

**APPLICATION FOR  
MISCELLANEOUS HEALTH CARE FACILITY LIABILITY COVERAGE**

**OHA INSURANCE SOLUTIONS (OHAIS)**

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

**PART I - GENERAL 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: \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_

Retroactive Date: \_\_\_\_\_

Limits Request:

Primary: \_\_\_\_\_ Umbrella: \_\_\_\_\_

Type of Facility:

- |  |                                     |  |
|--|-------------------------------------|--|
| <input type="checkbox"/> Individual    | <input type="checkbox"/> Profit     | <input type="checkbox"/> Licensed by the state |
| <input type="checkbox"/> Partnership   | <input type="checkbox"/> Non-Profit | <input type="checkbox"/> Accredited by AOA     |
| <input type="checkbox"/> Corporation   | <input type="checkbox"/> Charitable | <input type="checkbox"/> Medicare Approved     |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government | <input type="checkbox"/> Member of JCAHO       |
|  |                                     | <input type="checkbox"/> Accredited by CARF    |
|  |                                     | <input type="checkbox"/> Other                 |

Professional Liability (Claims-Made Only)

Limit: Per Claim \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_ Retroactive Date \_\_\_\_\_  
Deductible:  \$25,000  \$50,000  \$100,000  Other \_\_\_\_\_

General Liability (Claims-Made Only)

Limit: Per Claim \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_ Retroactive Date \_\_\_\_\_



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Umbrella Liability (Claims-Made Only)

Limit: Per Claim \$ \_\_\_\_\_ Aggregate \$ \_\_\_\_\_ Retroactive Date \_\_\_\_\_

**PART II - ACCREDITATION AND MEMBERSHIP IN PROFESSIONAL ASSOCIATIONS**

1. Is your organization accredited by:
- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Commission on the Accreditation of Rehabilitation Facilities (CARF)?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Community Health Accreditation Program (CHAP)?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Joint Commission of Accreditation of Healthcare Organizations (JCAHO) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Any other accrediting organization(s)?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- If yes, please specify \_\_\_\_\_
2. Are you a member of any state association(s)?  Yes  No  
If yes, please specify: \_\_\_\_\_
3. Are you a member of any other industry associations(s)?  Yes  No  
If yes, please specify: \_\_\_\_\_

**PART III - EXPOSURE DATA**

1. Health Care Services Provided: (Check each box that applies, giving the requested information for each classification. Give projected information for the next 12 months.)

Attach any brochures, course catalogs or other advertising material used by your facility.

<b>Counseling/Rehabilitation</b>	<b>*Visits</b>	<b>**Beds</b>	<b>Laboratory</b>	<b>***Annual Receipts</b>
Cardiac Rehab	_____	_____	Dental	_____
Developmental Disability	_____	_____	Medical	_____
Mental Health/Counseling	_____	_____	Ocular	_____
Physical or Occupational Rehab	_____	_____	Optical Establishment	_____
Substance Abuse	_____	_____	Pathology	_____
Counseling	_____	_____	Pharmaceutical	_____
Residential	_____	_____	Pharmacy	_____
Skilled Medical Services	_____	_____	Quality Control/Reference	_____
Trauma Rehabilitation	_____	_____	Research/Development	_____
Therapy	_____	_____	X-Ray/Imaging Center	_____
Transitional Living	_____	_____		_____
Skilled Medical	_____	_____	Durable Medical Equipment	_____
Weight Loss Center	_____	_____	Pharmacy within Home Health Agency	_____



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<b>Surgical</b>	<b>*Visits</b>	<b>**Beds</b>	<b>Organ/Blood/Tissue</b>	<b>***Annual Receipts</b>
Abortion Clinic	_____	_____	Organ or Tissue Procurement	_____
Birthing Center	_____	_____	(No Direct Processing or Contact)	_____
Emergicenter	_____	_____	Organ or Tissue Procurement	_____
Surgicenter	_____	_____	(Direct Processing or Contact)	_____
College or University Health Center	_____	_____		
Community Health Center	_____	_____	Blood or Plasma Bank	<b>****Donations</b> _____
Crisis Stabilization	_____	_____		
Dialysis	_____	_____		
Health Department	_____	_____		
Urgicenter	_____	_____		
<b>Other</b>	_____	_____		

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\*Visits - Use a threshold count. Count each patient each time they enter your facility for health related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time you visit for health related services.

\*\*Beds - Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.

\*\*\*Annual - This figure can be found on your financial statement. Do not adjust this figure for items such Receipts as profit, uncollectible accounts or amounts billed but not paid by third party payers. However, the number must represent an annual figure.

\*\*\*\*Donations - Use the number of units received from a donor, whether it is from a paid donor or not.

