MUNICH RE SPECIALTY INSURANCE
HOSPITAL PROFESSIONAL AND GENERAL LIABILITY APPLICATION

Portions of the policy for which this application is made provide claims made and reported coverage, which applies only to claims first made against the insured during the policy period or an applicable extended reporting period and reported in accordance with the policy's reporting provisions. Read the policy and this application carefully and contact your producer with any questions.

INSTRUCTIONS:

- Carefully review and fully answer each of the following questions completely.
- Complete the application in its entirety. Don't leave any question unanswered. If a question does not apply to you, state N/A.
- If additional space is needed to answer any questions fully, attach a separate page.
- This application must be completed, dated and signed by a principal or officer of the business.

Please attach the following:

The items requested below are to be submitted with this application before a quotation can be developed and released.

1. Recently valued loss run (within 6 months of the proposed effective date). Minimum 10 years of historical ground up and unlimited losses including the current or expiring year. (xls format)
2. Copy of most recent accrediting agency report. (TJC, DNV, AOA, CARF, etc.)
3. Copy of most recent state survey report with recommendations and POC, if applicable.
4. Copy of most recent CPA prepared and audited financial statement.
5. Copy of most recent self-insured trust fund report, if applicable.
6. Copy of most recent actuarial funding study, if applicable.
7. Minimum 10 years historical hospital professional liability exposure data. If an actuarial funding study is not available, complete the attached Historical Exposure Data Addendum.
8. Current and historical employed physician exposure data. If an actuarial funding study is not available, include: (a) name, (b) specialty, (c) FTE status, (d) date of hire, (e) retroactive date, (f) termination date. Identify whether employed physicians are provided individual professional liability coverage. Include terminated physicians for whom tail coverage is requested. (xls format)
9. Named insureds to be covered under the policy. Include a brief explanation of the relationship to the applicant and retroactive date, if applicable.
10. Copy of risk management, patient safety and emergency management preparedness plans.
11. Copy of corporate and risk management organizational charts.
12. Copy of claims management procedures.
13. General Liability: provide a schedule of locations owned, leased or operated by the applicant. (xls format)

SECTION I. GENERAL INFORMATION: ☐ New Applicant ☐ Renewal (If Renewal, POLICY NUMBER):_____

1. Employers Federal Tax ID # (FEIN): _____
2. Effective Date of Coverage: ___/___/_____ 3. Retro Date: ___/___/_____
4. Applicant name (the legal name of the hospital or entity to be insured):

_____

5. Corporate Address: _____

City: _____ State: _____ Zip Code: _____

6. Website Address: _____

7. Contact Person: _____ Title: _____

8. E-mail: _____ 9. Phone #:_____ 10. Fax #: _____

11. Number of years the organization has been operating: _____ 12. Number of years under current ownership: _____

13. Applicant is (check all that applies):

☐ Hospital – General Acute Care	☐ Profit	☐ Individual	Accreditations:
☐ Hospital – Children's	☐ Non-Profit	☐ Partnership	☐ TJC
☐ Hospital – Teaching	☐ Governmental	☐ Corporation	☐ DNV
☐ Hospital – Psychiatric		☐ Joint Venture	☐ AOA
☐ Hospital – Rehabilitation			☐ CARF
☐ Hospital – LTAC			☐ Other(s):
☐ Hospital – Women's			
☐ Other – **Please explain**:			

SECTION II. COVERAGE INFORMATION:

Current Insurance Program Coverage: (expand the table with additional rows as needed, or attach separate page)

Primary	Carrier or SIR	Occ. or Claims Made	Effective Date	Retro Date	Limits of Insurance Per Occ/Agg	Deductible	SIR	Premium
Professional Liability			/ /	/ /	$	$	$	$
General Liability			/ /	/ /	$	$	$	$
Employee Benefits Liability			/ /	/ /	$	$	$	$
Other:			/ /	/ /	$	$	$	$
Excess/Umbrella								
Professional Liability			/ /	/ /	$	$	$	$
General Liability			/ /	/ /	$	$	$	$
Employee Benefits Liability			/ /	/ /	$	$	$	$
Automobile Liability			/ /	/ /	$	$	$	$
Employer's Liability			/ /	/ /	$	$	$	$
Helipad			/ /	/ /	$	$	$	$
Non owned Aviation			/ /	/ /	$	$	$	$
Other:			/ /	/ /	$	$	$	$

