expiring application, acceptable answer would be the same as last year's.
3. If the answer to any question is none, state NONE.
4. If space is insufficient to answer any question fully, attach separate sheet.
5. Application must be signed and dated by a DULY AUTHORIZED REPRESENTATIVE.
6. Please do not complete application earlier than 90 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT)

Producer Information

Producer Name: ______________________________

Agency Name: ______________ Federal Tax ID: ______________

Address: ______________________________

Phone: ______________ E-Mail Address: ______________

Producer License Number: ______________ State: ______________

PART I – APPLICANT INFORMATION

First Named Insured: ______________________________

Street Address: ______________________________

City/State/Zip Code: ______________________________

Contact Person: ______________________________

Title: ______________________________

Office Telephone: ______________________________

Risk Management/Quality Assurance Contact Person: ______________

Telephone: ______________ E-Mail Address: ______________

Website Address: ______________________________

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For questions 2-11, please respond for all Named Insureds. If coverage is requested for multiple, separate organizations, please complete page 19 on subsidiaries.

1. Have you ever filed for bankruptcy? ☐ Yes ☐ No
   If yes, when? ______________________________

2. Geographical/County area in which you operate: ______________________________

3. Have you sold, acquired, begun or discontinued any operations in the past five years? ☐ Yes ☐ No
   If yes, please explain: ______________________________

4. Are you expecting any changes or growth in operations or services offered in the next 12 months? ☐ Yes ☐ No
   If yes, please explain: ______________________________

5. Type of hospital:

   ☐ Children's Hospital
   ☐ General Hospital
   ☐ Geriatric Hospital
   ☐ Osteopathic Hospital
   ☐ Psychiatric Hospital
   ☐ Rehabilitation Hospital
   ☐ Teaching Hospital
   ☐ Women's Hospital
   ☐ Other Hospital
   Please specify: ______________________________

   ☐ Individual
   ☐ Corporation
   ☐ Joint Venture
   ☐ Government
   ☐ Partnership
   ☐ Charitable

   ☐ For-Profit
   ☐ Non-Profit

   ☐ Accredited by JCAHO
   ☐ Accredited by AOA
   ☐ Accredited by CARF
   ☐ Licensed by State
   ☐ Medicare Approved
   ☐ Member of AHA
   ☐ Member of OHA

6. Facilities/Services Provided:

   ☐ Abortion Clinic
   ☐ Alternative Medicine
   ☐ Ambulatory Care Clinics
   ☐ Blood Bank
   ☐ Burn Unit
   ☐ CCU
   ☐ Cardiac Cath
   ☐ Chemical Dependency
   ☐ Chemotherapy
   ☐ Clinics, Women's Prenatal
   ☐ Day Care children/ adults
   ☐ Dental
   ☐ Dialysis
   ☐ Dietary Services
   ☐ Durable Medical Equipment Service

   ☐ Hospice**
   ☐ ICU
   ☐ Intermediate Care
   ☐ Laundry
   ☐ Mobile Units (Mammography, CAT scan units, etc.)
   ☐ Morgue
   ☐ Neonatal ICU
   ☐ Nuclear Medicine
   ☐ Nursery
   ☐ Neurosurgery
   ☐ Emergency Services
   ☐ Genetic Counseling
   ☐ Gift Shop
   ☐ Home Health Care**
   ☐ Other

   Nursing Home*
   - ☐ Assisted Living
   - ☐ Independent Care
   - ☐ Intermediate Care
   - ☐ Personal Care
   - ☐ Skilled Nursing
   - ☐ Subacute Care

   ☐ Obstetrics
   ☐ Occupational Therapy
   ☐ Office Practices
   ☐ Open Heart Surgery
   ☐ Organ Bank
   ☐ Pathology
   ☐ Pediatrics
   ☐ Pharmacy
   ☐ Physical Fitness Center

   ☐ Physical Therapy
   ☐ Psychiatric Unit
   ☐ Radiology
   ☐ Rehabilitation
   ☐ Respiratory Therapy
   ☐ Restaurant
   ☐ Same Day Surgery
   ☐ Speech Therapy
   ☐ Substance Abuse Center
   ☐ Surgery
   ☐ Transplants
   ☐ Trauma Center
   ☐ Ultrasound
   ☐ Wellness Center
   ☐ Weight Loss

*Separate application for Nursing Home, Independent Living and Assisted Living facilities will need to be completed.
** Separate application for Hospice and Home Health Care, if it is a separate facility, will need to be completed.

