LOUISIANA HOSPITAL

Application for Professional Liability Insurance

In order to allow adequate time for our underwriting review process, we ask that you please submit your application at least 30 days in advance of your requested effective date. Incomplete submissions or lack of required information will delay the underwriting process. After your application has completed the underwriting process, you will be promptly notified.

Please read the following instructions in order to expedite the review of your application:

1. Save this PDF to your local computer
2. Answer all questions or mark “N/A” where appropriate
3. Save and print your document
4. Sign and date your application
5. Fax the signed application to 504.841.5205 or scan the signed application to email to your Underwriter

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to required attachments listed in the below application, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

If you have questions, please call the Underwriting Department at 504.831.3756 or 800.452.2120.

Thank you for your interest in LAMMICO. We look forward to serving your dental professional liability insurance needs.

When completed, please remit this application to:

LAMMICO
One Galleria Blvd., Suite 700
Metairie, LA 70001
FAX: 504.841.5205

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LOUISIANA HOSPITAL APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

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

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

Agency Name (if using agent)	Agency Address (include city, state, zip)	Producer

Part I: Applicant

Hospital Name	AHA Number	Tax ID Number (TIN)

Applicant Mailing Address (include 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)

(LAMMICO Use Only)

Coverage Start Date _____

Retro Date _____ Limit/Option _____

Parish Code _____ Tax Code _____

Discount Code _____ Discount _____ %

Requested Effective Date: _____ / _____ / _____
MM DD YYYY

Requested Retro Date: _____ / _____ / _____
MM DD YYYY

NOTE: Please attached 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.

Type of Hospital

☐ General ☐ Children's ☐ Psychiatric ☐ Teaching ☐ Specialty (type) _____ ☐ Other _____

Applicant's Legal Structure (check all that apply)

☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Governmental ☐ Charitable ☐ For Profit ☐ Not For Profit ☐ Medicare-Approved

For teaching hospitals, please identify medical school(s) affiliation(s) in the Comments Section (Part XIII).

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

Business Name & Address (street, city, state, zip)	Your Ownership Percentage	Description of Operations	Is this location a subsidiary?	Is this 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 hospital.

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.

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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).

- ☐ $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
- ☐ Higher Limits: Please refer to Company

B. Reimbursement Amount*

(Reimbursement amount applies separately to Professional and General Liability).

- ☐ None ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000
- ☐ 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. Medical Professional Services Provided (Check each box that applies for the primary facility listed in this application)

- ☐ Abortions
- ☐ Ambulance Services
- ☐ Assisted Living
- ☐ Bariatrics
- ☐ Bariatric Surgery
- ☐ Birthing Center
- ☐ Blood Bank
- ☐ Burn Unit
- ☐ Cardiac Cath Lab
- ☐ Cardiac Rehab Services
- ☐ Complimentary Medicine
- ☐ Coronary Care Unit
- ☐ Day Care (Adult/Child)
- ☐ Department of Corrections
- ☐ Dialysis
- ☐ Emergency Services
- ☐ Fertility Clinic
- ☐ Gender Reassignment Surgery
- ☐ Genetic Counseling/Research
- ☐ HMO
- ☐ Home Health Care
- ☐ Hospice
- ☐ Hospital Foundation
- ☐ Hyperbaric Treatment
- ☐ Inhalation Therapy
- ☐ Laboratory
- ☐ Lifeline
- ☐ Long Term Care
- ☐ Medical Advice Line/TeleMed
- ☐ Mobile Units/Services (Bloodmobile, Mammography, CT)
- ☐ Neonatal Intensive Care
- ☐ Nursing Home
- ☐ Nursery
- ☐ Observation Unit
- ☐ OB/GYN
- ☐ Occupational Health
- ☐ Offsite Food Service
- ☐ Oncology
- ☐ Offsite - Other
- ☐ Open Heart
- ☐ Outpatient Surgi-Center
- ☐ Pain Management
- ☐ Pastoral Care
- ☐ Pediatrics
- ☐ Pediatric ICU
- ☐ Pharmacy
- ☐ Psychiatric
- ☐ Pulmonary Rehab Services
- ☐ Radiation Therapy
- ☐ Refractive Surgery
- ☐ Robotic Surgery
- ☐ Skilled Nursing Care
- ☐ Sleep Disorder Services
- ☐ Sports Medicine
- ☐ Surgery (General)
- ☐ Trauma
- ☐ Urgent Care
- ☐ Wellness/Fitness Services
- ☐ Other

B. Inpatient Services

Bed Type	Total # Licensed Beds	Average ADC*	Projected ADC*
1. Acute - Adult			
2. Acute - Pediatric			
3. OB/Maternity (LDRP)			
4. Cribs/Bassinets			
5. ICU/CCU			
6. PICU/NICU			
7. Long Term Acute Care (LTAC)/Extended Care			
8. Psychiatric - Adult			
9. Psychiatric - Adolescent			
10. Chemical Dependency			
11. Trauma Rehab			
12. Skilled Nursing (Swing Beds)			
13. Hospice			
14. Other: _____			

*ADC: Average Daily Census: Total annual inpatient days divided by 365

Services/Procedures	Number in Current Year	Number in Projected 12 Months
1. Inpatient Surgeries		
2. Births (includes C-Sections & VBACs)		
3. C-Sections		
4. VBACs		
5. Other: _____		

