Correctional Medical Facilities and Contractors

Professional Liability Coverage Application

Instructions:

1. **Please read the instructions carefully.** Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. **All application questions must be fully answered.** If a question does not apply, please write "N/A".
3. **If more space is needed,** continue on a separate sheet of the applicant's letterhead and indicate the question number.
4. **To this application, please attach copies of:**
   a. Marketing or Advertising brochures or descriptive materials provided to clients.
   b. Latest annual financial statement.
   c. Claim loss runs for the past 5 or more years for all coverages being applied for.
   d. If the applicant is a new business submit professional qualifications (i.e. resume or C.V.) of each owner, partner, officer and key employee.
   e. Most recent state survey reports and accreditation survey reports as applicable.
   f. Quality Improvement/Risk Management plan.
5. This application must be completed, signed and dated by a principal of the business.

The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate. A separate physician application is required for all physicians requesting coverage under this policy.

I. GENERAL INFORMATION

1. Name of Applicant (Legal Name): _____
2. Physical Address: _____
3. Mailing Address: (if different) _____
4. Corporate Address: (if different) _____
5. City: _____ State: _____ Zip Code: _____ County: _____
6. Corporate Contact: _____ Email Address: _____

   Tel. Number: _____ Fax Number: _____ Website: _____

7. Date Established: _____ ☐ Corporation ☐ Partnership ☐ Professional Association ☐ For Profit ☐ Not for Profit ☐ Individual
8. In what state(s) is the Applicant registered and licensed to practice? _____
9. Please specify any professional societies or associations which you are a member: _____
10. Is the firm engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No
11. Is the firm owned by any physician? ☐ Yes ☐ No
12. Have there been any changes in ownership of the business since the date the entity was established? ☐ Yes ☐ No
13. Does the applicant own any other medical-related business not shown on this application? ☐ Yes ☐ No

14. Gross Revenue:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Gross Revenue	$	$	$	$	$

15. How many years has the applicant been in operation? _____

16. Within the next twelve month period, does the applicant plan to:

- ☐ Obtain another operation or entity? ☐ Yes ☐ No
- ☐ Add to the number of employees? ☐ Yes ☐ No
- ☐ Expand the number of locations? ☐ Yes ☐ No
- ☐ Eliminate/add current services? ☐ Yes ☐ No
- ☐ Operate in other states? ☐ Yes ☐ No

If yes, please explain: _____

17. Within the past five years has the applicant acquired, sold or discontinued any operations: ☐ Yes ☐ No

If yes, please explain: _____

Please provide information on your professional liability insurance history:

	Current Year	1st Prior Year	2nd Prior Year
Policy Year			
Company			
Limits of Liability			
Liability Deductible (if any) or Self-Insured Retention	☐ Deductible $ _____ ☐ SIR $ _____	☐ Deductible $ _____ ☐ SIR $ _____	☐ Deductible $ _____ ☐ SIR $ _____
Claims Made or Occurrence	☐ Claims Made ☐ Occurrence	☐ Claims Made ☐ Occurrence	☐ Claims Made ☐ Occurrence
If Claims Made, Retroactive Date			
Premium			

II. COVERAGE/LIMITS/DEDUCTIBLES

1. Requested Effective Date: _____ Requested Prior Acts Date: _____

2. Requested Limits of Liability: $ _____per claim $ _____aggregate

3. Deductible: $ _____per claim

4. Do you desire excess liability coverage? ☐ Yes ☐ No *If yes, complete this section. If no, complete application.*

   a. Excess Liability requested limit $ _____ per claim, $ _____ aggregate in excess of primary coverage limits.

   b. Have your excess professional or commercial general liability limits been increased within the last five years? ☐ Yes ☐ No

      If yes, what was the prior limit and when was it increased? _____

5. Does a state the applicant is operating in have a Patient Compensation Fund? ☐ Yes ☐ No
   If yes, is the applicant currently enrolled in the Patient Compensation Fund? ☐ Yes ☐ No

6. Has any insurance carrier canceled or refused to renew coverage? ☐ Yes ☐ No
   If yes, please explain: _____

III. ADMINISTRATION AND STAFF

Provide information for the Medical Director providing services at applicant's facility. Attach additional sheet if necessary.