Has any insured canceled or declined to renew professional liability coverage (**Missouri Residents Do Not Answer**)? ☐ Yes ☐ No
If "yes", please explain_____

Neither the Applicant nor any individual or entity proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they have reason to believe may result in a claim that may fall within the scope of the proposed insurance, except as follows: (If "no", state so): _____

It is agreed that with respect to the immediately preceding question, if any such fact, circumstance, situation, transaction, event, act, error, or omission exists, then such fact, circumstance, situation, transaction, event, act, error, or omission and any claim, proceeding or action arising therefrom is excluded from the proposed coverage.

Insurance Program Coverage Requested (multiple retroactive dates: show the earliest retroactive date below. Submit additional retroactive dates for each insured to be included in coverage).

Primary	Occ. or Claims Made	Effective Date	Retro Date	Limits of Insurance Per Occ/Agg	Deductible	SIR
Professional Liability		/ /	/ /	$	$	$
General Liability		/ /	/ /	$	$	$
Employee Benefits Liability		/ /	/ /	$	$	$
Other:		/ /	/ /	$	$	$
Excess/Umbrella						
Professional Liability		/ /	/ /	$	$	$
General Liability		/ /	/ /	$	$	$
Employee Benefits Liability		/ /	/ /	$	$	$
Automobile Liability		/ /	/ /	$	$	$
Employer's Liability		/ /	/ /	$	$	$
Helipad		/ /	/ /	$	$	$
Non owned Aviation		/ /	/ /	$	$	$
Other*:		/ /	/ /	$	$	$

***Managed Care coverage requests**: Please include a detailed description of the Plan services including the number of enrollees with the submission.

Are expenses included within the Limits of Insurance? ☐ Yes ☐ No

SECTION III. PROFESSIONAL LIABILITY EXPOSURE INFORMATION:

Services (check all that apply):

☐ Ambulance services	☐ Nursery	☐ Bariatric
☐ Ambulance services (911)	☐ Ob/Gyn	☐ Cardiothoracic
☐ Birthing Center	☐ Oncology	☐ Experimental
☐ Blood Bank	☐ Pathology	☐ General
☐ Burn Unit	☐ Pediatrics	☐ Neurosurgery
☐ Day Care (☐ Adult; ☐ Child)	☐ Pharmacy – Other than patient use	☐ Orthopedics
☐ Emergency Department	☐ Psychiatry	☐ Plastic/Cosmetic
☐ Fitness Center	☐ Radiation Therapy	☐ Transplant
☐ Home Health Care	☐ Radiology	☐ Trauma
☐ ICU/CCU	☐ Research/Clinical Trials	☐ Other:
☐ Geriatrics/Long Term Care	**Surgery:**	☐ Other:
☐ NICU	☐ Ambulatory Surgery	☐ Other:

1. Does the organization intend to commence a service identified above within the next 12 months? ☐ Yes ☐ No
   If "yes", please explain _____
2. Does the organization intend to cease a service identified above within the next 12 months? ☐ Yes ☐ No
   If "yes", please explain _____

Beds	No. of Licensed Beds	No. of Occupied Beds Projected next 12 months	No. of Occupied Beds Current Year
Acute Care			
Intensive Care			
Cribs/bassinets			
Pediatrics			
Psychiatric			
Chemical Dependency			
Rehabilitation			
Swing beds			

Long Term Care:			
Skilled Care			
Sub-acute Care			
Assisted Living			
Residential Care			
Intermediate Care:			
Other:			
Other:			
Inpatient Services*		**No. Projected next 12 Mos.**	**No. in Current Year**
Inpatient Surgeries			
Transplant Surgeries			
Bariatric Surgeries			
Vaginal Births			
C-Sections			
VBACs			
Other:			

Outpatient Services*		**No. Projected Services next 12 Mos.**	**No. in Current Year**
Outpatient Surgeries			
Chemical Dependency			
Rehabilitation			
Psychiatric			
Home Health Care			
Clinical			
Emergency Room			
Other:			

*If available, please provide this information in an excel file.

