Louisiana Medical Mutual Insurance Company
One Galleria Blvd., Suite 700 • Metairie • Louisiana • 70001-7510
Phone: 504-831-3756 • 800-452-2120
Fax: 504-841-5300 • 504-841-5205
www.lammico.com

HEALTH CARE FACILITY APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

☐ New Application ☐ Renewal Application – Expiring Policy Number: _____

Please complete a separate application for EACH location if multiple locations exist. If additional space is needed to answer any questions fully, use the Comments Section (Part XIV) or attach a separate page.

DO NOT USE THIS APPLICATION FOR SPECIALTY HOSPITALS

Agency Name (If using Agent):	Agency Address: *(City, State, Zip)*	Producer:

PART I – APPLICANT

Complete Legal Name of Applicant:	Doing Business As:

Applicant Mailing Address: *(Street, City, State, Zip)*	Website Address:

Primary Contact Person:	Primary Contact Title:	Primary Contact Phone:	Primary Contact Fax:	Primary Contact Email:

Contact Person (Accounting):	Contact Title (Accounting):	Contact Phone (Accounting):	Contact Fax (Accounting):
Contact Person (Risk Management):	**Contact Title (Risk Management):**	**Contact Phone (Risk Management):**	**Contact Fax (Risk Management):**

Requested Coverage Effective Date: From: To:	Requested Retro Date:	NOTE: Please attach verification of current retro date *(i.e., copy of current policy declarations page)*

Please attach a copy of your Organizational Chart, Articles of Incorporation and audited Financial Statements for past two years.

Applicant's legal structure *(Check all that apply)*:

☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ For Profit ☐ Not for Profit

Complete the following information for each location you own. Location No. 1 should be the business address for the primary facility.

Business Name & Address *(Street, City, State, Zip)*	Your Ownership Percentage	Description of Operations	Is this location a subsidiary?	Is coverage desired for this location?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

List the following details for each **medical professional** that has a financial interest in your facility.

Name	Profession	Policy No.* *(if LAMMICO insured)*	Interest *(Owner, director, etc.)*	Patient Care For the Facility	Patient Care Outside Practice
				%	%
				%	%
				%	%

If not LAMMICO insured please attach copy of current certificate of insurance.

LAMMICO USE ONLY						
Coverage Start Date:	Retro Date:	Limits / Option:	Facility Code:	Discount:	Parish Code:	Tax Code:

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PART II – LIMITS AND REIMBURSEMENT AMOUNTS*

A. PRIMARY PROFESSIONAL LIABILITY LIMITS

(A separate General Liability application must be completed for General Liability coverage).

Professional Liability

☐ $100,000 Per Claim / $300,000 Total Annual Aggregate
☐ $500,000 Per Claim / $500,000 Total Annual Aggregate
☐ $1,000,000 Per Claim / $3,000,000 Total Annual Aggregate
☐ $2,000,000 Per Claim / $2,000,000 Total Annual Aggregate

B. REIMBURSEMENT AMOUNT*

(Reimbursement amount applies separately to Professional and General Liability)

☐ None ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other_____ ☐ Indemnity Only ☐ Indemnity & Expense

**Reimbursement amount means the amount you would reimburse LAMMICO following a loss and / or loss adjustment expense payment on your behalf.*

PART III – DESCRIPTION OF SERVICES

A. **HEALTH CARE SERVICES PROVIDED** *(Check each box that applies, giving the requested information for each classification. Give projected information for the next 12 months. Complete a separate sheet for each location listed).*

ATTACH ANY BROCHURES, COURSE CATALOGS OR OTHER ADVERTISING MATERIAL USED BY YOUR FACILITY.

