Inspirien Insurance Company

PO Box 211359
Montgomery, Alabama 36121-1359
334-271-5515

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR ALLIED HEALTHCARE PROVIDERS (CLAIMS MADE - ENTITY)

Throughout this application, where sufficient space is unavailable for a complete answer, please attach a separate sheet, referencing the question(s) being answered, signed and dated at the bottom.

Applicant:______________________________
Legal Name:______________________________
Address:______________________________
Email Address: ______________________________
Telephone:______________________ Date of this Application: ______________
Person Preparing this Application:______________________________

A. General Data

1. Applicant is: ☐ Professional Corporation (For Profit)
   ☐ Professional Corporation (Not For Profit)
   ☐ Partnership
   ☐ Professional Association

2. Indicate Applicant's professional specialty:______________________

3. In what states is Applicant registered and licensed to practice:______________

4. Accredited by:______________ Last Date:______________
   Licensed by:______________ Last Date:______________

5. Affiliation/Management Contract: (Explain)______________________

6. Does Applicant maintain beds for overnight occupancy? ☐ Yes ☐ No
   If yes, give number of: Licensed______________________
   In Service______________________
   Inpatient Days_____

7. Does Applicant own (wholly or in part), operate, or administer any hospital, nursing home, or other institution where medical services are customarily rendered? ☐Yes ☐No
   If yes, give details, including name, location, size, and number of beds.______________

8. Total Annual Gross Patient Billings: Recent Year____
Projected____

9. Do you comply with CDC recommendations for Universal Blood and Body Fluid precautions?
☐Yes ☐No

10. Does Applicant have a Risk Manager designated to handle complaints and/or potential problems? ☐Yes ☐No
If yes, list name:____

11. Does Applicant own or lease vehicles? ☐Yes ☐No
If yes, explain:____

12. Does Applicant use a collection agency? ☐Yes ☐No
If yes, give name of agency.____

13. What is the name and version of your EHR (Electronic Healthcare Records) software?
Please provide a current copy of your EHR contract. You may mark out the cost.

B. Outpatient Utilization of Facilities and Services Offered by or Under Jurisdiction of Your Facility: Projected for Current Year.

Outpatient Utilization		Number of Annual Visits	Number of Procedures
a.	Emergency Room	_____	_____
b.	Abortion Clinic	_____	_____
c.	Drug/Alcohol Abuse	_____	_____
d.	Extended Hours Clinic	_____	_____
e.	Home Health Care/Hospice	_____	_____
f.	Oncology Clinic	_____	_____
g.	Health Clinic	_____	_____
h.	Dialysis	_____	_____
i.	Outpatient Surgery	_____	_____
j.	Lab, X-ray, Etc.	_____	_____
k.	Mobile MRI		
i.	Other Outpatient	_____	_____
	(Specify Type	_____	

C. Other Services Offered by or Under Jurisdiction of the Facility:_________________________

1. Are any of the above listed services under a contract: ☐Yes ☐No
   If yes, please identify and explain:____

D. Professional Personnel – Employed and Contracted. Show the number of persons and full time equivalents (FTE) based on 40 hour work week.

Physicians	EMPLOYED		CONTRACTED	
	Number	FTE	Number	FTE
1. No surgery other than incision of boils, suturing of skin, or obstetrical procedures.	_____	_____	_____	_____
2. Minor Surgery or obstetrical procedures, not requiring major surgery.	_____	_____	_____	_____
3. Proctologists, Urologist, and Ophthalmologists	_____	_____	_____	_____
4. Obstetrics-Gynecologist, Plastic Surgeons, and Otolaryngologists doing plastic surgery.	_____	_____	_____	_____
5. General Surgeons, Cardiac Surgeons and Otolaryngologists doing no plastic surgery.	_____	_____	_____	_____
6. Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeon, and Orthopedic Surgeons.	_____	_____	_____	_____

NOTE: If you require any of the above to be Named Insureds, please submit separate physician application for each such individual.

*Non-Physician Support Personnel	EMPLOYED		CONTRACTED	
	Number	FTE	Number	FTE
1. Physician's Assistant	_____	_____	_____	_____
2. Psychologist	_____	_____	_____	_____
3. RN	_____	_____	_____	_____
4. LPN	_____	_____	_____	_____
5. Nurse Practitioner	_____	_____	_____	_____
6. Nurse Midwife	_____	_____	_____	_____
7. CRNA	_____	_____	_____	_____
8. Lab Techs	_____	_____	_____	_____

9.	X-Ray Techs	_____	_____	_____	_____
10.	Radiation Therapists	_____	_____	_____	_____
11.	Nuclear Medicine Techs	_____	_____	_____	_____
12.	Physical Therapists	_____	_____	_____	_____
13.	Pharmacists	_____	_____	_____	_____
14.	Respiratory Therapist	_____	_____	_____	_____
15.	Emergency Medical Techs	_____	_____	_____	_____
16.	Speech Therapist	_____	_____	_____	_____
17	Occupational Therapist	_____	_____	_____	_____
18.	Medical Assistants	_____	_____	_____	_____
19.	Nurse Aides/techs/orderlies	_____	_____	_____	_____

*Be sure to include support personnel in the figures as “contracted” if they are employees of the physician and on your premises.