Professional Employees (provide the number of professionals employed by the organization)

Type	No. of Total FTEs	No. of Employed FTEs	No. of Contracted FTEs
Physicians			
Fellows			
Residents			
Interns			
Podiatrists			
Physicians Assistants			
Nurse Midwives			
Doulas			
Nurse Practitioners			
CRNAs			
Anesthesia Assistant			
Dentists			
Oral Surgeons			
Registered Nurses			
LPNs			
Total Number			

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SECTION IV. DEPARTMENT SPECIFIC PROFESSIONAL LIABILITY EXPOSURE INFORMATION:

A. PERIOPERATIVE – SURGICAL SERVICES

1. Are patients/legal surrogates always involved in the marking of the proper surgical site? ☐ Yes ☐ No
   If "no", explain: _____
2. Is a final pre-op "time out" always performed with more than one surgical team member to confirm the correct patient, procedure, side, and site? ☐ Yes ☐ No
   If "no", explain: _____
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. Is there a surgeon on premises 24 hours a day? ☐ Yes ☐ No
   If "no", is travel time to the facility less than 30 minutes? ☐ Yes ☐ No

TRANSPLANT DIVISION

1. Tissue donations: Past 12 months: _____ Projected next 12 months: _____
2. Organ donations: Past 12 months: _____ Projected next 12 months: _____
3. Accreditation(s): ☐ AOPO ☐ AATB ☐ EBAA ☐ Other _____
4. Is there a formal policy regarding the informed consent process? ☐ Yes ☐ No
5. Has the organization been involved in any tissue FDA recalls? ☐ Yes ☐ No
   If "yes", please explain _____
6. Has the organization initiated any voluntary tissue recalls in the past 5 years? ☐ Yes ☐ No
   If "yes", please explain _____
7. Are any tissues procured/recovered from outside the U.S.? ☐ Yes ☐ No
   If "yes", please explain _____
8. Are any non-human tissues used in any way at the organization? ☐ Yes ☐ No
   If "yes", please explain _____
9. Does the organization accept "John Doe" donors? ☐ Yes ☐ No
10. Does the organization participate in a living donor program? ☐ Yes ☐ No
11. Has the organization agreed to unilaterally hold harmless or indemnify others under contract? ☐ Yes ☐ No
12. Does the organization place all organs through UNOS? ☐ Yes ☐ No
    If "no", is a protocol in place to ensure compatibility? ☐ Yes ☐ No
13. Please check all transplant services offered:

☐ OPO	☐ Eye Procurement ("Gift of Life")	☐ Tissue Procurement ("Gift of Life")
☐ Tissue Labeling	☐ Tissue Distribution	☐ Tissue Storage
☐ Tissue Processing	☐ Lab Testing ☐	☐ Other:

B. ANESTHESIA SERVICES

1. Anesthesiology department staffing: ☐ Employed Physicians ☐ Staff Physicians ☐ Contract Group
   ☐ CRNAs ☐ Anesthesia Assistants
2. Service provided by a contract group:
   Name of group: _____
   Does the organization require the contract group to carry professional liability insurance? ☐ Yes ☐ No
   If "yes", what limits are required? $ _____ per occurrence $ _____ annual aggregate.
   ☐ Shared Limits ☐ Individual Physician Limits
   Does the organization require contract physicians to furnish certificates of insurance? ☐ Yes ☐ No
3. Certification: board certified _____% board eligible _____%
4. Is an anesthesiologist on premises 24 hours a day? ☐Yes ☐ No
5. Are CRNAs or AAs employed by the organization? ☐ Yes ☐ No
   If "no", please identify if an independent contractor or employed by a group: _____
6. Is CRNA or AA anesthesia care supervised and reviewed by an anesthesiologist? ☐ Yes ☐ No
   If "no", please explain: _____
7. Do any of the anesthesia department staff routinely work more than a 16-hour shift? ☐ Yes ☐ No
   If "yes", please explain: _____
8. Are oxygen analyzers provided with anesthesia equipment? ☐ Yes ☐ No
9. Can anesthesia equipment alarms be disconnected or inactivated? ☐ Yes ☐ No
   If "yes", under what circumstances is this done? _____