7. Does hospital engage in any of the following research/experimental activities:

   ☐ Formal clinical research under the auspices of an institutional review board.
   ☐ Administration of non-FDA approved pharmaceuticals (experimental drugs).
   ☐ Biomedical device research and development.
   ☐ Animal research.
   ☐ Medical and/or surgical experimentation that is not approved by an institutional review board.

8. Provide details to any of above: ______________________________

   ____

9. Does your facility have a bioethical or similar committee, which approves the activity? ☐ Yes ☐ No

10. Do you engage in any types of alternative medicine/alternative therapy? ☐ Yes ☐ No
    If yes, please describe on a separate sheet of paper.

PART II – HEALTH CARE TRAINING PROGRAM

1. Do you have any teaching affiliations? ☐ Yes ☐ No
   If yes, please explain: ______________________________

   ____

2. Who provides the insurance coverage for the students while at your facility? ______________________________

   ____

3. If applicant has a training school, complete the following. Attach separate schedule, if needed.

Profession for which Students are Being Trained	Max. No. of Students Per Session	No. of Sessions Per Year	% of Time Involved in Clinical Setting	Number of Faculty	Qualifications of Faculty (e.g. MD, RN, PhD, etc).

4. a. Does applicant have any involvement with any accredited residency program? ☐ Yes ☐ No

   If yes, ☐ Owned ☐ Consortium ☐ Neither
   (List name of parties involved on separate sheet. Explain program including names and relationships to your hospital on separate sheet.)

b. Number of residents in the program:

Allergy & Immunology	_____	Orthopedic Surgery	_____
Anesthesiology	_____	Otolaryngology	_____
Colon & Rectal Surgery	_____	Pathology	_____
Dermatology	_____	Pediatrics	_____
Family Practice	_____	Physical Medicine &	
General Practice	_____	Rehabilitation	_____
General Surgery	_____	Plastic Surgery	_____
Internal Medicine	_____	Preventative Medicine	_____
Neurological Surgery	_____	Psychiatry	_____
Neurology	_____	Radiology	_____
Nuclear Medicine	_____	Thoracic Surgery	_____
Obstetrics-Gynecology	_____	Urology	_____
Ophthalmology	_____	Other (identify)	_____

PART III – COVERAGE/LIMITS/DEDUCTIBLES

1. Requested Policy Effective Date: _______________ Requested Policy Expiration Date: ________________

2. Retroactive Date: _____________________________

3. Coverage:

☐ Professional Liability ☐ General Liability ☐ Umbrella Liability

	Limits of Liability	Deductible/SIR
Hospital Professional Liability:	______ Each Incident	______ Each Incident
	______ Annual Aggregate	______ Annual Aggregate
Physicians Professional Liability:	______ Each Incident	______ Each Incident
	______ Annual Aggregate	______ Annual Aggregate
General Liability:	______ BI & PD – Each Occurrence	______ Each Incident
	______ PI & AI – Each Occurrence	______ Annual Aggregate
	______ Prod/Comp Ops – Aggregate	
	______ Annual Aggregate	
Umbrella Liability:	______ Each Incident	
	______ Annual Aggregate	

4. Self Insured Retention (SIR), if applicable:

a. What line(s) of coverage will the SIR apply to? ☐ Professional Liability ☐ General Liability
b. How are loss adjustment expenses handled? ☐ Within SIR limit ☐ Outside SIR limit
c. Is there a dedicated trust? ☐ Yes ☐ No
d. What financial institution manages the trust? ____
e. Who handles claims within the SIR? ____

4. Self Insured Retention (SIR) (cont'd):

   f. Is there an independent actuarial review? ☐ Yes ☐ No
      1. Who performs the actuarial review? ____
      2. How often is the actuarial review performed? ____

PART IV – PROFESSIONAL LIABILITY EXPOSURES

Fiscal Period Ending: ______________________.

