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

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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:

PART I – APPLICANT INFORMATION

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

Applicant Mailing Address: *(Street, City, State, Zip)*	Website Address:

Primary Contact Person:	Primary Contact Title:	Primary Contact Phone:	Primary Contact Fax:	Primary Contact Email:

Contact Person (Risk Management):	Contact Title (Risk Management):	Contact Phone (Risk Management):	Contact Fax (Risk Management):

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)*

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?**
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ 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:	☐ Occurrence ☐ Claims Made	If Claims Made, state retro date:
$_____ Each Person $_____ 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

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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

☐ $100,000 Per Claim / $300,000 Total Annual Aggregate
☐ $2,000,000 Per Claim / $2,000,000 Total Annual Aggregate
☐ $1,000,000 Per Claim / $3,000,000 Total Annual Aggregate
☐ Other: Please refer to Company

B. REIMBURSEMENT AMOUNT (DEDUCTIBLE)*

☐ None	☐ $5,000	☐ $10,000	☐ $25,000	☐ $50,000	☐ Other_____	☐ Indemnity Only ☐ Indemnity & Expense

**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.

Counseling / Rehabilitation	Visits [1]	Beds [2]
☐ Cardiac Rehab		
☐ Developmental Disability		
☐ Behavioral Health / Counseling		
☐ Physical or Occupational Rehab		
☐ Substance Abuse		
Counseling		
Residential		
Skilled Medical Services		
☐ Trauma Rehabilitation		
Therapy		
Transitional Living		
Skilled Medical		
☐ Weight Loss Center		

Surgical		
☐ Birthing Center		
☐ Emergicenter		
☐ Surgicenter		
☐ Bariatrics		

Home Care / Hospice		
☐ Hospice Care		
☐ Intravenous Therapy		
☐ Personal / Companion Care		
☐ Rehabilitation Therapy		
☐ Respiratory Therapy		
☐ Skilled Care		

Other		
_____		
	Indicate Beds[2], Receipts[3], or Visits[1]	Annual Number

Laboratory	Annual Receipts [3]	Beds [2]
☐ Dental		
☐ Medical		
☐ Ocular		
☐ Optical Establishment		
☐ Pathology		
☐ Pharmacy		
☐ Quality Control / Reference		
☐ Research / Development		
☐ X-Ray / Imaging Center		
☐ CAT Center		
☐ PET Center		
☐ MRI Center		
☐ Mammography		
☐ Lithotripsy		
☐ Sleep Disorder Services		

	Donations [4]
☐ Blood or Plasma Bank	

Treatment	Visits [1]	Beds [2]
☐ College / University Health Center		
☐ Community Health Center		
☐ Crisis Stabilization		
☐ Dialysis		
☐ Health Department		
☐ Urgicenter		
☐ Pain Management [5]		
☐ Physicians Clinic		
☐ Sleep Disorder Services		
☐ Medi Spa / Aesthetics		
☐ Wound Care		

[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?
*(i.e., home health, outpatient, **telemedicine**, etc.)*..... ☐ Yes ☐ No

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

_____

_____

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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)

	Limit		Limit
☐ Emergency Room	$ _____	☐ Physical / Occupational Therapy	$ _____
☐ Laboratory / Pathology	$ _____	☐ Respiratory Therapy	$ _____
☐ Pharmacy	$ _____	☐ Other _____	$ _____
☐ Radiology / Nuclear Medicine	$ _____	☐ Other _____	$ _____
☐ Anesthesia	$ _____	☐ Other _____	$ _____
☐ Home Health Care	$ _____	☐ 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
			☐ Board Certified ☐ Eligible	☐ Employee ☐ 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
			☐ Board Certified ☐ Eligible	☐ Employee ☐ Contractor
			☐ Board Certified ☐ Eligible	☐ Employee ☐ 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 – 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.

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COMMENTS SECTION