Counseling / Rehabilitation	**Visits** [1]	**Beds** [2]
☐ Cardiac Rehab		
☐ Developmental Disability		
☐ Mental Health / Counseling		
☐ Physical or Occupational Rehab		
☐ Substance Abuse		
Counseling		
Residential		
Skilled Medical Services		
☐ Trauma Rehabilitation		
Therapy		
Transitional Living		
Skilled Medical		
☐ Weight Loss Center		

Surgical		
☐ Abortion Clinic		
☐ Birthing Center		
☐ Emergicenter		
☐ Surgicenter		
☐ Bariatrics		

Home Care / Hospice	
☐ Hospice Care	
☐ Intravenous Therapy	
☐ Personal / Companion Care	
☐ Rehabilitation Therapy	
☐ Respiratory Therapy	
☐ Skilled Care	

Other	**Annual Receipts** [3]	**Beds** [2]
☐ Sleep Disorder Services		

Laboratory	**Annual Receipts** [3]
☐ Dental	
☐ Medical	
☐ Ocular	
☐ Optical Establishment	
☐ Pathology	
☐ Pharmacy	
☐ Quality Control / Reference	
☐ Research / Development	
☐ X-Ray / Imaging Center	
☐ CAT Center	
☐ PET Center	
☐ MRI Center	
☐ Mammography	
☐ Lithotripsy	

Organ / Blood / Tissue	
☐ Organ or Tissue Procurement (No Direct Processing or Contact)	
☐ Organ or Tissue Procurement (Direct Processing or Contract)	

	Donations [4]
☐ Blood or Plasma Bank	

Treatment	**Visits** [1]	**Beds** [2]
☐ College / University Health Center		
☐ Community Health Center		
☐ Crisis Stabilization		
☐ Dialysis		
☐ Health Department		
☐ Urgicenter		
☐ Pain Management [5]		
☐ Physicians Clinic		

[1] 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.

[2] Beds Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.

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

[4] Donations Use the number of units received from a donor, whether it is from a paid donor or not.

[5] Additional Pain Management Supplement required

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B. Does the Applicant anticipate any facility expansions (increase in licensed beds, new services) within the next year? ☐ Yes ☐ No

If yes, please provide details: _____

C. Are any medical services provided by the facility performed outside the State of Louisiana? ☐ Yes ☐ No
*(i.e., home health, outpatient, **telemedicine**, etc.)*

D. Do you provide services to correctional facility inmates? ☐ Yes ☐ No

If yes, how often? _____ Name of Facility serviced: _____

E. 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? _____

The maintenance is performed by: ☐ Facility Employees ☐ Independent Contractors

If Independent contractor, what limits of liability insurance do you require them to carry? _____

F. Do you sell or lease any medical equipment or other products in connection with your operation? ☐ Yes ☐ No
If yes, answer the questions below and describe the equipment in the Comments Section (Part XIV).

Do you repackage or redesign the equipment you sell or lease? ☐ Yes ☐ No
If yes, describe in the Comments Section (Part XIV).

Do you service the equipment you sell or lease? ☐ Yes ☐ No

If no, who provides preventative maintenance? _____

What limits of liability insurance do you require them to carry? $ _____

What are your annual receipts from the sale or lease of medical equipment? $ _____

For the following questions, please explain all "Yes" answers in the Comments Section (Part XIV).

G. Do you conduct or assist in conducting training programs for other Institutions (Universities, Colleges, etc)? ☐ Yes ☐ No

H. Do you conduct formal clinical research under the auspices of an Institutional Review Board (IRB)? ☐ Yes ☐ No

I. Do you conduct medical and / or surgical experimentation that is not approved by an Institutional Review Board (IRB)? ☐ Yes ☐ No

J. Do you administer non-FDA approved pharmaceuticals (experimental drugs)? ☐ Yes ☐ No

K. Do you conduct bio-medical device research and development? ☐ Yes ☐ No

L. Do you conduct animal research? ☐ Yes ☐ No

M. Do you purchase separate coverage for clinical trails? ☐ Yes ☐ No

N. Is the primary facility named in this application an additional insured under a sponsor's clinical research policy? ☐ Yes ☐ No