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C. Outpatient Services

Services/Procedures	Number in Current Year	Number in Projected 12 Months
1. Outpatient Surgeries.....	_____	_____
2. Outpatient Clinic Visits.....	_____	_____
3. Emergency Room Visits.....	_____	_____
4. Fast Track Visits.....	_____	_____
5. All Other Hospital-Based Outpatient Visits*..... (Radiology, Laboratory, Physical/Occupational Therapy, Psychiatric, Alcohol/Drug Therapy, Counseling, Endoscopic Procedures, etc.)	_____	_____
6. Home Care - Personal Care.....	_____	_____
7. Home Care - Skilled Care.....	_____	_____
8. Home Care - Rehabilitation.....	_____	_____
9. Home Care - Intravenous Therapy.....	_____	_____
10. Home Care - Durable Equipment.....	_____	_____

*Outpatient Visits: Each appearance of an outpatient in a hospital outpatient unit, regardless of the number of procedures / treatments performed within each unit (AHA Def.). Report VISITS to outpatient units, NOT "occasions of service." Report number of visits to patient homes for home health care services. Outpatients are persons, not lodged in the hospital, who receive medical, dental or other health-related services

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

If *yes*, please describe: _____

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

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

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

G. 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 contractors, what limits of liability insurance do you require them to carry? _____

H. 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 XIII).

Do you repackage or redesign the equipment you sell or lease? ☐ Yes ☐ No

If *yes*, describe in the Comments Section (Part XIII).

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 XIII).

I. Do you conduct or assist in conducting training programs for other institutions (universities, colleges, etc.)? ☐ Yes ☐ No

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

K. Do you conduct medical and/or surgical experimentation that is not approved by an IRB? ☐ Yes ☐ No

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

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

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

O. Do you purchase separate coverage for clinical trials? ☐ Yes ☐ No

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

Q. 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

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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	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 XIII) for additional space if necessary.

_____

_____

Part V: 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** (Please complete for each specialty. Use the Comments Section (Part XIII) for additional specialties)

Specialty	Number of Employed Physicians & Surgeons	Number of Contract Physicians & Surgeons	Number of Staff with Privileges

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

**Attach copy of Physician Service Contracts. Separate LAMMICO application is required for coverage.

C. Allied Healthcare 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
CRNAs*					Lab Technicians				
Interns*					LPN/LVNs				
Midwives*					Paramedics/EMTs				
Nurse Practitioners*					RNs				
Pharmacists*					X-ray Technicians				
Physician's Assistants*					Other (describe)				
Perfusionists*									
Residents/Fellows*									
Surgeon's Assistants*									

*Separate LAMMICO application is required for coverage

Do the **pharmacists** that are employed by your facility dispense prescriptions to:

Discharged patients ☐ Yes ☐ No

Non-hospital patients ☐ Yes ☐ No

D. Insurance Requirements for the Applicable Staff Listed in A and B Above

Please explain any "No" answers in the Comments Section (Part XIII)

1. Are all staff members required to maintain medical professional liability insurance? ☐ Yes ☐ No
2. Is this requirement stated in the staff bylaws?* ☐ Yes ☐ No
3. What limits are required? _____
4. 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 XIII).

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 VI: Contractual Agreements

A. Does your facility have any signed contracts that require your facility to name another party as additional insured or extend contractual indemnity coverage? ☐ Yes ☐ No
If *no*, please explain in the Comments Section (Part XIII).

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 and include the minimum professional liability limits required:

	Limit		Limit
☐ Emergency Room	$ _____	☐ Physical/Occupational Therapy	$ _____
☐ Laboratory/Pathology	$ _____	☐ Respiratory Therapy	$ _____
☐ Pharmacy	$ _____	☐ Nursing Services	$ _____
☐ Anesthesia	$ _____	☐ Other: _____	$ _____
☐ Home Health Care	$ _____	☐ Other: _____	$ _____

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

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

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

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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? ☐ Yes ☐ No
If *yes*, please include a copy of the program.
Is the program reviewed for effectiveness and necessary changes implemented? ☐ Yes ☐ No

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

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

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

Part VIII: Admission/Discharge Criteria

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

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

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

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

Part IX: Anesthesia Services

A. Anesthesia Staffing is provided by: (Check all that apply)

☐ Employed Physicians ☐ Contract Physicians ☐ Residents ☐ CRNAs

B. If you checked "CRNAs" in question A, indicate the relationship between the Applicant and the CRNAs below.

Employed by the Applicant ☐ Yes ☐ No
Employed by the Anesthesiologist ☐ Yes ☐ No
Employed by the Surgeon ☐ Yes ☐ No
Independent ☐ Yes ☐ No
Do CRNAs work under the direct supervision of an anesthesiologist?*

*If *no,* please submit written guidelines developed with the collaborative physician or qualified physician designee of the primary physician or the dentist responsible for the patient's immediate care.

C. Describe the minimum qualifications required for the administration of general anesthesia:

_____

_____

_____

_____

Part X: Radiology Services

A. Radiology Staffing is provided by: (Check all that apply)

☐ Employed Physicians ☐ Contract Physicians ☐ Residents

B. If Teleradiology is in use, please describe how below: ☐ N/A

_____

_____

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Part XI: 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 If Claims-Made, state retro date: ☐ Claims-Made

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

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? ☐ Yes ☐ No
If *yes*, please attach a description of each claim.

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

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

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

Part XII: 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**

Part XIII: Comments Section

Question No.	Remarks (Attach additional sheets, if necessary)