

LAMMICO

OUTPATIENT HEALTHCARE FACILITY

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 note that this application should not be used for Hospital submissions.

Please read the following instructions to expedite the review of your application. Complete and submit all requested information and/or required attachments:

1. All application questions must be fully answered. If a question does not apply, please write "N/A" where appropriate.
2. Complete the attached Claim Addendum if a claim or suit has been filed against you.
3. Submit a loss summary report from your previous carrier(s) – 10 years if applicable.
4. Provide a copy of your current professional liability policy or declarations page.
5. Provide a copy of your Organizational Chart and Articles of Incorporation.
6. For Louisiana submissions, include a copy of the completed Patient's Compensation Fund Hospital
7. Application.
8. If you need more space for your responses, continue in the Comments Section indicating question number.
9. Sign and date your application.

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (3) above, 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 medical professional liability insurance needs.

When completed, please remit this application to:

LAMMICO

One Galleria Blvd., Suite 700

Metairie, LA 70001

FAX: 504.841.5205 or 504.841.5300



OUTPATIENT HEALTHCARE FACILITY APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

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 or attach a separate page.

Agency Name (If using Agent):	Agency Address: (City, State, Zip)	Producer:
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PART I – APPLICANT INFORMATION

Complete Legal Name of Applicant:	Doing Business As:	Tax ID# (TIN):	NPI Number:
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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 (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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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?
			<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 facility.

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.**

PART II – CURRENT PROFESSIONAL LIABILITY COVERAGE

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: <input type="checkbox"/> Claims Made
\$ _____ Each Event \$ _____ Total Limit		

- 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



PART III – LIMITS AND REIMBURSEMENT AMOUNTS*

A. PRIMARY PROFESSIONAL LIABILITY LIMITS

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

Professional Liability	
<input type="checkbox"/> \$100,000 Per Claim / \$300,000 Total Annual Aggregate	<input type="checkbox"/> \$1,000,000 Per Claim / \$3,000,000 Total Annual Aggregate
<input type="checkbox"/> \$2,000,000 Per Claim / \$2,000,000 Total Annual Aggregate	<input type="checkbox"/> Other: Please refer to Company

B. REIMBURSEMENT AMOUNT (DEDUCTIBLE)*

<input type="checkbox"/> None	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> Other _____	<input type="checkbox"/> Indemnity Only	<input type="checkbox"/> Indemnity & Expense
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*Reimbursement amount means the amount you would reimburse LAMMICO following a loss and / or loss adjustment expense payment on your behalf.

PART IV – 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.