O. Have you ever received a Regulatory Letter from the Office of Human Research Protections or from the Department of Health & Human Services or any other Regulatory organization? ☐ Yes ☐ No

PART IV – GENERAL INFORMATION

A. Indicate the number of years the primary facility has been:

Operating: _____ Owned by present owners: _____ Managed by Present Management: _____

B. List all licenses held by your facility, including type and expiration dates.	C. List all accreditations (e.g., JCAHO, DHHS, CAP) and association memberships held by your facility

D. Has your license been suspended, revoked or placed under probation within the last three years? ☐ Yes ☐ No
(If "yes", please indicate the date and provide details below. Use the Comments Section (Part XIV) for additional space if necessary).

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PART V – CONTRACTUAL AGREEMENTS

A. Does your facility have any signed contracts which require your facility to name another party as additional insured or extend contractual indemnity coverage? *(If "yes", please include a copy of contract)* ☐ Yes ☐ No

B. Do you lease or rent any medical equipment from others? ☐ Yes ☐ No

If yes, describe. _____

If yes, do you indemnify (hold harmless) the owner for liability? ☐ Yes ☐ No

C. Have you signed any contractual agreements where you have agreed to provide services to others? ☐ Yes ☐ No

If yes, describe the types of services. _____

D. Have you signed any contractual agreements where others are providing services to you? ☐ Yes ☐ No

(If "yes", please specify below)

	Limit		Limit
☐ Emergency Room	$ _____	☐ Physical / Occupational Therapy	$ _____
☐ Laboratory / Pathology	$ _____	☐ Respiratory Therapy	$ _____
☐ Pharmacy	$ _____	☐ Other _____	$ _____
☐ Radiology / Nuclear Medicine	$ _____	☐ Other _____	$ _____
☐ Anesthesia	$ _____	☐ Other _____	$ _____
☐ Home Health Care	$ _____	☐ Other _____	$ _____
☐ Emergency Room	$ _____	☐ Other _____	$ _____

Do you require proof of this coverage? *If no, please explain in the Comments Section (Part XIV)* ☐ Yes ☐ No

E. Is any part of your facility operated/leased by a management corporation? *(If "yes", please include a copy of contract)* ☐ Yes ☐ No

F. Is your facility involved in the management of any other facility, hospital services or health care provider? *(If "yes", please include a copy of contract)* ☐ Yes ☐ No

PART VI – ADMINISTRATION AND STAFF

TO BE COMPLETED BY ALL APPLICANTS.

A. Medical Director

Do you employ / contract a medical director? ☐ Yes ☐ No

If yes, does your Medical Director have direct patient contact? ☐ Yes ☐ No

Name of Medical Director	Specialty	Insurance Carrier and Policy Number*	Board Status	Employment Status
			☐ Board Certified ☐ Eligible	☐ Employee ☐ Contractor

B. Physicians and Surgeons**

Physicians and Surgeons Names	Specialty	Insurance Carrier and Policy Number	Board Status	Employment Status
			☐ Board Certified ☐ Eligible	☐ Employee ☐ Contractor

If not LAMMICO insured please attach copy of current certificate of insurance.
****Attach copy of Physician Service Contracts. Include additional names and information in the Information Section (Section IV)***

C. Allied Health Care Professionals – *Indicate the number of personnel in each applicable category.*

	Employees		Contract			Employees		Contract	
	Full-Time	Part-Time	Full-Time	Part-Time		Full-Time	Part-Time	Full-Time	Part-Time
CRNA's*					Lab Technicians				
Interns*					LPN / LVN's				
Midwives*					Paramedics / EMT's				
Nurse Practitioners*					RN's				
Pharmacists*					X-Ray Technicians				
Physician's Assistants*					Other (describe)				
Perfusionists*									
Residents / Fellows*									
Surgeon's Assistants*									

**Separate LAMMICO application is required for coverage*

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D. Insurance Requirements for the Applicable Staff Listed in A, B & C Above – *Please explain any no answers in the Comments Section (Part XIV).*

a. Are all staff members required to maintain medical professional liability insurance? ☐ Yes ☐ No

b. Is this requirement stated in the staff bylaws?* ☐ Yes ☐ No

c. What limits are required? _____

d. What evidence of compliance is required?

