

ORGANIZATIONAL LOCATIONS

Names and addresses of **ALL** locations for which insurance coverage is sought.

Location Name of Hospital Street, City, State	Annual Number of ED Visits Annual Number of Fast Track Visits	Number ED Hours/Year	✓ if Free Standing or Clinic	Number Clinic Visits/Year	Number Clinic Hours/Year	Other Types of Operations/ Services	Location to be Covered/ Retro Date
1.			<input type="checkbox"/>				
2.			<input type="checkbox"/>				
3.			<input type="checkbox"/>				
4.			<input type="checkbox"/>				
5.			<input type="checkbox"/>				
6.			<input type="checkbox"/>				
7.			<input type="checkbox"/>				
8.			<input type="checkbox"/>				
9.			<input type="checkbox"/>				
10.			<input type="checkbox"/>				
11.			<input type="checkbox"/>				

What is the Trauma level(s) of the Emergency Department location(s) being covered? _____

What is your average door to doctor time? _____

What is your average length of stay in the ED for non-admitted patients? _____

What is your average length of stay in the ED for admitted patients? _____

ORGANIZATIONAL LOCATIONS (cont.)

Are any of the group's physicians medical directors of any EMS or other organization?

YES NO If "YES," please attach list.

Is the adding of additional sites contemplated during the coming year: YES NO

If "YES," please describe _____

Provide the following information for the past five years:

Fiscal Year	Total # of ER Visits	Total # of Clinic Visits
20		
20		
19		
19		
19		

PROFESSIONAL LIABILITY INSURANCE COVERAGE

Current Professional Liability Insurance:

Present Insurance Carrier: _____

Coverage Type: Occurrence Claims Made

IF CLAIMS MADE, ATTACH COPY OF CURRENT POLICY.

Present Premium: _____

Present Limits of Liability \$ _____ / \$ _____

Policy expiration date: __ / __ / __

Previous Professional Liability Insurance - past five years:

Policy Year	Insurance Carrier	Policy Limits	Policy Type	SIR/Deductible Amount
20			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
20			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
19			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
19			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	
19			<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims Made	

Has any company refused coverage, canceled, or refused to renew any insurance?

YES NO If Yes, please explain: _____

In the last five years, have claims or suits for any alleged malpractice ever been brought against the group, any of its employed or contracted physicians or paraprofessionals (whether or not affiliated with the group at the time of claim/suit)? YES NO

In the last five years, have any incidents occurred involving the group, any of its employed or contracted physicians or paraprofessionals (whether or not affiliated with the group at the time of incident), that could lead to a suit or claim? YES NO

If Yes, to either of the two preceding questions, complete the following page - include all items reported to other carriers.

List all insurance claims for each physician for the last five years. Use a separate sheet if necessary, or attach a copy of the loss report.

Physician's Name	Institution City/State	Allegation	Type of Injury	Date of Treatment Date of Claim	Status (Event, Claims, Suit)	Amounts Paid to Date	Amounts Reserved to Date	Name of Insurance Carrier
1.	_____							
2.	_____							
3.	_____							
4.	_____							
5.	_____							
6.	_____							
7.	_____							
8.	_____							

MEDICAL INDEPENDENT CONTRACTORS/EMPLOYEES	MEDICAL SPECIALTY	Number Full Time	Number Part Time
	Anesthesiology		
	Family Practice		
	Emergency Medicine		
	Internal Medicine		
	Pathology		
	Pediatrics		
	Psychiatry		
	Radiology		
	Other		

	SURGICAL SPECIALTY	Number Full Time	Number Part Time
	General		
	Neurosurgery		
	OB/GYN		
	Oral Surgery		
	Ophthalmology		
	Orthopedics		
	Plastic		
	Urology		
	Vascular/Thoracic		

Are the physicians employed or contracted by the Named Insured? _____

What is your turnover rate for physicians that work for you? _____ %

Are references listed by new applicants checked in writing? YES NO

Are diplomas, licenses and other credentials for applicants verified prior to employment? YES NO

What percentage of physicians American Board Certified in Emergency Medicine? _____ %

What percentage board certified in another specialty? _____ %

How many physicians are not American Board Certified in any medical specialty? _____

What percentage of physicians ATLS and ACLS certified? _____ %

Is the initial employment for a specified probationary period? YES NO If "Yes," what is the probationary period? _____

Does the organization have a formal physician peer-review process? YES NO

Is there a Risk Manager? YES NO If yes, please provide a copy of his/her resume.

