



## HEALTH CARE FACILITY APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

New Application     Renewal Application – Expiring Policy Number: \_\_\_\_\_

**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 (Part XIV) or attach a separate page.**

**DO NOT USE THIS APPLICATION FOR HOSPITALS**

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

Complete Legal Name of Applicant:	Doing Business As:
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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.**

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
			<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.*

LAMMICO USE ONLY						
Coverage Start Date:	Retro Date:	Limits / Option:	Facility Code:	Discount:	County 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).*

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"/> \$500,000 Per Claim / \$500,000 Total Annual Aggregate	<input type="checkbox"/> \$2,000,000 Per Claim / \$4,000,000 Total Annual Aggregate
<input type="checkbox"/> Higher Limits (refer to company)	<input type="checkbox"/> \$3,000,000 Per Claim / \$5,000,000 Total Annual Aggregate

**B. REIMBURSEMENT AMOUNT\***  
*(Reimbursement amount applies separately to Professional and General Liability)*

<input type="checkbox"/> None	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500	<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

\*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. 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 <sup>1</sup>	Beds <sup>2</sup>	Laboratory	Annual Receipts <sup>3</sup>
<b>Counseling / Rehabilitation</b>				
<input type="checkbox"/> Cardiac Rehab	_____	_____	<input type="checkbox"/> Dental	_____
<input type="checkbox"/> Developmental Disability	_____	_____	<input type="checkbox"/> Medical	_____
<input type="checkbox"/> Mental 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	_____
<b>Surgical</b>			<b>Organ / Blood / Tissue</b>	
<input type="checkbox"/> Abortion Clinic	_____	_____	<input type="checkbox"/> Organ or Tissue Procurement	_____
<input type="checkbox"/> Birthing Center	_____	_____	(No Direct Processing or Contact)	
<input type="checkbox"/> Emergicenter	_____	_____	<input type="checkbox"/> Organ or Tissue Procurement	_____
<input type="checkbox"/> Bariatrics	_____	_____	(Direct Processing or Contract)	
<input type="checkbox"/> Surgicenter	_____	_____		
List major procedures performed:	_____			
<b>Home Care / Hospice</b>			<input type="checkbox"/> Blood or Plasma Bank	<b>Donations <sup>4</sup></b>
<input type="checkbox"/> Hospice Care	_____	_____		_____
<input type="checkbox"/> Intravenous Therapy	_____	_____	<b>Treatment</b>	<b>Visits <sup>1</sup></b>
<input type="checkbox"/> Personal / Companion Care	_____	_____	<input type="checkbox"/> College / University Health Center	_____
<input type="checkbox"/> Rehabilitation Therapy	_____	_____	<input type="checkbox"/> Community Health Center	_____
<input type="checkbox"/> Respiratory Therapy	_____	_____	<input type="checkbox"/> Crisis Stabilization	_____
<input type="checkbox"/> Skilled Care	_____	_____	<input type="checkbox"/> Dialysis	_____
			<input type="checkbox"/> Health Department	_____
<b>Other</b>			<input type="checkbox"/> Urgicenter	_____
	<b>Annual Receipts <sup>3</sup></b>	<b>Beds <sup>2</sup></b>	<input type="checkbox"/> Pain Management <sup>5</sup>	_____
<input type="checkbox"/> Sleep Disorder Services	_____	_____	<input type="checkbox"/> Physicians Clinic	_____

<sup>1</sup> 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.

<sup>2</sup> Beds Use the average number of occupied beds, which is defined as total annual inpatient days divided by 365.

<sup>3</sup> 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.

<sup>4</sup> Donations Use the number of units received from a donor, whether it is from a paid donor or not.

<sup>5</sup> 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 the State of Arkansas?  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 (Part XIV).

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

If yes, describe in the Comments Section (Part XIV).

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 XIV).**

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

\_\_\_\_\_  
 \_\_\_\_\_



**PART V – 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                     \$ _____<br><input type="checkbox"/> Laboratory / Pathology             \$ _____<br><input type="checkbox"/> Pharmacy                                 \$ _____<br><input type="checkbox"/> Radiology / Nuclear Medicine     \$ _____<br><input type="checkbox"/> Anesthesia                             \$ _____<br><input type="checkbox"/> Home Health Care                    \$ _____<br><input type="checkbox"/> Emergency Room                     \$ _____ | <div style="text-align: right;"><b>Limit</b></div> <input type="checkbox"/> Physical / Occupational Therapy   \$ _____<br><input type="checkbox"/> Respiratory Therapy                 \$ _____<br><input type="checkbox"/> Other _____ \$ _____ |
|---|---|
- Do you require proof of this coverage? If no, please explain in the Comments Section (Part XIV).....  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 VI – 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\*\***

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

\*If not LAMMICO insured please attach copy of current certificate of insurance.  
 \*\*Attach copy of Physician Service Contracts. Include additional names and information in the Information Section (Section IV)

**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



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

- 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? \_\_\_\_\_

**\*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 XIV)).

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





**PART XII – 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 Claim \$ _____ Total Limit		<input type="checkbox"/> Claims Made	

- B. If your most recent professional liability policy was written on a claims-made basis, did you purchase the reporting endorsement (“tail” coverage)? .....  Yes  No
- a. If no, are you applying for prior acts coverage from LAMMICO? .....  Yes  No  
 If no, I realize that not purchasing the “tail” from my current carrier can result in an uninsured exposure for any claims which may arise in the future as a result of professional services rendered while insured by my current carrier’s policy. I understand that the policy I am purchasing from LAMMICO will not provide prior acts coverage.  
 Initial here \_\_\_\_\_
- C. Have you had any professional claims or suits made against your facility during the last ten years? .....  Yes  No  
*(If yes, provide a current loss summary from your present or previous carrier).....*
- D. 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
- E. 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
- F. 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
- G. 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 XIII – 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

**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.**