If this is a new business submission, or if you have had a change in your bylaw this past year, please submit a copy of the staff bylaw.

E. Hiring / Screening Procedures

Check below 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.
☐ Check criminal history.
☐ Require information regarding medical professional claims history that resulted from the performance 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?

_____

_____

Are each of the above procedures you follow documented? ☐ Yes ☐ No
(If no, please explain in the Comments Section (Part XIV)).

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

_____

_____

Indicate the type of employees for which you have written job descriptions? ☐ Professionals ☐ Clinical Support Staff ☐ None

PART VII – RISK MANAGEMENT

A. Do you have a full-time Risk Manager? ☐ Yes ☐ No

If full time, please provide a job description and Curriculum Vitae for your current Risk Manager. If other than full-time, indicate nature of employment activities *(i.e., Quality Improvement, Safety Coordinator, etc.)*

_____

_____

B. Is there a written, formalized Risk Management program? *(If yes, please attach a copy of the program)* ☐ Yes ☐ No

Is the program reviewed for effectiveness and necessary changes implemented? ☐ Yes ☐ No

C. Do you have a formalized Quality Improvement program? *(If yes, please attach a copy of the program)* ☐ Yes ☐ No

D. Do you have a formalized Patient Safety program? *(If yes, please attach a copy of the program)* ☐ Yes ☐ No

E. Do you have a formalized Evacuation Plan? *(If yes, please attach a copy of the plan)* ☐ Yes ☐ No

PART VIII – ADMISSION / DISCHARGE CRITERIA

A. Is there an admission policy in place? *If no, please explain in the Comments Section (Part XIV)* ☐ Yes ☐ No ☐ N/A

B. Are there record and chart protocols in place? *If no, please explain in the Comments Section (Part XIV)* ☐ Yes ☐ No ☐ N/A

C. Is there a discharge policy in place? *If no, please explain in the Comments Section (Part XIV)* ☐ Yes ☐ No ☐ N/A

D. How long are orders, consent forms and charts maintained? _____

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PART IX – SURGICAL SERVICES

A. Are patients screened to ascertain that they are low-risk and are able to withstand having a surgical procedure performed on an outpatient basis? *If no, please explain in the Comments Section (Part XIV).* ☐ Yes ☐ No ☐ N/A

B. What is the distance and the length of travel time between your facility and the nearest hospital?

C. Do you have an agreement with a hospital allowing your patients to be directly admitted to that facility in an emergency situation? ☐ Yes ☐ No ☐ N/A

D. Do you have an agreement with an ambulance company for transportation of emergency cases? ☐ Yes ☐ No ☐ N/A

E. If a critically ill patient must be transferred to a hospital, who accompanies the patient?

F. What types of follow-up procedures or counseling services are offered to patients? ☐ None

PART X – REHABILITATION SERVICES

A. Do you manufacture any products for sale or provide services as part of vocational training, developmental disabilities workshops or rehabilitation? ☐ Yes ☐ No ☐ N/A

If yes, describe and indicate annual receipts.

B. What type of counseling services do you provide? ☐ None

C. 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 XI – HOME HEALTH CARE

A. Are home health care services provided under the direction and supervision of a physician based on physician orders and plan of care? ☐ Yes ☐ No ☐ N/A

If no, please explain.

B. Is there a comprehensive orientation program for home care staff and volunteers? ☐ Yes ☐ No ☐ N/A

If no, please explain.