C. RADIOLOGY SERVICES

1. Radiology department staffing: ☐ Employed Physicians ☐ Staff Physicians ☐ Contract Group
2. If service provided by a contract group:
   Name of group: _____
   Does the organization require the contract group to carry professional liability insurance? ☐ Yes ☐ No
   If "yes", what limits are required? $ _____ per occurrence $ _____ aggregate.
   ☐ Shared Limits ☐ Individual Physician Limits
   Does the organization require contract physicians to furnish certificates of insurance? ☐ Yes ☐ No
3. Certification: board certified _____% board eligible _____%
4. Is a radiologist on premises 24 hours a day? ☐ Yes ☐ No
   If "no", is a tele-radiology service available? ☐ Yes ☐ No
   If "no", please explain: _____

D. EMERGENCY SERVICES

1. Emergency department staffing: Employed Physicians ☐ Rotating Staff Physicians ☐ Contract Group ☐
2. If service provided by a contract group:
   Name of group: _____
   Does the organization require the contract group to carry professional liability insurance? ☐ Yes ☐ No
   If "yes", what limits are required? $ _____ per occurrence $ _____ annual aggregate.
   ☐ Shared Limits ☐ Individual Physician Limits
   Does the organization require contract physicians to furnish certificates of insurance? ☐ Yes ☐ No
3. Certification: board certified _____% board eligible _____%
4. Emergency department classification: ☐ Level I (Tertiary) ☐ Level II (Comprehensive) ☐ Level III (Basic)
   ☐ None (Standby) ☐ Other (please explain): _____
5. Are emergency department physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the organization? ☐ Yes ☐ No
6. Emergency department equipment includes: ☐ defibrillator ☐ EKG machine
7. Are all emergency department nurses required to be ACLS certified? ☐ Yes ☐ No
8. Emergency department has: ☐ staffed radiology rooms ☐ dedicated triage area with staff ☐ dedicated trauma room ☐ dedicated lab personnel
9. Do any of the emergency department staff routinely work more than a 16-hour shift? ☐ Yes ☐ No
   If "yes", please explain: _____
10. Are protocols in place for rapid treatment of high-risk presentations, e.g. chest pain, abdominal pain, children with high fever, trauma, and deliveries? ☐ Yes ☐ No
    If "no", explain: _____
11. Do all discharge instructions contain specific written contact information and time frame for follow-up visits? ☐ Yes ☐ No

E. OBSTETRICAL SERVICES

1. Obstetrics department staffing: ☐ Employed Physicians ☐ Independent Medical Staff Members ☐ Contract Group
2. If service provided by a contract group:
   Name of group: _____
   Does the organization require the contract group to carry professional liability insurance? ☐ Yes ☐ No
   If "yes", what limits are required? $ _____ per occurrence $ _____ annual aggregate.
   ☐ Shared Limits ☐ Individual Physician Limits
3. Certification: board certified _____% board eligible _____%
4. Which of the following obstetrical service providers have delivery privileges: ☐ Obstetrician ☐ Family/General Practitioner
   ☐ Certified Nurse Midwife ☐ Physician's Assistant ☐ Other (specify): _____
5. Are nurse midwives subject to the organization's credentialing process? ☐ Yes ☐ No
6. Do nurse midwives perform home deliveries? ☐ Yes ☐ No
   If "yes", does the organization have a written emergency transport policy and procedure in place? ☐ Yes ☐ No
7. Is the organization a regional referral center for high risk pregnancies or newborns requiring intensive care? ☐ Yes ☐ No
   If "no", does the organization have a written high-risk patient and/or newborn transfer policy and procedure in place? ☐ Yes ☐ No
8. Please check the Level(s) of care provided:
   Level I: Well baby ☐ no. bassinets: _____
   Level II: Intermediate care ☐ no. bassinets: _____
   Level III: Neonatal intensive care ☐ no. bassinets: _____
9. Are all C-sections performed by obstetricians? ☐ Yes ☐ No
   If "no", please identify all other specialties performing C-sections: _____

10. Is continuous electronic fetal monitoring performed on all patients in active labor? ☐ Yes ☐ No
    If "no", please explain: _____
11. Is an obstetrician on the premises 24 hours a day? ☐ Yes ☐ No
12. Are labor inducing drugs administered only by an obstetrician? ☐ Yes ☐ No
    If "no", explain:
13. Induction rate: _____% Type of inducing agents administered: _____
14. Are all emergency C-sections performed within 30 minutes? ☐ Yes ☐ No
    If "no", explain:
15. Number of C-sections previous 12 months: _____
16. Number of vaginal births after C-section previous 12 months: _____
17. Are bilirubin levels tested on all neonates prior to routine discharge? ☐ Yes ☐ No
    If "no", explain:

