Mack *Specialty* Brokerage

Professional Liability Application for Clinics

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INSTRUCTIONS: ANSWER ALL QUESTIONS; IF THE ANSWER IS NONE, STATE NONE. IF THE QUESTION IS NOT APPLICABLE, STATE NOT APPLICABLE (N/A). IF THE SPACE PROVIDED IS INSUFFICIENT TO FULLY ANSWER THE QUESTION, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART 1. GENERAL INFORMATION

1.1 Applicant Name: _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 Total premises square footage occupied by applicant: _____

1.5 County (parish) of each location: _____

1.6 Telephone Number: Office _____/_____ Fax _____/_____

1.7 Person to contact for survey: Name _____

Title _____

1.8 Year entity established: _____

1.9 Entity is ___ Individual ___ Corporation ___ Partnership

___ Professional Association/Corporation ___ Other. Describe _____

1.10 Entity is ___ For Profit ___ Non-Profit. Describe source of funds: _____

1.11 Proposed effective date _____

1.12 Requested Limits of Liability (if available):

Professional Liability $ _____ /$ _____

General Liability $ _____ each occurrence

$ _____ general aggregate

1.13 Annual Gross Receipts: Estimated next twelve months - $ _____

Last twelve months - $ _____

1.14 Annual Remuneration: Estimated next twelve months - $ _____

Last twelve months - $ _____

1.15 List all memberships in professional organizations: _____

_____

NOTICE

THIS POLICY (IF ISSUED) IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

PART 11. EXPOSURES

2.1 Breakdown of patient services (%) by outpatient visits:

_____ % AIDS	_____ % Gynecology	_____ % Pediatric
_____ % Alcoholic	___ % Hemodialysis	_____ % Physical Rehab
_____ % Bariatric	_____ % Holistic Medicine	_____ % Psychiatric
_____ % Communicable	_____ % Major Surgery	_____ % Research/Experimental
_____ % Dental	_____ % Minor Surgery	_____ % Stress Testing
_____ % Disability	___ % Nutritional (diet)	_____ % Substance Abuse
_____ % Drug Addiction	_____ % Obstetrical	_____ % Other (describe) _____
_____ % Emergency Med.	_____ % Occupational	_____ % _____
_____ % Family Planning	_____ % Optometry	_____ % _____
_____ % General Exams	_____ % Orthopedic	_____ % _____

2.2 Indicate the number of professional employees, volunteers and independent contractors: IF NONE, STATE NONE.

2.2.1 Physicians, Surgeons & Dentists	No. of Employees and Volunteers	No. of Independent Contractors
a) Physicians: No surgery (other than incisions of boils, suturing of skin) or other obstetrical procedures)	_____	_____
b) Physicians: Minor surgery or obstetrical procedures not constituting major surgery	_____	_____
c) Proctologists, Ophthalmologists and Urologists	_____	_____
d) General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____
e) Obstetrics-Gynecologists, Plastic Surgeons and Otolaryngologists doing plastic surgery	_____	_____
f) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	_____	_____
g) Physician's & Surgeon's Assistants, Nurse Practitioners (describe duties on separate sheet)	_____	_____
h) Unlicensed Interns	_____	_____
i) Dentists (no oral surgery)	_____	_____
j) Orthodontists	_____	_____
k) Oral Surgery	_____	_____

IF ANY OF THESE CATEGORIES ARE PROVIDING SERVICES, COMPLETE PHYSICIAN EXPOSURE SUPPLEMENT.

2.2.2 Allied Health Professionals

	No. of Employees and Volunteers	No. of Independent Contractors		No. of Employees and Volunteers	No. of Independent Contractors
a) Chiropractor	____	____	1) Pharmacist	____	____
b) Dental Hygien	____	____	m) Phys. Therapist	____	____
c) Dialysis Technician	____	____	n) Physician's Asst.	____	____
d) EEG/EKG Technician	____	____	o) Podiatrist	____	____
e) Medical Lab Tech.	____	____	p) Social Worker	____	____
f) Nurse Anesthetist	____	____	q) Psychotherapist	____	____
g) Nurse Midwife	____	____	r) Radiation Tech.	____	____
h) Nurse Practitioner	____	____	s) Resp. Therapist	____	____
i) Occupational Therapist	____	____	t) RN, LVN, LPN	____	____
j) Optician/Optornotrist	____	____	u) Speech Therapist	____	____
k) Perfusionist	____	____	v) Surgical Tech.	____	____

2.3 Are all of the above individuals licensed in accordance with applicable state and federal regulations? _____ Yes No If no, attach explanation.