Is there in-service training related to:

☐ High-technology equipment areas ☐ Safe client lifting, transferring, and ambulating techniques

☐ Proper use of equipment ☐ Infection control and safety

Which of the following assessments and evaluations of employees are documented?

☐ Training ☐ Competence level ☐ Other:

For the following questions, please explain all "No" answers in the Comments Section (Part XIV).

C. Are there policies and procedures for safe procurement, storage, distribution, use and disposal of drugs, in compliance with state and federal regulations? ☐ Yes ☐ No

D. Is there documentation of the home health care services provided? ☐ Yes ☐ No

E. Is patient care reviewed by supervisors to ensure compliance with acceptable standards? ☐ Yes ☐ No

F. Do you retain clinical records according to federal, state and local laws and regulations? ☐ Yes ☐ No

G. Do you have written guidelines for emergency services? ☐ Yes ☐ No

H. What is the average length of time your employees and contracted staff remain employed / contracted with your home health agency?

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PART XII – CURRENT PROFESSIONAL LIABILITY COVERAGE

Complete questions A through E for new business ONLY.

A. Current professional liability coverage.

Current Carrier:		Policy Period From:	To:
Current Limits of Liability: $_____ Each Person $_____ Total Limit	Deductible:	☐ Occurrence ☐ Claims Made	If Claims Made, state retro date:

B. Have you had any professional claims or suits made against your facility during the last ten years? (*If yes, provide a current loss summary from your present or previous carrier)* ☐ Yes ☐ No

C. Do you have knowledge of any allegation that might be made against you that might give rise to a claim or suit in the future? *(If yes, please attach a description of each claim)* ☐ Yes ☐ No

D. Do you have knowledge of any activities or incidents that might give rise to a claim or suit in the future? *(If yes, please attach a description of each activity or incident. Include any non-billing or non-record transfer request for medical records)* ☐ Yes ☐ No

E. Has any insurer cancelled, declined to issue, or non-renewed your Professional Liability Insurance coverage? *(If "Yes", please attach an explanation including the name of the carrier, the date and the reason)* ☐ Yes ☐ No

F. For renewal business, have you reported any losses to your prior carrier during the past year? (*If yes, please attach a description of each loss)* ☐ Yes ☐ No

PART XIII – APPLICANT NOTICE AND DECLARATION

The Applicant expressly represents and warrants that the above statements and facts are true and correct and that no material facts have been suppressed or misstated. Applicant specifically acknowledges that LAMMICO has relied on statements contained in this application to issue coverage, particularly as to claims made and prior acts or retro coverage as to disclosing all incidents occurring in the last ten (10) years where Applicant knows or has reason to believe a claim may be made in the future. Any failure to disclose material facts affecting coverage, losses and premiums, including incidents that have occurred at the time of this application, but not made until after coverage is instituted may constitute a material misrepresentation or fraud causing the denial of coverage.

I understand the submission of this application does not bind LAMMICO to issue me, or our institution to purchase, this insurance. By signing below, I grant permission (1) to LAMMICO to contact third parties and (2) for third parties to release to LAMMICO information which relates to the issuance and continuation of this coverage. I also understand that knowingly providing false, incomplete or misleading information to LAMMICO the purpose of defrauding LAMMICO may constitute a crime punishable by imprisonment, fines, and/or a denial of insurance benefits.

I represent the information provided in this application (and attachments) is true. I understand (1) that this application and any previous applications are the basis of and will become a part of the coverage contract with LAMMICO; (2) that the application information I provided is material to LAMMICO; (3) that LAMMICO is relying on this information in determining whether to issue a coverage contract and in establishing the premium to charge for the contract; and (4) that LAMMICO may rescind or void the coverage contract if this application or any previous application contains any misrepresentations or omission. Furthermore, I understand that my failure to disclose to LAMMICO any material fact that I become aware of subsequent to the completion of this application but prior to the effective date of the coverage may also void the contract.

Applicant Signature	Title	Date

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PART XIV – COMMENTS SECTION