Do you have a formal, written risk management protocol? YES NO

Is credentialing done for all physicians? YES NO

Is credentialing done _____ internally or _____ by a third party?

How often does the Insured re-credential its physicians? _____

Provide credentialing policies and procedures (including copy of application new physicians are required to complete).

Are any non-physician professionals (employees/independent contractors) associated with your organization? YES NO If "Yes," please describe: _____

Have any of your physicians been involved in an impaired physician program for substance abuse or mental or nervous disorder? YES NO If "Yes," please attach details.

Have any of your physicians had a license suspended or revoked, or hospital privileges suspended or revoked? YES NO If "Yes," please attach details.

Group Practice Policies		Please indicate if the policies and procedures listed below exist in written form and require mandatory compliance. If none exists, state the alternative or reason or plans to rectify on a separate sheet. Please explain all "no" answers on a separate sheet.	
		Yes	No
1.	Triage Policy	○	○
2.	Medical Screening Exam	○	○
3.	Transfer (COBRA) Policy	○	○
4.	Clinical Protocols	○	○
5.	Patient Satisfaction Survey	○	○
Average Score _____			
6.	Claims Management	○	○
Incident Reporting		○	○
Report & Track Claims		○	○
Credentialing Protocols		○	○
7.	Medical Records	○	○
Dictated		○	○
Dictated		○	○
Handwritten		○	○
8.	If handwritten, are preformatted charts used?	○	○
9.	Mechanism to handle Test Discrepancies:	○	○
Radiology		○	○
Lab		○	○
EKG		○	○

CURRENT PHYSICIAN
ROSTER

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____
28. _____
29. _____
30. _____

PRIOR ACTS SUPPLEMENTARY INFORMATION

Name of Group (Insured): _____

Requested Policy Term: _____

PRIOR ACTS COVERAGE IS PROVIDED FOR ALL PHYSICIANS ONLY FOR WORK PERFORMED ON BEHALF OF THE ABOVE NAMED GROUP AT SCHEDULED LOCATIONS SUBSEQUENT TO THE RETROACTIVE DATE SHOWN FOR EACH LOCATION, AND DOES NOT INCLUDE ANY MOONLIGHTING OR WORK PERFORMED OUTSIDE OF THE GROUP CONTRACT. IF COVERAGE FOR WORK OUTSIDE OF THE GROUP CONTRACT AT SCHEDULED LOCATIONS IS NEEDED, PLEASE COMPLETE THE FOLLOWING.

Is Prior Acts coverage requested for work performed on behalf of the Group, but at an unscheduled location? If so, please list location and retroactive period to be covered.

LOCATION - CITY/STATE	START DATE	TERMINATION DATE

Is Prior Acts coverage requested for individual specific physicians for work performed outside of the group contracts? If so, please provide the following:

PHYSICIAN'S NAME	RETROACTIVE DATE	LIMITS DURING RETROACTIVE PERIOD	SPECIALTY	LOCATION

CONDITIONS OF APPLICATION

By applying for Medical Malpractice Insurance from National Fire & Marine Insurance Company, I hereby:

- consent to the inspection by National Fire & Marine Insurance Company or their agents of all documents that may be material to an evaluation of the group's qualifications and competence.
- release from liability National Fire & Marine Insurance Company, their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications;
- release from liability any and all individuals and organizations who provide information to National Fire & Marine Insurance Company, in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

Date

X _____
Applicant's Signature

Signing this application does not bind National Fire & Marine Insurance Company or any other insurance carrier to complete the insurance. All information requested in this application is considered material and important. If National Fire & Marine Insurance Company agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, or attempt to defraud or lie to us about any matter contained in this application.