INSPIRIEN INSURANCE COMPANY

P.O. Box 211359
Montgomery, Alabama 36121-1359
334-271-5515

MEDICAL PROFESSIONAL LIABILITY APPLICATION

Name of Applicant *(First Named Insured)* _____

Additional Named Insured(s) _____
(Attach list if necessary – Including Retroactive Date(s).)

Street Address _____

_____

_____
City State Zip

Billing Address _____

_____

_____
City State Zip

Type of Facility: *(Please check those that apply)*

For Profit NFP Gov't Critical Access Center

Brief Description of Operations: _____

_____

Are any management services provided for others? Yes No If yes, please describe. _____

Limits Requested: Each Claim Aggregate

Deductible: Per Claim – Indemnity & Defense

Effective Date: Retro Date:

Contact Person Phone Number

Email Address Fax Number

Class	Inpatient Days		Class	# Visits/Surg. Renewal
Hospital Beds			**Hospital Inpatient**	
Hospital Bassinets			**Surgeries**	
Deliveries excluding C Section(Actual Number)			**Hospital Outpatient**	
Deliveries C Sections (Actual Number)			**Surgeries**	
Psychiatric/Substance Abuse Beds			**Hospital Emergency**	
Rehabilitation Beds			**Department Visits**	
			Clinics, Dispensaries, Infirmaries Visits	
Nursing Home Beds			**Other Hospital**	
Assisted Living Beds			**Outpatient Visits**	
			Psychiatric/Substance Abuse Visits	
			Rehabilitation Visits	
			Home Health Visits	

Class	Units	Exposure Units Current Year
Wellness Center	*Receipts	
Medical/X-ray **Laboratory**	*Receipts	
Pharmacy	*Receipts	
Total # Employees	#	
.*Receipts for services performed for outside firms not hospital patients.		

Employed Position Classes	# Hrs. Wrk/Wk Current Year
Certified Midwives	
CRNAs – No On-Site Supervision	
CRNAs – On-Site Supervision	
Dentists NOC (Contracted) **Dentists NOC (Employed)**	
Dentists/Oral Surgeons (Employed)	
Dentists/Oral Surgeons (Contracted)	
Medical Students/Externs	
Nurse Practitioner	
Optometrists	
Physicians or Surgeons Assistants	
Podiatrists – Major Surgery	
Podiatrists – No Surgery	
Student (CRNAs)	
Student Nurses	

PROFESSIONAL LIABILITY APPLICATION

(Persons to be Covered on Your Policy)

Each physician, surgeon or resident must complete a physician application and be underwritten and approved before coverage will apply.

EMPLOYED Physicians, Surgeons and Residents			
Name	**Specialty Practice at Facility**	***FTEs**	**Retroactive Date**

(Please continue on a separate sheet if necessary)

CONTRACTED Physicians, Surgeons and Residents			
Name	**Specialty Practice at Facility**	***FTEs**	**Retroactive Date**

(Please continue on a separate sheet if necessary)

All Contracted Allied Health Professionals, other than Physicians or Surgeons, who require coverage must be listed below (i.e. LPNs, RNs, Security Guards, etc.).

CONTRACTED Allied Health Professionals			
Name	**Specialty Practice at Facility**	***FTEs**	**Retroactive Date**

(Please continue on a separate sheet if necessary)

* FTEs – Full-time equivalency is based on the total number of hours worked each week for each specialty group at the facility (class code) divided by 40

GENERAL QUESTIONS

a. Does your hospital have a management contract to provide management services to other facilities? Y N

b. Does another facility provide management services to your hospital? Y N
(If yes please provide the name address of the entity and a copy of contract)

c. Percent of RN care hours as a total of all nursing care hours: %

d. Percent of contract (agency) RN hours as a total of all nursing care hours: %

e. Licensed Nurse/patient ratio (e.g. 1: X); Surgery Critical Care:

f. Total number of physicians **with** hospital privileges:

g. Are all medical staff required to provide a Certificate of Insurance: Y N

h. Any plans to purchase other healthcare facilities? Y N

i. Do you provide telemedicine services? Yes No
If yes, please describe.

j. 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.

Nursing Home / Assisted Living

a. Do you conduct a background check (for criminal history and abuse/neglect at minimum) on all Nursing Home/Assisted Living care staff? Y N

b. Number of RN

c. Number of LPN

d. How many patients have dementia?

Emergency Department

a. What percent of Emergency physicians are board certified? %

b. Are all Emergency physicians PAL certified? Y N

c. Do all discharge instructions contain specific contact information and time frame for follow-up visits? Y N
If **NO**, Please explain:

d. Are protocols in place for rapid treatment of high risk presentations? (e.g. chest pain, abdominal pain, children with fever, headache and trauma)? Y N

e. Provide the following annualized data for the past 12 months:
Average wait time in minutes (arrival to treatment time):
Average length of time in ED in hours (arrival to physical discharge):

Residents:

a. Do you have residents/fellows at your hospital? Y N

b. Does your residency/fellowship program include defined scope of care and supervision requirements for different levels of training? Y N

c. Is the hospital part of an accredited medical school? Y N

Obstetrics

a. Do you provide Obstetrics? Y N

b. Are PALS/NALS trained staff present at every delivery? Y N

Credentialing/Staff Privileges

a. Does the recredentialing process include a confirmation of competence regarding procedure specific staff privileges? Y N

b. Do you credential/appoint your physicians every 2 years? Y N
If not, how often?

c. Do you credential/appoint non-physician providers (CRNA, PA, NP etc.) every 2 years? Y N
If not, how often?

d. Are current Certificates of Insurance kept on file for all medical staff? Y N

e. J.A.C.H.O. Accredited: Y N Date of Last Accreditation:
f. State Certified: Y N Date of Last Certification:

Do you know of any claims or incidences that reasonably may result in a claim that have not been reported to your Insurance Carrier? If yes, please explain.

Please provide your prior five year plus the current year loss history. This should be provided by your insurance carrier(s).

DECLARATION
I understand the submission of this application does not bind the Company to issue or me to purchase this insurance. By signing below, I grant permission (1) to the Company to contact third parties and (2) to third parties to release to the Company information which relates to the issuance and continuation of this insurance.

I represent that the information provided in this application (and attachments) and any previous applications is true. I understand (1) that the applications are the basis of and will become a part of the insurance contract with the Company; by reference (2) that the application information I provided is material to the Company; (3) that the Company is relying on this information in determining whether to rescind the insurance contract if any application contains any misrepresentation or omission with intent to deceive. Further, I agree to notify the Company of any change in the information provided. ***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.***

Signature and Title of Applicant	Date	Phone Number
Printed Signature		