2. Do you use any non-expendable medical, dental or surgical machines or devices for diagnostic monitoring or treatment purposes?  Yes  No
- If yes, how often is the equipment inspected and maintained? \_\_\_\_\_
- a. Who performs the maintenance inspection?  Facility employees  Independent contractors  
If independent contractor, what limits of liability insurance do you require them to carry? \$ \_\_\_\_\_

**PART IV - PROFESSIONAL EMPLOYEES**

Indicate the number of professional employees in each category.

<b>Position</b>	<b>Full-Time</b>	<b>Total FTE</b>	
		(E)mployed/(C)ontracted/(V)olunteers	
Physicians/Surgeons	_____	_____	_____
Aides	_____	_____	_____
Dentists	_____	_____	_____
Dietician's	_____	_____	_____
EMT's	_____	_____	_____
CRNA's	_____	_____	_____
Nurse Midwives	_____	_____	_____
Nurse Practitioners	_____	_____	_____



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<b>Position</b>	<b>Full-Time</b>	<b>Total FTE</b> (E)mployed/(C)ontracted/(V)olunteers	
Occupational Therapists	_____	_____	_____
Oral Surgeon	_____	_____	_____
Pharmacists	_____	_____	_____
Physical/Speech Therapists	_____	_____	_____
Physician/Surgeons	_____	_____	_____
Assistants	_____	_____	_____
Podiatrist	_____	_____	_____
RN's/LPN/LVN's	_____	_____	_____
Social Workers	_____	_____	_____
Technicians	_____	_____	_____
Medical Director	_____	_____	_____
Other (describe)	_____	_____	_____

**PART IV - STAFF PRIVILEGES**

1. Please indicate the number of staff physicians in each of the following categories:

\_\_\_\_\_ Active      \_\_\_\_\_ Consulting      \_\_\_\_\_ Emeritus      \_\_\_\_\_ Provisional  
 \_\_\_\_\_ Associate      \_\_\_\_\_ Courtesy      \_\_\_\_\_ Probationary

2. Are credentials for new staff members checked and approved prior to granting staff privileges?  Yes  No  
By whom? \_\_\_\_\_
3. Are privileges probationary for at least six months for all staff members?  Yes  No
4. Does the applicant have any staff members who are not licensed or who have restricted privileges?  Yes  No  
If yes, please explain on a separate piece of paper.
5. Do department heads evaluate the work of their staff members?  Yes  No  
If yes, are these evaluations done in writing? How often? \_\_\_\_\_
- 
6. Is an ongoing medical audit maintained on all staff members' clinical work?  Yes  No
7. Are all staff privileges reviewed at a minimum of every other year?  Yes  No
8. Does the applicant require foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates?  Yes  No
9. Staff members' medical professional liability insurance:
- a. Are all medical staff members required to maintain medical professional liability insurance?  Yes  No
  - b. Is this requirement stated in the staff by laws?  Yes  No
  - c. What limits are required? \_\_\_\_\_



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d. What evidence of compliance is required? \_\_\_\_\_  
If no, please explain on a separate sheet of paper.

10. Have there been any complaints or suits against the applicant brought by a member of the medical staff?  Yes  No  
If yes, please describe each situation in detail on a separate sheet of paper.

11. Indicate whether or not you require health care professionals providing services for your facility to carry professional liability insurance:

- a. Employed or contracted physicians or surgeons?  
 Yes, in by laws  Yes, in contract  No
- b. Oral surgeons, dentists, nurse anesthetists and nurse midwives?  
 Yes, in by laws  Yes, in contract  No
- c. Contracted allied health care professionals?  
 Yes, in by laws  Yes, in contract  No
- d. Indicate the minimum professional liability insurance limits required for
  - i. Employed or contracted physicians or surgeons \$ \_\_\_\_\_
  - ii. Oral surgeons, dentists, nurse anesthetists and nurse midwives \$ \_\_\_\_\_
  - iii. Contracted allied health care professionals \$ \_\_\_\_\_
- e. Do you require proof of this coverage?  Yes  No  
If no, please explain on a separate piece of paper.

12. Indicate each of the procedures you use when hiring professionals and clinical support staff to provide patient care services at your facility.

- Verify educational background, or residency program, when applicable.
- Check previous employers.
- Check personal references.
- Confirm hospital privileges for physicians, oral surgeons and dentists.  
How often do you update your list of specific privileges? \_\_\_\_\_
- Check for any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
- Require information regarding medical professional claims history that resulted from the performance of or failure to perform professional services. If an individual has had a previous claim, how does that impact your procedures for hiring that person? Are any additional criteria applied?

a. Is each of the above procedures you follow documented?  Yes  No  
If no, please explain on a separate piece of paper.

b. What training do you provide for new clinical support staff (e.g. aides, technicians)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

c. Indicate the type of employees for which you have written job descriptions?  
 Professionals  Clinical support staff  None



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**PART V – ADMISSIONS/DISCHARGE CRITERIA**