1. Type of Patients (Indicate % of each):

____% Medical ____% Substance Abuse ____% Surgical
____% Psychiatric ____% Obstetrical ____% Rehabilitation
____% Long Term ____% Pediatric ____% Other

2. Beds:

Facility	# of Licensed Beds	# Patient Days
Acute Care		
Bassinets/Cribs		
Hospice		
ICU/CCU		
Maternity		
Neonatal		
Nursing Home		
Assisted Living		
Independent Care		
Intermediate Care		
Personal Care		
Skilled Nursing		
Subacute Care		
Psychiatric		
Rehabilitation		
Substance Abuse		
Swing Beds		
Other		

Please provide similar information for the past five years on a separate sheet of paper.

3. Outpatient Visits:
(Use visits rather than occasions of service. For example, a patient referred to the hospital by a physician for a laboratory test and an x-ray would be counted as one visit, but two occasions of service. A visit is a threshold crossing which may involve multiple occasions of service from more than one clinical department.)

3. Outpatient Visits (cont'd):

Clinic (prenatal, women's health, etc.)	_______________	Occupational Therapy	_______________
Community Health Center	_______________	Respiratory Therapy	_______________
Emergency Dept.	_______________	Speech Therapy	_______________
Home Health Care	_______________	Substance Abuse	_______________
Physical Rehabilitation	_______________	Urgent Care	_______________
Physical Therapy	_______________	Other	_______________
Psychiatric	_______________		

4. Surgeries:

Total Inpatient Surgery	__________________	Total number of surgical procedures for:	
Total Outpatient Surgery	__________________		
Total Operating Rooms	__________________	Weight Reduction	__________________
Total Deliveries	__________________	Sex Change	__________________
Total Annual Lab	__________________	Experimental	__________________
Receipts	__________________		
Endoscopy	__________________		

PART V – PROFESSIONAL EMPLOYEES

1. Please provide total number in each category:

Position	Employed	Contracted		Employed	Contracted
Chiropractors*			Other Employees		
Cytotechnologists*			Paramedics*		
Dentists*			Pharmacists		
Employed Physicians*			Physician Assistants*		
Employed Surgeons*			Podiatrists		
Externs			Perfusionists*		
Heart-Lung Technicians			Psychologists*		
Interns*			Registered Nurses		
Lab Technicians			Residents*		
LPNs			Respiratory Therapists		
Mental Health Counselors			Social Workers		
Nurse Anesthetists* (CRNAs)			Student Nurses		
Nurse Midwives*			Surgeon Assistants*		
Nurse Practitioners*			Teaching Physicians*		
Occupational Therapists			X-ray Technicians		
Optometrists*					

*If coverage is requested for any of the above categories, please provide a list of names and specialties including date of hire. Individual applications are required, if coverage is requested.

2. Are employed physicians, surgeons, residents and health care providers covered by the hospital's primary insurance policy or self-insurance program? ☐ Yes ☐ No

3. If professional coverage is not being requested for employed physicians, surgeons, residents and health care providers,

   a. Where are they insured?______________________________
   b. Does their insurance provide coverage for their corporation? ☐ Yes ☐ No

4. Does the hospital use agency nurses? ☐ Yes ☐ No

   a. If yes, what percentage of nurse staffing is provided by agency personnel? ______________
   b. Who provides the insurance coverage?______________________________

5. Is there a separate subsidiary used for the employment of physicians? ☐ Yes ☐ No
   If yes, please provide the following:

   a. Name of subsidiary: ______________________________
   Please make sure all information is provided on page 19.

Staff/Contract Physician and Allied Health Insurance Requirements

1. Do you require all medical staff and contract physicians, as well as, allied health professionals to carry professional liability insurance? ☐ Yes ☐ No
   If yes, what limits are required? ______________________________

   ____

2. Do you require certificates of insurance? ☐ Yes ☐ No
   If no, how do you monitor compliance with insurance requirement? ______________

   ____

Administrative Procedures

1. Do you have a formal written risk management program? ☐ Yes ☐ No

2. Do you have a formal, written quality (assurance) program? ☐ Yes ☐ No

3. Provide the name, title and phone number of the individual at the hospital responsible for claims handling:

   ____

4. Are written procedures in effect for incident reporting? ☐ Yes ☐ No

5. Describe your claim handling procedures: ______________________________

Medical Staff Privileges

1. Are credentials for staff physicians checked and approved prior to granting staff privileges? ☐ Yes ☐ No
   If yes, by whom? ______________________________