F. BLOOD BANK SERVICES

1. Please identify the screening test(s) utilized by the organization: _____
2. Accreditation(s): ☐ AABB ☐ ARC ☐ ABC ☐ CAP ☐ TJC ☐ Other: _____
3. Is blood or any blood components bought or obtained from outside the U.S.? ☐ Yes ☐ No
   If "yes", explain: _____
4. Does the organization sell or distribute blood or blood components (plasma, red cells, or PRB) to third parties? ☐ Yes ☐ No
   If "yes", explain: _____
5. Does the organization collect blood or blood components (plasma, red cells, or PRB) and use it for other than the treatment and care of patients? ☐ Yes ☐ No
   If "yes", please explain: _____

   If "yes" applies to question 4 or 5 above, please provide the following information:

Annual number of units sold or distributed:	
Annual receipts from units sold:	$
Last AABB accreditation date:	
FDA licensed:	☐ Yes ☐ No

6. Is blood testing outsourced? ☐ Yes ☐ No
   If "yes", provide details: _____
7. Number of volunteer and paid donations in the past 12 months: _____
8. Number of pheresis procedures in the past 12 months: _____
9. Number of outpatient transfusions in the past 12 months: _____
10. Number of therapeutic plasma exchanges in the past 12 months: _____

G. CHILD DAY CARE SERVICES

1. Does the organization own, operate or provide child day care services? ☐ Yes ☐ No (If "no" skip to Section H.)
2. Are services provided on the premises? ☐ Yes ☐ No
3. Is the day care center open to the public? ☐ Yes ☐ No
4. Number of children enrolled in the past 12 months: _____
5. Are day care staff required to be certified? ☐ Yes ☐ No
6. Does the organization conduct a background check for criminal history and abuse or neglect, at a minimum, on all day care staff? ☐ Yes ☐ No
7. Are premises secured during hours of operation? ☐ Yes ☐ No
   Please provide details: _____

H. ADULT DAY CARE SERVICES

1. Does the organization own, operate or provide adult day care services? ☐ Yes ☐ No (If "no" skip to Section H.)
2. Are services provided on the premises? ☐ Yes ☐ No
3. Number of adults enrolled in the past 12 months: _____
4. Are day care staff required to be certified? ☐ Yes ☐ No
5. Does the organization conduct a background check for criminal history and abuse or neglect, at a minimum, on all day care staff? ☐ Yes ☐ No
6. Does the organization provide for dementia patient safety? ☐ Yes ☐ No
   Please provide details: _____

I. PHARMACY SERVICES

1. Does the organization utilize the unit dose system of dispensing medicine? ☐ Yes ☐ No
2. Does all unit dose packaging have barcodes? ☐ Yes ☐ No
   If "no", please explain: _____
3. Do all high-alert drugs undergo an independent double check prior to administration? ☐ Yes ☐ No
   If "no", explain: _____
4. Do clinical pharmacists actively participate in clinical consultations with prescribers? ☐ Yes ☐ No
   If "no", please explain: _____
5. Date (or projected date) of computerized physician order entry implementation: _____
6. Is the pharmacy for patient use only? ☐Yes ☐ No
   If "no", specify annual receipts: $_____
7. Is the pharmacy staffed by a contract group? ☐Yes ☐ No
   Name of group: _____
   Does the organization require the contract group to carry professional liability insurance? ☐ Yes ☐ No
   If "yes", what limits are required? $ _____ per occurrence $ _____ annual aggregate.
   ☐ Limits shared ☐ Individual Pharmacist Limits

J. MEDICAL STAFF PRIVILEGES

1. A committee approves all credentials prior to granting privileges? ☐ Yes ☐ No
   If "no", explain: _____
2. Prior employment verification always includes: ☐ history of previous employment ☐ references
3. All privileges granted to staff physicians are always included in written documentation? ☐ Yes ☐ No
   If "no", explain: _____
4. The probationary period is at least six (6) months? ☐ Yes ☐ No
   If "no", please explain: _____
5. A peer review process is in place. ☐ Yes ☐ No
   If "yes", how frequently? _____ If "no", please explain:
6. The performance of each active medical staff member is periodically reviewed by medical staff committee and/or the organization review board? ☐ Yes ☐ No
7. Number of active medical staff members: _____% board certified _____% board eligible
8. Are non-physician providers (NPPs) required to undergo the same credentialing process as physicians? ☐ Yes ☐ No
   If "no", please explain: _____
9. Disciplinary Actions