Medical Director	Specialty Board Certification	Ins. Carrier, Policy Number, and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month

Provide information for the physician/surgeon providing services at applicant's facility. Attach additional sheet if necessary.

Physicians/ Surgeons	Specialty Board Certification	Ins. Carrier, Policy Number, and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month

1. Are physicians and licensed independent practitioners credentialed? ☐ Yes ☐ No
2. Is credentialing and privileging formalized? ☐ Yes ☐ No
3. Is new technology included in the delineation of privileges? ☐ Yes ☐ No
4. Does the applicant require employed or contracted physicians and surgeons to carry professional liability insurance?
   ☐ Yes, in by-laws ☐ Yes, in contract ☐ No (If no, please explain) _____
5. Indicate minimum professional liability insurance limits required for:
   Employed/Contracted Physicians/Surgeons $ _____ per claim $ _____ aggregate
6. How often do you verify Professional Liability Insurance? _____
7. Has there **ever** been any review by a state medical board or other federal, state, or non-governmental oversight entity of any health care professional with privileges at the applicant's facility? ☐ Yes ☐ No
8. Has any health care professional with privileges in the applicant's facility **ever** had their license suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
9. Has any health care professional with privileges in the applicant's facility **ever** had their DEA license suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
10. Have any limitations or conditions **ever** been imposed on any health care professional's privileges? ☐ Yes ☐ No

ALLIED HEALTHCARE PROFESSIONALS

Indicate number of personnel in each applicable category:

	EMPLOYEES		CONTRACTORS	
	Full Time	**Part Time**	**Full Time**	**Part Time**
Administration (Office/Clerical)				
Registered Nurses				
Licensed Practical Nurses				
Physicians				
Physicians Assistants				
Pharmacists				
Dentists				
Certified Nurse Assistants				
Residents				
Interns				
Psychiatrists				
Psychologists				
Other:				
Other:				

IV. HIRING/SCREENING/TRAINING PROCEDURES

1. Do your screening/hiring procedures contain any of the following?
   - ☐ Educational background ☐ Yes ☐ No
   - ☐ Previous employers/employment history ☐ Yes ☐ No (PRIOR to hiring or placement)
   - ☐ Personal references ☐ Yes ☐ No
   - ☐ How are references checked? ☐ Written ☐ Verbal ☐ Both
   - ☐ Hospital privileges for physicians ☐ Yes ☐ No
   - ☐ How often do you update your list of specific privileges? _____
   - ☐ Pending license suspensions, revocations ☐ Yes ☐ No
   - ☐ Pending disciplinary actions by other facilities ☐ Yes ☐ No
   - ☐ Criminal background check ☐ County ☐ State ☐ Federal ☐ None
   - ☐ Medical professional claims history ☐ Yes ☐ No
2. Are each of your hiring procedures indicated above followed and documented? ☐ Yes ☐ No
3. If an individual has had a previous claim, license suspension or revocation, how does that impact your procedures for hiring that person? _____ Are any additional criteria applied? ☐ Yes ☐ No
4. What training is provided for new staff (e.g. aides, volunteers, technicians)? _____
5. Are written job descriptions established for all employees and volunteers? ☐ Yes ☐ No
6. Before staff can provide care, is a competency based checklist used to assess and document their skills? ☐ Yes ☐ No

V. RISK MANAGEMENT/QUALITY ASSURANCE

2. Does the applicant utilize a formal written Risk Management Program? ☐ Yes ☐ No
3. Does the governing body periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No
4. Is there a peer review process in place? ☐ Yes ☐ No

MEDICAL/PATIENT RECORDS

1. Are records stored: ☐ Electronically ☐ Paper Files ☐ Both
2. How long are records stored? _____
3. If electric, how often are backups made? _____
4. If paper, where are records stored? ☐ On site ☐ Off site
5. Do the buildings in which paper records are stored contain sprinklers? ☐ Yes ☐ No
6. Who has the overall responsibility for Risk Management & Quality Assurance?