Medical Staff Privileges (cont'd):

2. Are privileges probationary for at least six months for new staff physicians? ☐ Yes ☐ No

3. Are privileges for all physicians subject to annual review? ☐ Yes ☐ No

4. Do you have any physicians who are not licensed or who have restricted licenses or privileges? ☐ Yes ☐ No
   If yes, please explain: ______________________________

5. Describe your peer review process for physicians: ______________________________

   ____

6. Have you ever been sued by a member of the medical staff for the following:

   a. Antitrust Violations? ☐ Yes ☐ No
   b. Staff Privileges or Credentialing? ☐ Yes ☐ No
   c. Civil Rights/Discrimination? ☐ Yes ☐ No
   If yes to any of the above, please explain: ______________________________

   ____

   ____

Allied Health Privileges

1. Are credentials for allied health providers checked and approved prior to granting staff privileges? ☐ Yes ☐ No
   If yes, by whom? ______________________________

2. Are privileges probationary for at least six months for allied health providers? ☐ Yes ☐ No

3. Are privileges for all allied health providers subject to annual review? ☐ Yes ☐ No

4. Do you have any allied health providers who are not licensed or who have restricted licenses or privileges? ☐ Yes ☐ No
   If yes, please explain: ______________________________

5. Describe your peer review process for allied health providers: ______________________________

   ____

6. Have you ever been sued by an allied health provider for the following:

   a. Antitrust Violations? ☐ Yes ☐ No
   b. Staff Privileges or Credentialing? ☐ Yes ☐ No
   c. Civil Rights/Discrimination? ☐ Yes ☐ No
   If yes to any of the above, please explain: ______________________________

   ____

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PART VI – HIGH RISK SERVICES

Anesthesiology Department

1. Anesthesiology Department is staffed by:

   ☐ Employed Anesthesiologists ☐ Employed CRNAs
   ☐ Contract Physicians ☐ Contract CRNAs
   ☐ Employed Residents ☐ Staff Physicians

2. If under contract, to whom is staffing contracted? ______________________________

   a. Who owns and maintains the equipment? ______________________________
   b. Do you obtain hold harmless agreements in favor of your facility? ☐ Yes ☐ No

3. Are all anesthesiologist board certified? ☐ Yes ☐ No
   If no, what percentage of physicians is not board certified? ____________%

4. In addition to the above, can anyone else at your facility administer anesthesia? ☐ Yes ☐ No
   If yes, who? ______________________________

5. Can anyone administer anesthesia without the direct supervision of an anesthesiologist? ☐ Yes ☐ No
   If yes, please explain: ______________________________

6. Is an anesthesiologist or CRNA immediately available on a 24-hour basis or in-house? ☐ Yes ☐ No
   If no, please explain: ______________________________

Obstetrical Services

1. Is the applicant a regional referral center for either high-risk OB or newborns requiring intensive care? ☐ Yes ☐ No

2. Does the applicant have a separate birthing center? ☐ Yes ☐ No

3. Can Cesarean sections be performed within 30 minutes at all times? ☐ Yes ☐ No

4. Are all obstetricians board certified? ☐ Yes ☐ No
   If no, what percentage is not board certified? ____________%

5. Is an obstetrician available in-house 24 hours per day for the obstetrical suite? ☐ Yes ☐ No
   If no, what is the maximum time for arrival at hospital? ____________

6. Do Family Physicians, General Surgeons or Nurse Midwives perform obstetrical services? ☐ Yes ☐ No

7. Do Family Physicians or Nurse Midwives perform VBACs or C-sections: ☐ Yes ☐ No

Obstetrical Services (cont'd):

8. If the applicant has a neonatal intensive care unit (NICU), state:

   a. total number of neonates admitted to NICU in the past 12 months: ______________________
   b. total number of neonates admitted to NICU who were transferred from other facilities: ____________
   c. whether full-time attending neonatologist is on-site in NICU 24 hours per day: ______________

9. Do you sponsor any off-site delivery programs? ______________________ ☐ Yes ☐ No
   If yes, please explain: ____

10. Please provide the following information for the past 12 months.

    _____ Total Number of Deliveries
    _____ Number of C-Sections Performed
    _____ Number of Stillborn Deliveries
    _____ Number of VBAC

Emergency Services

1. Describe physician staffing of the emergency department.

   ☐ Employed Physicians ☐ Under Contract ☐ Employed Residents ☐ Staff Physicians.