	Visits ¹	Beds ²	Laboratory	Annual Receipts ³	Beds ²
Counseling / Rehabilitation					
<input type="checkbox"/> Cardiac Rehab	_____	_____	<input type="checkbox"/> Dental	_____	
<input type="checkbox"/> Developmental Disability	_____	_____	<input type="checkbox"/> Medical	_____	
<input type="checkbox"/> Behavioral Health / Counseling	_____	_____	<input type="checkbox"/> Ocular	_____	
<input type="checkbox"/> Physical or Occupational Rehab	_____	_____	<input type="checkbox"/> Optical Establishment	_____	
<input type="checkbox"/> Substance Abuse			<input type="checkbox"/> Pathology	_____	
Counseling	_____	_____	<input type="checkbox"/> Pharmacy	_____	
Residential	_____	_____	<input type="checkbox"/> Quality Control / Reference	_____	
Skilled Medical Services	_____	_____	<input type="checkbox"/> Research / Development	_____	
<input type="checkbox"/> Trauma Rehabilitation			<input type="checkbox"/> X-Ray / Imaging Center	_____	
Therapy	_____	_____	<input type="checkbox"/> CAT Center	_____	
Transitional Living	_____	_____	<input type="checkbox"/> PET Center	_____	
Skilled Medical	_____	_____	<input type="checkbox"/> MRI Center	_____	
<input type="checkbox"/> Weight Loss Center	_____	_____	<input type="checkbox"/> Mammography	_____	
			<input type="checkbox"/> Lithotripsy	_____	
			<input type="checkbox"/> Sleep Disorder Services	_____	_____
Surgical				Donations ⁴	
<input type="checkbox"/> Birthing Center	_____	_____		_____	
<input type="checkbox"/> Emergicenter	_____	_____	<input type="checkbox"/> Blood or Plasma Bank	_____	
<input type="checkbox"/> Surgicenter	_____	_____			
<input type="checkbox"/> Bariatrics	_____	_____			
Home Care / Hospice			Treatment	Visits ¹	Beds ²
<input type="checkbox"/> Hospice Care	_____	_____	<input type="checkbox"/> College / University Health Center	_____	
<input type="checkbox"/> Intravenous Therapy	_____	_____	<input type="checkbox"/> Community Health Center	_____	
<input type="checkbox"/> Personal / Companion Care	_____	_____	<input type="checkbox"/> Crisis Stabilization	_____	_____
<input type="checkbox"/> Rehabilitation Therapy	_____	_____	<input type="checkbox"/> Dialysis	_____	
<input type="checkbox"/> Respiratory Therapy	_____	_____	<input type="checkbox"/> Health Department	_____	
<input type="checkbox"/> Skilled Care	_____	_____	<input type="checkbox"/> Urgicenter	_____	
			<input type="checkbox"/> Pain Management ⁵	_____	
			<input type="checkbox"/> Physicians Clinic	_____	
Other			<input type="checkbox"/> Sleep Disorder Services	_____	_____
_____	_____	_____	<input type="checkbox"/> Medi Spa / Aesthetics	_____	
			<input type="checkbox"/> Wound Care	_____	

Indicate Beds²,
Receipts³, or
Visits¹

Annual
Number

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.



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 your primary state? 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.

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

If yes, describe in the Comments Section.

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.

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 trials?..... 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 V – 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., TJC, AAAHC, CAP, etc.) and association memberships held by your facility

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



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)
- | | |
|---|--|
| <input type="checkbox"/> Emergency Room \$ _____
<input type="checkbox"/> Laboratory / Pathology \$ _____
<input type="checkbox"/> Pharmacy \$ _____
<input type="checkbox"/> Radiology / Nuclear Medicine \$ _____
<input type="checkbox"/> Anesthesia \$ _____
<input type="checkbox"/> Home Health Care \$ _____ | <p style="text-align: center;">Limit</p> <input type="checkbox"/> Physical / Occupational Therapy \$ _____
<input type="checkbox"/> Respiratory Therapy \$ _____
<input type="checkbox"/> Other _____ \$ _____ |
|---|--|
- Do you require proof of this coverage? If no, please explain in the Comments Section 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 – 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

Do you employ / contract any Physicians and/or Surgeons? Yes No If yes, please list below.

Physicians and Surgeons Names	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
			<input type="checkbox"/> Board Certified <input type="checkbox"/> Eligible	<input type="checkbox"/> Employee <input type="checkbox"/> Contractor

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

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

Professional Type:	Employed	**Contract	Professional Type:	Employed	**Contract
*Certified Nurse Midwife (CNM)			Aesthetician		
*Chiropractor			*Orthotist		
*Clinical Nurse Specialist (CNS)			*Perfusionist		
*Nurse Anesthetist (CRNA)			Physical Therapist		
*Nurse Practitioner			*Prosthetist		
*Optometrist			RN First Assistant		
*Pharmacist			Surgical Assistant		
*Physician Assistant			Specify type:		
*Podiatrist			Other:		
*Psychologist					

**Separate LAMMICO application is required for coverage / **For independent contractors, list names and provide certificates of ins.*



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

- 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? _____

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.)