1. Is there an admission policy in place?  Yes  No  N/A  
If yes, please describe: \_\_\_\_\_
2. Is there a record and chart protocol in place?  Yes  No  N/A  
If no, please explain: \_\_\_\_\_
3. Is there a discharge policy in place?  Yes  No  N/A  
Is yes, please describe: \_\_\_\_\_
4. How long are orders, consent forms and charts maintained? \_\_\_\_\_

**PART VI – EMERGICENTER, SURGICENTER, BIRTHING CENTERS AND ABORTION CLINICS**

1. Check if the facility is equipped with the following on a 24 hour basis:
- |  |  |
|--|--|
| <input type="checkbox"/> Anesthetics                   | <input type="checkbox"/> Electrocardiograph machine  |
| <input type="checkbox"/> Oxygen                        | <input type="checkbox"/> X-ray machine capable of accommodating an unconscious patient in any position |
| <input type="checkbox"/> Blood (at least "O" negative) |  |
| <input type="checkbox"/> C.P.R. equipment              |  |
2. Are the patients screened to ascertain that they are low risk and are able to withstand having a surgical procedure performed on an outpatient basis?  Yes  No
3. What is the distance and the length of travel time between your facility and the nearest hospital? \_\_\_\_\_
4. Do you have an agreement with a hospital allowing your patients to be directly admitted to that facility in an emergency situation?  Yes  No
5. Do you have an agreement with an ambulance company for transportation of emergency cases?  Yes  No
6. If a critically ill patient must be transferred to a hospital, who accompanies the patient? \_\_\_\_\_  
\_\_\_\_\_
7. What types of follow-up procedures or counseling services are offered to patients? \_\_\_\_\_  
\_\_\_\_\_



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**PART VII – DEVELOPMENTAL DISABILITY REHABILITATION**

1. Do you manufacture any products for sale or provide services as part of vocational training, developmental disabilities workshops or rehabilitation?  Yes  No
  
2. What type of counseling services do you provide? \_\_\_\_\_  
\_\_\_\_\_
  
3. How often are patients seen by professionals and in what context (e.g. daily counseling with social worker and/or monthly evaluation by psychologist)? \_\_\_\_\_  
\_\_\_\_\_

**PART VIII – RISK MANAGEMENT/QUALITY**

1. Risk management/performance improvement
  - a. Who coordinates your risk management program? (Please include name, title, phone and e-mail) \_\_\_\_\_  
\_\_\_\_\_
  
  - b. Is there a written, risk management/quality management program?  Yes  No
  - c. Is there a written performance improvement program that has been approved by a governing body?  Yes  No
  - d. Does the governing body review the effectiveness of the program and approve necessary changes?  Yes  No
  - e. Is the risk manager accountable and solely responsible for risk management?  Yes  No  
If no, explain other responsibilities: \_\_\_\_\_

2. Commercial general liability exposure

Location	Area	Age	Type of Construction	# of Floors	Type of Fire Protection (City, State)
Patient Care Buildings					
Other Buildings					

Attach a separate sheet, if needed.

- a. Are there elevators or escalators on any premises owned, leased or occupied by the insured?  Yes  No  
If yes, how many? \_\_\_\_\_
- b. List the number and type of owned or leased vehicles: \_\_\_\_\_  
\_\_\_\_\_
  
- c. Do you sell or lease any medical equipment or products to patients or others in connection with your operation?  
 Yes  No



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d. Has the applicant sold, acquired, or discontinued any operations in the past ten years?  Yes  No  
If yes, please explain: \_\_\_\_\_

e. Is the applicant considering any changes in operations or products over the next 12 months?  Yes  No  
If yes, please explain: \_\_\_\_\_

3. If interested in umbrella or excess coverage, please provide the following information:

Coverage	Carrier	Policy Dates	Limit	Policy Number
Automobile				
Professional				
General Liability				

Please provide loss information for the above if these lines are being requested.

4. Claims History:

a. Have any claims ever been made against you?  Yes  No  
Please provide currently valued carrier loss runs

b. Are you aware of any incident, circumstance or loss which has occurred after the proposed retroactive date, which is likely to result in a claim?  Yes  No  
If yes, please provide details

Have they been reported to your current or previous carrier(s)?  Yes  No

Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in Questions 1 and 2 is excluded from the proposed coverage.

The applicant represents the above statement and facts are true and that no material facts have been omitted or misstated. This application is material to and relied upon by the company. Completion of this form does not bind coverage. Applicant's acceptance of company's quotation is required before applicant may be bound and a policy issued.

The hospital agrees to cooperate with the company in implementing an ongoing program of loss-control and will allow the company to review and monitor such programs that the hospital undertakes in managing its medical professional exposures.



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**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: \_\_\_\_\_



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**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: \_\_\_\_\_