2. If under contract, to whom is staffing contracted? ________________________________

3. Can residents render emergency services without an attending physician being present? ☐ Yes ☐ No

4. How is your emergency department classified according to JCAHO standards?

   __ Level I (Tertiary) __ Level II (Comprehensive) __ Level III (Basic)
   __ Non (Standby) __ Other (Specify) ________________________________

5. Is the ED staffed by physicians 24 hours per day, seven days per week? ☐ Yes ☐ No
   If no, please describe staffing arrangements for evening and weekends. ______________________

   ____

6. Are the following services available on a 24-hour basis?

   Support Facilities: Radiology ☐ Yes ☐ No
   Surgery ☐ Yes ☐ No
   Laboratory ☐ Yes ☐ No

7. If required, is specialty consultation available within 30 minutes? ☐ Yes ☐ No
   If no, what is the maximum time limit? ________________________________

Emergency Services (cont'd):

8. Are patients transferred in accordance with the COBRA legislation requirements? ☐ Yes ☐ No
   If no, please attach explanation.

9. Are all ED physicians board certified? ☐ Yes ☐ No
   If no, what percentage is not board certified? ____________

Radiology

1. Describe staffing of the radiology department.

   __ Employed Physician __ Under Contract __ Employed Residents
   __ Staff Physicians __ Others (Describe)

2. If under contract, to whom is staffing contracted? ____

3. Do you require a radiologist to be on-site 24 hours per day? ☐ Yes ☐ No
   If no, please explain: ____

   ____

4. Are all radiology examinations interpreted by, and are all final reports rendered by radiologists? ☐ Yes ☐ No
   If no, please explain: ____

   ____

5. Are all radiologists board certified or eligible? ☐ Yes ☐ No
   If no, what percentage is not board certified? ___________%

6. Is the radiological services accredited? ☐ Yes ☐ No
   If yes, please list all accreditations: ____

   ____

Surgery Services

1. Can residents perform surgery without an attending surgeon being present? ☐ Yes ☐ No
   If yes, under what circumstances? ____

Pharmacy

1. Please list all areas where you have satellite pharmacies (e.g. OR, ICU, etc.): ________________________________

   ____

2. What are the hours of operation for the pharmacy?____________

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Blood Bank/Blood Testing Operations

1. Do you operate a blood bank for uses other than storage? ☐ Yes ☐ No

2. If you have a blood bank, is it accredited? ☐ Yes ☐ No

3. If you do not operate a blood bank, from what sources(s) do you obtain blood or blood products? ________________

   ____

4. Do you distribute blood to parties or patients outside of your facility? ☐ Yes ☐ No

5. If you utilize independent blood banks, labs or testing facilities:

   a. Do you obtain certificates of insurance from all such facilities? ☐ Yes ☐ No
      If yes, what minimum limits of insurance are required?________________________
   b. Do you require facilities to demonstrate proof of accreditation? ☐ Yes ☐ No

6. Do all such facilities provide you with a written hold harmless agreement in your favor? ☐ Yes ☐ No

PART VII – PREMISES & OPERATIONS

Identify all buildings by use i.e. Hospital, Clinic, Extended Care Facility, etc.