In the past 5 years how many medical staff members have had their license:		In the past 5 years how many medical staff appointments has the applicant:	
Denied:		Denied:	
Restricted:		Restricted:	
Suspended:		Suspended:	
Revoked:		Revoked:	

10. Minimum Medical Professional Liability insurance requirements contained in your medical staff by-laws:

Limits of Liability:	$_____Each Professional Incident/$_____ Annual Aggregate
Bylaws require coverage be purchased from a carrier with minimum A.M. Best Rating of A-:	☐ Yes ☐ No If "no", please explain: _____
Extended Reporting Period (ERP) Must Be Purchased or Prior Acts Provided by New Carrier:	☐ Yes ☐ No

K. RESEARCH SERVICES

1. Does the organization sponsor clinical trials? ☐ Yes ☐ No
   If "yes", does the applicant draft protocols for these trials? ☐ Yes ☐ No
2. Does the applicant act as an investigator in the clinical trial process for the product of another party? ☐ Yes ☐ No
3. Are clinical trials being conducted at the applicant's facility? ☐ Yes ☐ No
   If "yes", are these clinical trials approved by the applicant's Institutional Review Board? ☐ Yes ☐ No
4. Do any clinical trials involve the following test subjects:
   Children ☐ Yes ☐ No Pregnant Women or Fetus' ☐ Yes ☐ No
5. Please attach a list of all clinical trials where the applicant is acting as a sponsor. Include the following information:
   (a). clinical trial name (b). protocol number (c). # patients

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SECTION V. RISK & CLAIMS MANAGEMENT INFORMATION:

A. RISK MANAGEMENT

1. Person responsible for risk management: Name/Title: _____
   Phone. No.:_____ Fax No.:_____ E-mail: _____
2. No. years in risk management: _____ Designation(s) (CPHRM, FASHRM, DFASHRM): _____
3. Who does the risk manager report to? _____
4. Does the risk manager have responsibilities other than risk management? ☐ Yes ☐ No
   If "yes", describe: _____
5. Does the risk manager have access to legal counsel for legal advice not directly related to claim activities? ☐ Yes ☐ No
   If "yes", describe: _____
6. Does the Risk Manager participate in the following?

Claims Review:	☐ Yes ☐ No
Contract Evaluation:	☐ Yes ☐ No
Disclosure:	☐ Yes ☐ No
Institutional Review Board Committee:	☐ Yes ☐ No
Patient Representative Concerns:	☐ Yes ☐ No
Policy & Procedure Development:	☐ Yes ☐ No
Performance Improvement Committee:	☐ Yes ☐ No
Risk Management Committee:	☐ Yes ☐ No
Senior Management Committee:	☐ Yes ☐ No
Board of Directors Meetings	☐ Yes ☐ No
Patient Safety Program:	☐ Yes ☐ No
Emergency Management Plan:	☐ Yes ☐ No
Incident Reporting/State Reporting/Sentinel Event Reporting:	☐ Yes ☐ No
Other, specify: _____	

7. Formal Written Risk Management Plan:

The Risk Management Plan was last revised:	
Is the plan approved by the Board of Directors?	☐ Yes ☐ No
Is the plan reviewed annually?	☐ Yes ☐ No

8. Occurrence Reporting:

Is there a non-punitive/just culture for occurrence reporting?	☐ Yes ☐ No
Is there an electronic process for reporting incidents?	☐ Yes ☐ No If "yes", what system is in place? _____

9. Patient Safety Initiatives: please attach a brief description of patient safety initiatives implemented within the past year.
10. Do all clinical services contracts include mutual hold harmless and indemnification agreements? ☐ Yes ☐ No
    If "no", describe the contracted services where these provisions do not exist:
11. Do all clinical services contracts include minimum Professional Liability insurance requirements for the other party? ☐ Yes ☐ No
12. Is simulation lab training required for all clinical areas? ☐ Yes ☐ No
    If "yes", how often: _____ Clinical areas: _____
13. Is an electronic medical records system (EMR) fully integrated at all sites? ☐ Yes ☐ No
    If "no" what is the plan for full integration? _____
14. Does the organization have ANCC Magnet Status? ☐ Yes ☐ No
15. Does the organization have a formal Just Culture Program? ☐ Yes ☐ No