2.4 Describe hiring & verification processes for all employed/independently contracted physicians. _____

_____

_____

2.5 Does the applicant supervise any individuals other than those listed above? ____ Yes ____ No
If yes, on a separate sheet provide detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

2.6 Does the applicant maintain any beds for overnight occupancy? ____ Yes ____ No
If yes, indicate the number # _____, type _____ and the number of patient days the last 12 months _____

2.7 Please provide the number of outpatient visits by category.

Type	No. of Visits/Tests Next Twelve Months	Last Twelve Months
Clinics - Total	_____	_____
a. Physician	_____	_____
b. Dentists	_____	_____
c. Physician Asst./Nurse Practitioner	_____	_____
d. Other Allied Health Professionals	_____	_____
e. Laboratory	_____	_____
f Emergency Room	_____	_____
g. Surgery (procedures)	_____	_____
h. Imaging/X-Ray	_____	_____
i. Other _____	_____	_____

2.8 Does the clinic provide medical services for other than fee for service? ____ Yes ____ No
If yes, give details or arrangements, including a copy of contract(s).

2.9 What is patient mix? Fee for service _____% Prepaid _____%

2.10 What percent of prepaid patients are referred to outside physicians? _____%.

2.11 Does the applicant perform:

a. Acupuncture or acupuncture anesthesia? Explain _____ ___ Yes ___ No

b. Angiography/Arteriography/Venography? Explain _____ ___ Yes ___ No

c. Catheterization (other than urinary or umbilical?) Describe procedure. ___ Yes ___ No

_____

d. Closed reduction of compound fractures and/or Dermabrasion? ___ Yes ___ No

e. Injection of radioisotope and/or use of irradiated substances? Describe. ___ Yes ___ No

_____

f Radiation Therapy and/or Chemotherapy? Describe. _____ ___ Yes ___ No

9. Electroconvulsive Therapy? ___ Yes ___ No

h. Silicone Injections? Describe. _____ ___ Yes ___ No

1. Laser Treatment? Describe. _____ ___ Yes ___ No

J. Experimental procedures or research testing? Describe in detail on separate sheet. ___ Yes ___ No

k. Hypnosis? Describe. _____ ___ Yes ___ No

l. X-Ray Services? If yes, number of annual X-ray exposures for diagnosis: _____ for treatment _____ What qualifications are required of the staM ___ Yes ___ No

_____

m. Does the applicant prescribe drugs for weight reduction of patients? ___ Yes ___ No

n. Are any of the following preformed?

1) Obstetrics

a) Pre-natal ___ Yes ___ No

b) Deliveries ___ Yes ___ No

c) Elective or therapeutic abortions ___ Yes ___ No

d) If clinic provides pre-natal care only, does clinic physicians or nurse midwife attend patient at designated hospital at time of delivery? ___ Yes ___ No

e) if answer to d) is no, are clinic pre-natal records provided to delivering physician and to the designated hospital prior to delivery? ___ Yes ___ No

2) Chemical/Sub stance Abuse Services

a) Counseling ___ Yes ___ No

b) Methadone or similar substances, dispensed or prescribed. ___ Yes ___ No

c) If the answer to b) is yes, describe on a separate sheet treatment and controls used, and indicate number of treatments during last twelve months: _____

Next twelve months: _____

3) Do you provide home health care services? ___ Yes ___ No

If yes, do they account for more than 5% of your gross revenue? ___ Yes ___ No

If yes, please complete and attach our Home Health Care Service Application.

2.12 Is your facility owned by an M.D: ____ Yes ____ No If yes, owner name(s): _____

2.13 Is the applicant in the employ of any federal governmental entity? ___ Yes ___ No

If yes, attach explanation.

2.14 Is the applicant under contract to any federal governmental entity? ___ Yes ___ No

If yes, attach explanation.

2.15 Name and give locations of any hospitals or institutions the applicant uses in practice and describe how affiliated. _____

_____

_____

2.16 In what states is the applicant registered and licensed to practice? _____

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

2.18 Does applicant own or operate any business other than that shown in Question 2.17 above? If yes, please give details on separate sheet. ___ Yes ___ No

2.19 Does applicant perform or engage in any surgical procedure(s) in its professional office or similar non-hospital facility? _____ Yes _____ No. If yes, answer the following:

a. Please submit detailed list of all surgical procedures performed at the center.

b. Provide the number of procedures performed the last 12 months for each procedure listed in A. above.

c. For each procedure breakdown the number performed under general anesthesia (including IV sedation) versus local (topical of local infiltration)

2.20 Is anesthesia (other than topical or by means of local infiltration) administered by applicant? ___ Yes ___ No If yes, describe in detail by whom, whether employed or contracted, a list of agents utilized, whether an oxymeter is used, and attach a copy of the written policies and/or guidelines of the anesthesia service. If a CRNA administers anesthesia, include the CRNA under the Physician Exposure Supplement.