Address	Use	No. Stories	Year Built	Construction	Fire Protection	Sq. Feet	Sprinklered Yes or No

1. Are any of the premises leased to others? ☐ Yes ☐ No
   If yes, please list: ____

   ____

2. Are any of the premises leased from others? ☐ Yes ☐ No
   If yes, please list: ____

   ____

3. Are all other premises owned and occupied? ☐ Yes ☐ No
   If no, please explain: ____

   ____

4. If inpatient buildings and/or other owned buildings exceeding four floors are partially sprinklered, please indicate which areas are sprinklered. ______________________________

5. Do all patient care areas have:

   a. Self-closing fire doors on each floor? ☐ Yes ☐ No
   b. Automatic fire alarm systems connected to the fire department? ☐ Yes ☐ No
   c. Smoke detectors? ☐ Yes ☐ No
   d. A written emergency evacuation plan? ☐ Yes ☐ No
   e. Are there at least two clearly marked exits on each floor? ______________ ☐ Yes ☐ No
   f. Is there an emergency electrical system (generator)? ______________ ☐ Yes ☐ No

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

7. Have you planned or are you engaged in any new construction for this year? ☐ Yes ☐ No
   If yes, please provide details: ______________________________

   ____

8. Describe the type, cost and duration of the construction/renovation: ______________________________

   ____

9. What is the minimum limit of insurance you will require contractors to carry? ______________

10. Do you require certificates of insurance from all contractors? ☐ Yes ☐ No

11. Do you have a helipad or other landing area for helicopters? ☐ Yes ☐ No
    If yes, list location and number of landings per year: ______________________________

    ____

12. Distance from helipad to nearest building: ____________

13. Do you own/operate a day care center? ☐ Yes ☐ No
    If yes, answer the following questions:

    a. Day Care Center is open to:
       ☐ Children of general public ☐ Children of employees ☐ Adult day care center
    b. Average number of children per day: ____________
    c. Average number of adults per day: ____________
    d. Average number of supervisors? ______________________________
    e. Is day care center on or off hospital premises? ☐ On ☐ Off
    f. What are the hours of operation? ______________________________
    g. What are your security procedures: ______________________________

    ____

14. Do you provide any form of personal services (pick-up laundry, etc.) to your employees? ☐ Yes ☐ No
    If yes, please explain: ____________________

    ____

15. With respect to medical equipment, please provide:

    a. Estimated annual sales of medical equipment supplies. $ ________
    b. Estimated annual rental receipts of medical equipment. $ ________
    c. Do you have a contract for equipment repair and/or services? ☐ Yes ☐ No
       If yes, estimated annual receipts from servicing medical equipment of others. $ ________
       Provide sales from service contract. $ ________
    d. Do you modify the design or function of any medical equipment? ☐ Yes ☐ No
       If yes, please explain: ____________________

       ____

16. Do you obtain revenue from contracting with others for services
    (i.e. laundry, food, maintenance)? ☐ Yes ☐ No

17. Do you manage property for others? ☐ Yes ☐ No
    If yes, please provide details: ____________________

    ____

18. Are you involved in any manufacturing operations? ☐ Yes ☐ No
    If yes, please describe: ____________________

    ____

19. Do you provide any consulting or professional services to others? ☐ Yes ☐ No
    If yes, please describe: ____________________

    ____

20. Do all vendors and service providers provide you with certificates of insurance? ☐ Yes ☐ No

    If yes, what is the minimum limit of insurance all vendors and service providers are required to carry? ________

PART VIII – AUTOMOBILE EXPOSURES

1. List the number and type of owned or leased vehicles.

Number of Vehicles	Owned	Leased	Number of Light Trucks	Number of Vans	Number of PP Vehicles	Others

2. Do you own or operate ambulance or mobile care units that provide medical services? ☐ Yes ☐ No
   If yes, indicate number and type of vehicles and average number of calls per year. ______________________________

   ____

3. Please provide details of any automobile losses in excess of $10,000 during the past five years. (Use separate sheet, if necessary.) ____

4. Please provide an approximate number of employees that drive personal autos on behalf of the Named Insured on a regular basis. ____________________

PART IX – SCHEDULE OF CURRENT UNDERLYING COVERAGES

1. List below all primary liability policies for which umbrella coverage is desired.

Type	Company	Limit	Premium	Policy Period
Professional	________	________	________	________
CGL	________	________	________	________
Automobile	________	________	________	________
Employers	________	________	________	________
Helipad	________	________	________	________
Non-Owned	________	________	________	________
Others	________	________	________	________

2. Self Insured Retention (If Applicable):

   HPL $__________________ per claim $_________________________ annual aggregate
   CGL $__________________ per claim $_________________________ annual aggregate