B. CLAIMS MANAGEMENT

1. Who is responsible for claims management activities?
   Name: _____ Title:_____
   Phone No: _____ Fax No: _____ E-mail: _____
2. Is there a written claims management procedure? Yes ☐ No ☐
3. Does a Third-Party Administrator manage claims within the SIR? Yes ☐ No ☐
   If "yes", please provide the firm name and contact information: _____
4. Please provide names of defense firms currently representing the organization: _____

SECTION VI. LIFE SAFETY INFORMATION:

1. Please provide the following:
   # of patient care buildings owned, leased, or operated by the organization _____
   # of other, non-patient care buildings owned, leased, or operated by the organization _____
2. Do all the patient care buildings have:
   Sprinklers? ☐ Yes ☐ No
   Smoke detectors? ☐ Yes ☐ No
   Heat detectors? ☐ Yes ☐ No
   Automatic alarms? ☐ Yes ☐ No
3. Does the organization conduct evacuation drills? ☐ Yes ☐ No
   If "yes", which departments and how often? _____
4. Does the organization conduct fire drills? ☐ Yes ☐ No
   If "yes", how often? _____
5. Does the organization have a written Emergency Management Preparedness Plan? ☐ Yes ☐ No
   If "yes", does the organization complete at least an annual tabletop drill? ☐ Yes ☐ No
6. Is there planned new construction and/or abatement? ☐ Yes ☐ No
   If "yes", please explain: _____
7. Does the organization own or operate a heliport or helipad? ☐ Yes ☐ No
   If "yes", please provide the following:
   Average number of landings per month: _____
   Location: _____
   Is the landing pad FAA approved? ☐ Yes ☐ No
8. Does the organization own, lease, or operate any aircraft? ☐ Yes ☐ No
   If "yes", please attach details. Frequency of use: _____
9. Does the organization own, lease, or operate any watercraft? ☐ Yes ☐ No
   If "yes", please attach details. Frequency of use: _____
10. Has the organization identified and developed back-up systems for the loss of essential utilities, supplies, equipment, and dietary needs? ☐ Yes ☐ No If "no", explain:

SECTION VII. EXCESS AUTOMOBILE LIABILITY INFORMATION:

Please complete all that apply:

Vehicle Type	Service Radius (miles per vehicle)	Number of Urban Use Vehicles	Number of Non-Urban Use Vehicles	Used for Patient Transport?
Private Passenger Delivery				☐ Yes ☐ No
Private Passenger Service				☐ Yes ☐ No
Private Passenger Other				☐ Yes ☐ No
Emergency Ambulance				☐ Yes ☐ No
Non-Emergency Van (< 8 passengers)				☐ Yes ☐ No
Non-Emergency Van (8-15 passengers)				☐ Yes ☐ No
Light Truck Delivery				☐ Yes ☐ No
Light Truck Service				☐ Yes ☐ No
Light Truck Other				☐ Yes ☐ No
Medium Truck				☐ Yes ☐ No
Bus (5-30 passengers)				☐ Yes ☐ No
Bus (> 30 passengers)				☐ Yes ☐ No
Hired & Non-owned Autos				☐ Yes ☐ No
Other:				☐ Yes ☐ No

SECTION VIII. EMPLOYEE BENEFITS LIABILITY & EMPLOYER's LIABILITY INFORMATION:

A. Employee Benefits Liability
   1. Number of employees: _____
   2. Are employee benefits self-administered? ☐ Yes ☐ No
      If "yes", please provide the vendor name: _____

B. Employer's Liability

1. Has any applicant rejected a state Workers' Compensation Act? ☐ Yes ☐ No
   If "yes", indicate entity name and state: _____

ADDITIONAL DOCUMENTS AND INFORMATION INCORPORATED BY REFERENCE

ALL WRITTEN STATEMENTS, MATERIALS OR DOCUMENTS FURNISHED TO THE **INSURER** IN CONJUNCTION WITH THIS **APPLICATION**, REGARDLESS OF WHETHER SUCH DOCUMENTS ARE ATTACHED TO THE POLICY, ARE HEREBY INCORPORATED BY REFERENCE INTO THIS **APPLICATION** AND MADE A PART HEREOF, INCLUDING WITHOUT LIMITATION ANY SUPPLEMENTAL APPLICATIONS OR QUESTIONNAIRES.