2.21 Does the applicant perform any:

a. Surgery other than incision of superficial boils or suturing superficial fascia? ___ Yes ___ No

b. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? ___ Yes ___ No

c. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections? ___ Yes ___ No

d. Cosmetic Plastic Surgery? Describe _____ ___ Yes ___ No

e. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? ___ Yes ___ No

f Hysterectomies? ___ Yes ___ No

9. Open reduction of fractures? Describe. _____ ___ Yes ___ No

h. Surgery for weight reduction of patients? ___ Yes ___ No

1. Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month). _____ ___ Yes ___ No

_____

J. Cryosurgery (other than use on benign or pre-malignant dermatological lesions? Describe. _____ ___ Yes ___ No

k. Silicone Implants? Describe. _____ ___ Yes ___ No

1. Sterilization Procedures? Describe. _____ ___ Yes ___ No

m. Biopsies and/or endoscopies? List types performed. _____ ___ Yes ___ No

_____

n. Sex change operations? Describe and advise number yearly. _____ ___ Yes ___ No

_____

o. Experimental surgery or surgical research? Describe on separate sheet. ___ Yes ___ No

p. Other Surgery? Describe. _____ ___ Yes ___ No

2.22 Does the applicant have the following equipment at the center:

a. Laboratory with the following capabilities - CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine ___ Yes ___ No

b. X-ray with on premises processing ___ Yes ___ No

c. EKG - 12 lead ___ Yes ___ No

d. Monitor/Defibrillator ___ Yes ___ No

e. Crash cart with full cardiac life support capabilities and necessary intravenous fluids. ___ Yes ___ No

f Appropriate trays and equipment for accessing the airway,

pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage ___ Yes ___ No

g. Oxygen ___ Yes ___ No

h. Suction ___ Yes ___ No

i. Pneumatic anti-shock trousers ___ Yes ___ No

J. Dedicated telephone line to the closest appropriate hospital emergency department and/or two-way communication with the EMS ___ Yes ___ No

2.23 Describe peer review process for surgeons on a separate sheet.

2.24 Does the applicant perform gynecology:

a. Surgical ___ Yes ___ No

b. Family Planning ___ Yes ___ No

If yes, indicate number of patients _____ Describe range of services: _____

_____

PART 111. RISK MANAGEMENT

3.1 Name, qualifications and number or years of experience of the Medical Director:

Name Title Experience/Training Association Membership

_____

3.2 Who does the supervising of staff, and what is his/her experience? _____

_____

3.3 Does your clinic require the professional staff be CPR trained? ___ Yes ___ No

3.4 Describe the referral source(s) by which patients are directed to the entity. _____

_____

3.5 Does the clinic have a written policy and procedure to assure that contractors' credentials, liability insurance coverage and standards of performance are commensurate with entity's? ___ Yes ___ No

3.6 Do your contracts with vendors specify responsibilities, performance goals, warranties, liability insurance, and possible termination by either party? ___ Yes ___ No

3.7 Is the applicant eligible for certification or accreditation? ___ Yes ___ No

If yes, is applicant certified and/or accredited? ___ Yes ___ No

If no, explain the reason: _____

3.8 Is applicant approved to receive Medicare and Medicaid payments? ___ Yes ___ No

3.9 Does the applicant have a qualified physician(s) and other personnel trained in emergency medical care in the center during all hours of operation? ___ Yes ___ No

Please describe. _____

_____

3.10 Do you have any restricted licensed physicians on staM ___ Yes ___ No

If yes, explain on separate sheet.

3.11 Do you have any physicians on staff that do not maintain staff privileges at a hospital? If yes, explain. ___ Yes ___ No

3.12 Does the applicant participate in any activity (e.g. newspaper columns, broadcasts, etc.) whereby professional advice is offered to the public?

If yes, please attach detailed explanation of this activity. ___ Yes ___ No

3.13 Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? ___ Yes ___ No

If yes, attach a copy of ALL of the advertisements.

3.14 Is the applicant associated with any agency or organization that engages

in any kind of advertising for or solicitation of patients? ___ Yes ___ No

If yes, attach detailed explanation and a copy of ALL of the advertisements.

3.15 Does the applicant use a collection agency? ___ Yes ___ No

If yes, give name of agency: _____

Has the agency authority to file a collection suit at its discretion? ___ Yes ___ No

3.16 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? ___ Yes ___ No

If no, attach explanation of any exception.

3.17 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ___ Yes ___ No

b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ___ Yes ___ No

c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ___ Yes ___ No

IF THE ANSWER TO ANY OF 3.17 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

PART IV. **HISTORY**

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? _____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

___ Yes ___ No If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary). _____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?
___ Yes ___ No If yes, describe the event and indicate the reason for anticipation of a claim.

Underwtitten by **The Reciprocal Alliance**

Risk Retention Group

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date Applicant/Title