3. Have any primary or excess liability policies been cancelled or non-renewed in the past five years? ☐ Yes ☐ No

PART XI – ATTACHMENTS

Please attach a copy of the following to this application
☐ Audited Financial Statements for the last two years
☐ Copy of brochures and marketing information
☐ Copy of contract for contracted physicians/dentists
☐ Written procedures for claims handling and risk management
☐ Most recent JCAHO or other accreditation body organizational report with status of any recommendations made
☐ Copies of hold harmless agreements
☐ Minimum of 10 years loss history
☐ Copy of most current AHA Annual Survey
☐ Medical staff by-laws
☐ Organizational chart
☐ Copy of license(s)

If self insured, include the following:
☐ Actuarial review for the SIR
☐ Financial statement of the SIR
☐ Trust document including statement of coverage
☐ Risk management guidelines
☐ Copies of all contracts for services performed by a third party (such as TPAs)

What is the hospital's preference for payment of premiums?
☐ Annually ☐ Quarterly

NOTICE TO APPLICANT. PLEASE READ CAREFULLY

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should the policy be issued.

Fraud Warning: Any person who, with intent to defraud or knowledge that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

The information provided on this application and on any supplementary attachments is complete and correct to the best of my knowledge.

Signature ____________________ Title ____________________ Date ____________

This document must be signed and dated by a duly authorized representative of the first Named Insured.

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AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by OHA Insurance Solutions (the "Company") hereby authorizes their present and prior professional liability insurance carriers, and any and all attorneys who have represented the undersigned in connection with any claim of professional liability, to release to the Company upon its request information regarding closed, pending or anticipated claims and any underwriting or other information, which in the judgment of any such carrier, attorney or the Company may have a bearing upon their acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above and their agents, servants and employees, and the Company, its directors, officers, employees, agents and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photostatic copy of this Authorization, which shall be of equal validity with the signed original.

Facility: ______________________________________

Name (Printed): ______________________________

Title: ____

Signature: _____________________________________

Address: ______________________________________

____

____

Date: ____

APPLICATION FOR
HOSPITAL PROFESSIONAL AND/OR GENERAL LIABILITY INSURANCE
PRIMARY AND UMBRELLA
(Claims-Made Basis)

NO KNOWN CLAIMS DECLARATION

The undersigned applicant declares that they are not aware of, nor do they have any knowledge of, any claim or incident, any unreported conduct, or any circumstance or occurrence that could reasonably be expected to result in a claim against the facility subsequent to the date of the signature below that has not already been reported to the previous professional liability carrier and that has not been disclosed on the application to OHA Insurance Solutions (OHAIS).

All claims and all facts or circumstances have been reported that could give rise to a claim to appropriate prior carrier(s) and the undersigned understands that all such known claims or potential claims will not be covered by this insurance. The facility also understands that this insurance does not apply to any of the following:

Any incident or claim for which the facility has received notice of a claim.

Any incident or claim for which a legal action has been filed against the facility or employees of the facility.

Any incident or claim upon which any companies previously insuring the facility have previously established a claim file.

Any incident or claim arising out of any fact, circumstance or situation indicating the possibility of a claim, which was known to the facility as of the effective date of insurance for which we are applying.

Facility: ____

Name (Printed): ________________________________

Title: ____

Signature: _______________________________________

Address: ____

____

____

Date: ____

APPLICATION FOR
HOSPITAL PROFESSIONAL AND/OR GENERAL LIABILITY INSURANCE
PRIMARY AND UMBRELLA
(Claims-Made Basis)

SUBSIDIARIES

For all Named Insureds, please provide the following:

List all subsidiaries below:	Description of subsidiary operations:	Coverage Effective Date:	Is coverage desired for this subsidiary?	Annual Payroll	Total Number of Employees	Total Annual Gross Receipts	*Type of Facility	For Profit or Non-Profit
			☐ Yes ☐ No					
			☐ Yes ☐ No					
			☐ Yes ☐ No					
			☐ Yes ☐ No					
			☐ Yes ☐ No					
			☐ Yes ☐ No					
			☐ Yes ☐ No					

* Please indicate in “Type of Facility” column above.
1 – Individual
2 – Corporation
3 – Joint Venture
4 – Government
5 – Partnership
6 – Charitable