LEGAL NOTICE

BEFORE YOU SIGN THIS APPLICATION, READ THESE NOTICES CAREFULLY AND DISCUSS WITH YOUR BROKER IF YOU HAVE ANY QUESTIONS.

FOR THE PURPOSES OF THIS **APPLICATION**, THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE OF ALL PERSON(S) OR ENTITIES PROPOSED FOR THIS INSURANCE DECLARES THAT THE STATEMENTS IN THIS **APPLICATION**, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE.

THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE AGREES THAT IF THE STATEMENTS AND INFORMATION SUPPLIED ON THIS **APPLICATION** OR INCORPORATED BY REFERENCE CHANGES BETWEEN THE DATE OF THIS **APPLICATION** AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE **INSURER** OF SUCH CHANGES, AND THE **INSURER** MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

SIGNING OF THIS **APPLICATION** DOES NOT BIND THE **APPLICANT** OR THE **INSURER** TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THIS **APPLICATION** AND ANY INFORMATION INCORPORATED BY REFERENCE HERETO, SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IS INCORPORATED INTO AND IS PART OF THE POLICY.

SHOULD **INSURER** ISSUE A POLICY, **APPLICANT** AGREES THAT SUCH POLICY IS ISSUED IN RELIANCE UPON THE TRUTH OF THE STATEMENTS AND REPRESENTATIONS IN THIS **APPLICATION** OR INCORPORATED BY REFERENCE HEREIN. ANY MISREPRESENTATION, OMISSION, CONCEALMENT OR INCORRECT STATEMENT OF A MATERIAL FACT, IN THIS **APPLICATION**, INCORPORATED BY REFERENCE OR OTHERWISE, SHALL BE GROUNDS FOR THE RESCISSION OF ANY POLICY ISSUED.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

STATE FRAUD NOTICES

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE **APPLICANT**.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING 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.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

FOR THE PURPOSES OF THIS **APPLICATION**, THE UNDERSIGNED DULY AUTHORIZED REPRESENTATIVE OF ALL PERSON(S) OR ENTITIES PROPOSED FOR THIS INSURANCE DECLARES THAT THE STATEMENTS IN THIS **APPLICATION**, AND IN ANY ATTACHMENTS, ARE TRUE AND COMPLETE.

SIGNATURES

Signed: _____

Date: _____

Title: _____ Organization: _____

(Must be signed by an authorized officer) (Organization's seal)

Producer: _____

License Number: _____

Address: _____

_____

Munich RE

HOSPITAL PROFESSIONAL AND GENERAL LIABILITY
APPLICATION ADDENDUM
HISTORICAL EXPOSURE DATA

Historical Exposure Data:

Provide historical exposure data for at least 10 years prior, not including current or expiring years. *Enter the most recent data starting with **Year 1**.

Occupied Beds	**Yr. 1***	**Yr. 2**	**Yr. 3**	**Yr. 4**	**Yr. 5**	**Yr. 6**	**Yr. 7**	**Yr. 8**	**Yr. 9**	**Yr. 10**
Acute Care										
Crib/Bassinet										
Chemical Dependency										
ICU/CCU										
Pediatrics										
Psychiatric										
Rehabilitation										
Swing beds										
Long Term Care										
Skilled Care										
Sub-acute Care										
Assisted Living										
Residential Care										
Intermediate Care										
Other:										
Other:										
Inpatient Services	**Yr. 1***	**Yr. 2**	**Yr. 3**	**Yr. 4**	**Yr. 5**	**Yr. 6**	**Yr. 7**	**Yr. 8**	**Yr. 9**	**Yr. 10**
Surgeries										
Bariatric Surgery										
Vaginal Births										
C-sections										
VBACs										
Other:										
Outpatient Services	**Yr. 1***	**Yr. 2**	**Yr. 3**	**Yr. 4**	**Yr. 5**	**Yr. 6**	**Yr. 7**	**Yr. 8**	**Yr. 9**	**Yr. 10**
Surgeries										
Chemical Dependency										
Rehabilitation										
Psychiatric										
Home Health Care										
Clinical										
Emergency Room										
Other:										