Name: _____

Title: _____

Telephone Number: _____

VI. CORRECTIONAL FACILITY DATA

1. How many facilities do you have contracts with: _____

2. Please complete facility specific supplement (pg. 8).

3. Show the percentage of services at prisons with the following security levels (should equal 100%)

Supermax Security	%
Maximum Security	%
Close Security	%
Medium Security	%
Minimum Security	%

4. What is your patient population's age? (should equal 100%)

Under 20	%
20-30	%
31-40	%
41-50	%
50+	%

5. What is your patient population's sex? (should equal 100%)

Male	%
Female	%

6. Level of health care provided

		# Performed last year?	Comments
Medical Screening	☐ Yes ☐ No		
Diagnostic	☐ Yes ☐ No		
Treatment	☐ Yes ☐ No		
Referral	☐ Yes ☐ No		
Surgical	☐ Yes ☐ No		
Psych Evaluation	☐ Yes ☐ No		

7. Explain any specialized services

8. Are Physical Examinations provided to all inmates upon entrance to the facility? ☐ Yes ☐ No

9. Is security present at all times during service? ☐ Yes ☐ No Please provide details.

10. What are the reporting and documenting procedures for incidents and claims? Provide copy of incident log.

11. Does applicant operate an Intensive Care Unit? ☐ Yes ☐ No Please provide details.

12. What are the protocols for releasing a patient out of the health ward?

13. Please provide inmate intoxication protocols (i.e. Drunk Tank).

14. Do inmates participate in work release programs? ☐ Yes ☐ No
If yes, please describe nature, locations, and frequency. Please also describe how inmates are cleared for work release.

VII. LITIGATION/CLAIMS HISTORY/SANCTIONS/FINES

If the response is yes to any question below, additional information must be provided on the applicant's letterhead. Please submit actual loss runs from the previous carriers for the past five or more years.

1. Has the applicant had any Professional or General Liability claims or suits brought against them in the past five years? ☐ Yes ☐ No
2. Is the applicant aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ☐ No
3. Has the facility/operations license ever been suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
4. Has any Insurance Company declined, canceled or refused to renew or accept any of the applicant's liability insurance? ☐ Yes ☐ No
5. Has the Company with whom the applicant been previously affiliated with become insolvent? ☐ Yes ☐ No
6. Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the applicant's organization? ☐ Yes ☐ No
7. Has the applicant ever been sanctioned or decertified by Medicare? ☐ Yes ☐ No
8. Has the organization or any of it's officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional medical society, accreditation agency or other governmental or non-governmental oversight entity? ☐ Yes ☐ No

Provide the following for each claim, suit or incident (attach additional sheets if necessary):

Date of Accident: _____ Date of Notice:

Amount Paid or Reserved: $ _____ Claimant:

Insurance Carrier:

Allegations: _____

Description of Treatment Rendered: _____

Date of Accident: _____ Date of Notice: _____

Amount Paid or Reserved: $ _____ Claimant: _____

Insurance Carrier: _____

Allegations: _____

Description of Treatment Rendered: _____

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

This application does not bind the Applicant to buy, or the Company to issue the Insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the Company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

SIGNATURE OF APPLICANT X_____ **DATE X** _____

Name: _____ Job Title: _____

(Must be signed by principal partner or officer of group or individual applying for insurance.)

Producer: _____ Phone Number: _____

Producer's Address: _____

Tax I.D. Number: _____

Notice to New York Applicants. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Note: The professional liability coverage being applied for is Claims Made. If there are questions concerning these coverages, please contact your insurance agent.

FACILITY SPECIFIC SUPPLEMENT

Facility List

						Annual Average Daily Population of Inmates						
Facility Name	**Address**	**NCCHC accredited?**	**Retro Date:**	**Termination date: (if any)**	**Facility Type: (Jail, Prison, Juvenile, Etc.)**	**Projected**	**Current**	**1st prior year**	**2nd prior year**	**3rd prior year**	**4th prior year**	**5th prior year**