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 VIII – 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 IX – ADMISSION / DISCHARGE CRITERIA

- A. Is there an admission policy in place? If no, please explain in the Comments Section Yes No N/A
- B. Are there record and chart protocols in place? If no, please explain in the Comments Section Yes No N/A
- C. Is there a discharge policy in place? If no, please explain in the Comments Section..... Yes No N/A
- D. How long are orders, consent forms and charts maintained? _____



PART X – 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* 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 XI – 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 XII – 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.

- 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? _____



PART XIII – PHYSICAL / SEXUAL ABUSE INFORMATION

GENERAL INFORMATION

- A. Do you have Abuse Coverage with your current carrier? Yes No
If 'Yes', please provide a copy of the current endorsement or policy language.
 What are the current Abuse limits on your policy? _____
- B. Are you aware of any type of abuse (physical, emotional, financial, sexual, etc.) that has occurred in your facility? Yes No
- C. Do background checks of prospective employees and volunteers include information on all criminal convictions, abuse registry / sex related or child-abuse related offenses? Yes No
- D. Are employment-related references verified during hiring? Yes No
- E. Is there a written policy outlining management's commitment to sexual abuse prevention? Yes No
(If 'Yes', please attach a copy)
- F. Are all staff and volunteers trained in policies and procedures related to sexual abuse prevention and the consequences of non-adherence at all locations? *(If 'No', please explain in Comments Section)* Yes No

LOSS HISTORY

- A. Are you aware of any facts, incidents, circumstances, or allegations that may result in an abuse or molestation claim against you? *(If 'Yes', please explain in Comments Section)* Yes No
- B. Have you, any employee, counselor, independent contractor, sub-contractor, volunteer, 'others' or officers currently seeking coverage been involved in an allegation or claim relating to abuse or molestation? *(If 'Yes', please explain in Comments Section)* Yes No
- C. In the past 5 years, have any employees, counselors, independent contractors, sub-contractors, volunteers, 'others' or officers been disciplined, terminated or transferred due to their suspected or actual involvement in abusive behavior? *(If 'Yes', please explain in Comments Section)* Yes No

POLICIES & PROCEDURES

- A. Are the below items included in the code of conduct handbook for all employees, contractors and volunteers?
 - i. Zero tolerance statement for abuse perpetrated on children or other persons in the applicant's care. *(Please attach a copy)* Yes No
 - ii. Written policy that defines appropriate and inappropriate displays of affection. *(Please attach a copy)* Yes No
 - iii. Written procedure governing interactions between employees, contractors and volunteers when alone with children or other persons in your care. *(Please attach a copy)* Yes No
 - iv. Written policy / procedure governing the use of chaperones during patient examinations. *(Please attach a copy)* Yes No
- B. Do you have a written procedure for responding to reports of suspicious or inappropriate behavior or allegations of abuse? *(If 'Yes', please explain in Comments Section)* Yes No
- C. Do you have a designated investigator with specialized training in charge of handling sexual misconduct investigations? Yes No
- D. Do you use a standardized incident reporting form across all locations and programs? *(If 'Yes', please explain in Comments Section)* Yes No
- E. Are management / staff and volunteers trained in policies and procedures relating to abuse and molestation and the consequences of non-adherence at all locations? *(If 'No', please explain in Comments Section)* Yes No
- F. Are complete records maintained documenting adherence to all applicable policies and procedures (e.g., hiring & screening, code of conduct, training, incident & follow up, etc.)? Yes No
- G. Is there a formal procedure concerning when appropriate law enforcement authorities are called when there is a suspected incident of abuse or molestation? *(If 'Yes', please explain in Comments Section)* Yes No



PART XIII – APPLICANT NOTICE AND DECLARATION

Sign and date application in the space below.

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I understand that the statements and answers will be relied upon by LAMMICO and are material in determining not only whether insurance coverage will be issued or renewed, but also correct classification.

I hereby authorize release of my name, address, policy, and premium information by LAMMICO to its agents or designees subject to confidentiality and nondisclosure agreements.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions, or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

Applicant Signature	Title	Date
Print Name		

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE
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 of insurance is guilty of a crime and may be subject to fines and confinement in prison.

