



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: (City, State, Zip)	Producer:
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PART I – APPLICANT

Hospital Name:	AHA Number:	Tax ID# (TIN)
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Applicant Mailing Address: (Street, City, State, Zip)	Website Address:
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Primary Contact Person:	Primary Contact Title:	Primary Contact Phone:	Primary Contact Fax:	Primary Contact Email:
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Contact Person (Accounting):	Contact Title (Accounting):	Contact Phone (Accounting):	Contact Fax (Accounting):
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Contact Person (Risk Management):	Contact Title (Risk Management):	Contact Phone (Risk Management):	Contact Fax (Risk Management):
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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)
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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 schools 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 coverage desired for this location?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	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:



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 (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
- Vascular 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
- Intensive Care Unit
- 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
- Organ/Tissue Transplant
- Outpatient Surgi-Center
- Pain Management
- Pastoral Care
- Pediatrics
- Pediatric ICU
- Pharmacy
- Physician's Clinic
- Psychiatric
- Pulmonary Rehab Services
- Radiation Therapy
- Refractive Surgery
- Robotic Surgery
- Skilled Nursing Care
- Sleep Disorder Services
- Sports Medicine
- Surgery (General)
- Transportation Services
- 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

SERVICES / PROCEDURES	Number in Current Year	Number in Projected 12 Months
1. Inpatient Surgeries	_____	_____
2. Births (includes C-Sections & VBAC's)	_____	_____
3. C-Sections	_____	_____
4. VBAC's	_____	_____
5. Other (Please Specify) _____	_____	_____



C. OUTPATIENT SERVICES

SERVICES / PROCEDURES

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 provide details: _____

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 contractor, 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 Institutional Review Board (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 trails? 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



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?
 (If "yes", please indicate the date and provide details below. Use the Comments Section (Part XIII) for additional space if necessary). Yes No

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
			<input type="checkbox"/> Board Certified <input type="checkbox"/> Eligible	<input type="checkbox"/> Employee <input type="checkbox"/> 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 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

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 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 and include the minimum professional liability limits required)

	Limit		Limit
<input type="checkbox"/> Emergency Room	\$ _____	<input type="checkbox"/> Physical / Occupational Therapy	\$ _____
<input type="checkbox"/> Laboratory / Pathology	\$ _____	<input type="checkbox"/> Respiratory Therapy	\$ _____
<input type="checkbox"/> Pharmacy	\$ _____	<input type="checkbox"/> Nursing Services	\$ _____
<input type="checkbox"/> Radiology / Nuclear Medicine	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Anesthesia	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Home Health Care	\$ _____	<input type="checkbox"/> Other _____	\$ _____
<input type="checkbox"/> Emergency Room	\$ _____	<input type="checkbox"/> Other _____	\$ _____

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

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

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

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 CRNA's

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

Employed by the Applicant..... Yes No

Employed by the Anesthesiologist..... Yes No

Employed by the Surgeon..... Yes No

Independent..... Yes No

Do CRNA's work under the direct supervision of an anesthesiologist?*..... Yes No

*** 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



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:		Deductible:	<input type="checkbox"/> Occurrence If Claims Made, state retro date:
\$ _____ Each Person	\$ _____ Total Limit		<input type="checkbox"/> Claims Made

- 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 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