Other Non-Physician Professionals – List on a separate sheet. (i.e. Dieticians, Social Workers, Medical Records, and Patient Representatives.)

Credentialing Policy – (Non-Physician)

1. Who determines policy?____
2. Are all contract non-physician professional personnel required to maintain professional liability insurance? ☐Yes ☐No
   If yes, list limits required:____
3. Are Certificates of Insurance on file? ☐Yes ☐No
4. How often does a committee meet to review qualifications of non-physician professionals?_____

E. Residency Programs or Training Schools

Does your facility have any involvement with an accredited residency program or training school?
☐Yes ☐No

If yes: ☐Hospital Owned
☐Consortium (Name other parties involved on a separate sheet and attach to application)
☐Neither (Explain program including names and relationship to your hospital on separate page.)

Type of Program:____

Total Number of Residents:____

F. Anesthesia Services

1. Provided by: ☐Facility Employees ☐Private Practice
   ☐Contract Group
2. Performed by: ☐Anesthesiologist(s) ☐CRNA
   ☐Anesthesiologist/CRNA
3. If contract services, are they separately insured? ☐Yes ☐No
   Limits of Coverage: _____
   Insured By: _____
4. Does contract anesthesia service furnish "hold harmless" and certificates of insurance?
   ☐Yes ☐No
5. What level of supervision is required for non-physician providers? _____

G. Physician Services/Emergency Room

1. Physician service provided by: ☐ Employed MD
   ☐ Staff Physician
   ☐ Contract Physician
   ☐ Combination Contract/Staff
2. If contracted or combination of contracted/staff, are MD's separately insured?
   ☐Yes ☐No
3. Support Facilities:
   A. X-Ray Availability _____ (Number of Hours)
   B. Laboratories _____ (Number of Hours)
   C. Surgery _____ (Number of Hours)
   D. Anesthesia _____ (Number of Hours)

H. Credentialing Policy (Physician)

1. Total number of Physicians (all categories) with Privileges: _____
2. Who determines policy? _____
3. Are physicians required to maintain professional liability insurance?
   ☐Yes ☐No
   If yes, list limits required: _____
4. Are Certificates of Insurance on file? ☐Yes ☐No

I. Physical Plant

	First Location	Second Location	Third Location
1. Automatic Dry Chemical Extinguishing Systems In Kitchen Covering:			
Deep Fat Fryers	_____	_____	_____
Grills	_____	_____	_____
Ducts	_____	_____	_____

** Security Services ______ ______ ______
Contracted ______ ______ ______
In-House ______ ______ ______

2. If cafeteria is open to visitors, give total receipts for fiscal year: $______________________.
3. Are there any construction plans in next 18 months? ☐Yes ☐No
   If yes, give a brief description: ______

J. Total Area

Give the total area of all facilities related to premises operations. (Identify each building and include all floors.)

	Building Location (address)	Use	Square Feet
1.	______ ______	______	______
2.	______ ______	______	______
3.	______ ______	______	______

Do you participate in a Joint Venture? ☐Yes ☐No
If yes, explain your joint venture partner(s) and the type of venture: ______________________

If applicant owns, is a lessor, or is a lessee of any property not related to premises operations, list each property. Attach separate page is necessary. Example: physician office buildings, resident halls, private homes, trailers, apartment buildings, farms, or vacant lands.

Identify any premises where applicant is lessor:

	Building Location (address)	Use	Square Feet
1.	______ ______	______	______
2.	______ ______	______	______
3.	______ ______	______	______

PLEASE ATTACH AN ORGANIZATIONAL CHART

K. Current Information

1. Limits of Primary Coverage -_____ Premium –_____
2. Excess/Umbrella Limits -_____ Premium –_____
3. Deductible - $_____
4. Describe Deductible – _____
5. Type of Coverage – ☐ Claims Made ☐ Occurrence
6. Date of first Claims Made Coverage Policy
7. Renewal Date - _____ Present Carrier –_____

L. Limits of Coverage Requested

Coastal provides a primary $1,000,000.00/$3,000,000.00 on a claims made basis. Deductible plans are available.

1. Please indicate the amount of the deductible you would like for the purpose of quotation:
   ☐ $25,000 ☐ $50,000 ☐ $100,000
2. Increased Limits are available through established reinsurance companies. These limits are in excess of the primary limits provided by Coastal. Increased Limits Requested:_____________

M. Liability Loss Experience (Past 5 Years)

Year Outstanding	Number of Claims	Total Paid	Total Reserves
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please attach all available year-end claim summaries from each of the carriers and their respective policy periods for actuarial review.

Describe briefly each Claim in excess of $10,000.00

Accident Date	Description	Total Paid	Total Reserves Outstanding
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signing this application does not bind Coastal Insurance Company, Inc., to provide coverage, but it is agreed that this form is to be included with other information which shall be the basis of the contract should a policy be issued to the undersigned. Furthermore, should the undersigned withhold important information, supply misleading information, or attempt to defraud or lie to Coastal Insurance Company, Inc., about any matter contained in this application, then coverage provided by virtue of this application is void. **Any Person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.**

Date: ________________ ____

Applicant

By:____

Its:____

Agency: ____ Submitted By: ________________________________
Address: ____ Zip: _______ Phone: ________________________