



EXCESS CASUALTY HOSPITAL SURVEY

1. Legal name and address of hospital: _____

2. List all affiliates and subsidiaries to which this insurance is to apply. Include a complete description of the operations of each affiliate/subsidiary and their relationship to the hospital.

3. Please state below the name of the insurance exactly as it appears on the policy:

4. Please list below or attach a list of entities to be included as Additional Named Insureds and their interests:

5. Is this hospital:
a. Licensed as a hospital by the state? No Yes
b. Accredited by the Joint Commission on Accreditation of Health Organizations? No Yes
c. A member of the American Hospital Association? No Yes
d. Approved by Medicare? No Yes

6. Does your hospital have a management contract to provide management services to other facilities? No Yes

7. Does another facility provide management facilities to your hospital? No Yes
If "Yes," please provide name and address of other entity: _____

8. **If the answer to any item above is "no" or if accreditation, license, approval, or membership has ever been refused or canceled in the last ten years, please explain.** _____

9. Does the hospital participate in any teaching programs? No Yes
If "Yes," please list the type of program(s): _____

a. Is the hospital sponsored? No Yes

If "Yes," please give the name of the sponsoring institution: _____

10. Date of the most recent JCAHO accreditation: _____

a. Does the hospital have a Risk Management Program? No Yes

b. Does the hospital have a Quality Assurance Program? No Yes

If "Yes," please attach a synopsis of these programs. Please provide the names and telephone number of the person responsible for these programs:

Risk Manager _____ Telephone _____

Quality Assurance _____ Telephone _____

c. Does the hospital settle or coordinate the settlement of Professional Liability claims? No Yes

If "Yes," please provide the name of the person responsible for claims handling:

1. Full-time Risk Manager _____
2. Person responsible for reporting claims _____
3. Who sets claim reserves _____
4. Defense firm _____
5. Adjusting service _____

Coverage Desired

11. Excess/Umbrella Professional Liability coverage applied for:
 \$ _____/per claim, \$ _____/aggregate
12. Excess of total underlying limits of
 \$ _____/per claim, \$ _____/aggregate

13. Coverage: _____
 Effective: _____ Expiration: _____

14. Is underlying coverage provided on an occurrence basis or on a claims-made basis? No Yes

If claims made, what is the retroactive date: of underlying coverage? _____
 Of excess coverage? _____

Facilities and Services

15. Type of institution (X if appropriate)
- | | |
|--|--|
| <input type="checkbox"/> Hospital - General | <input type="checkbox"/> Hospital - Teaching/research |
| <input type="checkbox"/> Hospital - Children | <input type="checkbox"/> Convalescent or Nursing Home |
| <input type="checkbox"/> Hospital - Psychiatric | <input type="checkbox"/> Clinic (describe service) _____ |
| <input type="checkbox"/> Hospital - Rehabilitation | |

Operations: For Profit Non-Profit Governmental

16. Types of services provided (X if appropriate)
- | | | |
|---|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> OB/Gyn | <input type="checkbox"/> ICU |
| <input type="checkbox"/> CCU | <input type="checkbox"/> Open Heart | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Pathology | <input type="checkbox"/> Inhalation Therapy |
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Long-term Care |
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Neonatal | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Nursery | <input type="checkbox"/> Surgery | |

17. Special Services:
- | | | |
|-----------------|----------------------------|--------------------------------|
| a. Ambulance: | Number of Vehicles _____ | Number of Emergency Runs _____ |
| b. Blood Banks: | Number of Donors _____ | Purchased from Others _____ |
| c. Day Care: | Number of Children _____ | Number of Days per Week _____ |
| | On Hospital Premises _____ | Open to the Public _____ |

Beds and Utilization

<u>Hospital Beds</u>	<u># of Licensed Beds</u>	<u>Average # of Occupied Beds</u>
Acute Care	_____	_____
Cribs and Bassinets	_____	_____
Psychiatric	_____	_____
Alcohol or Drug Abuse	_____	_____
Other Rehabilitation	_____	_____
Extended Care	_____	_____
Hospice	_____	_____
Other _____	_____	_____

<u>Outpatient Visits</u>	<u># of Outpatient Visits</u>
Emergency Room	_____
Outpatient Surgery	_____
Alcohol or Drug Abuse	_____
Rehabilitation/Therapy	_____
Psychiatric	_____
Home Health Care	_____
All Other	_____

Employees	Physician	Resident/ Intern	Total F/ T Employees
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Class A

Anesthesiology	_____	_____	_____
Emergency Medicine	_____	_____	_____
Cardiovascular Surgery	_____	_____	_____
General Surgery	_____	_____	_____
Gynecology	_____	_____	_____
Neonatology	_____	_____	_____
Neurosurgery	_____	_____	_____
Obstetrical	_____	_____	_____
Orthopedics	_____	_____	_____
Otolaryngology/ENT	_____	_____	_____
Pediatric Surgery	_____	_____	_____
Plastic Surgery	_____	_____	_____
Podiatry	_____	_____	_____
Urology	_____	_____	_____

Total

Class B

Burn Treatment	_____	_____	_____
Cardiology	_____	_____	_____
Gastroenterology	_____	_____	_____
General Medicine/ Family Practice	_____	_____	_____
Intensive Care	_____	_____	_____
Ophthalmology	_____	_____	_____
Pain Management	_____	_____	_____
Pathology	_____	_____	_____
Pediatrics	_____	_____	_____
Psychiatry	_____	_____	_____
Radiology	_____	_____	_____

Total

Class C

Allergy	_____	_____	_____
Dentistry	_____	_____	_____
Dermatology	_____	_____	_____
Endocrinology	_____	_____	_____
Geriatrics	_____	_____	_____
Internal Medicine	_____	_____	_____
Hematology/Oncology	_____	_____	_____
Infectious Diseases	_____	_____	_____
Nephrology	_____	_____	_____
Nuclear Medicine	_____	_____	_____
Physical Med./Physiatry	_____	_____	_____
Pulmonary Disease	_____	_____	_____
Rheumatology	_____	_____	_____

Total

<u>Other Specialists</u>	<u>Number</u>
Nurse Practitioner	_____
R.N.	_____
CRNA	_____
Midwife	_____
Perfusionists	_____

Anesthesia

18. Is staffing by: _____ Residents _____ Employed Physicians _____ CRNA's _____ Contracted Physicians
19. Is the Physicians Board certified or eligible? No Yes
 If under contract, to whom is staffing contracted? _____
20. Are contracted physicians required to carry Professional Liability Insurance? No Yes
 If "Yes," what limits are required? \$ _____
21. Does the hospital obtain:
 a. Certificate of Insurance No Yes
 b. Hold Harmless Agreement No Yes
22. What are the staffing requirements - Please describe minimum qualifications for administration of general anesthesia? _____

Certified Registered Nurse Anesthetist (CRNA's)

23. Do CRNA's provide anesthesia service? No Yes
 If "Yes," please describe the relationship between hospital and CRNA's below:
 a. Are they employed by hospital No Yes
 b. Employed by Anesthesiologist No Yes
 c. Employed by Surgeon No Yes
 d. Independent No Yes
24. Is proof of insurance required by the hospital? No Yes
 If "Yes," what are the limits? \$ _____
25. Do CRNA's work under the direct supervision of an anesthesiologist? No Yes
 If "No," who is responsible for the supervision of the CRNA? _____

Emergency Room

26. Please indicate how your Emergency Department is classified according to JCAHO standards:
 _____ Level I (Tertiary)
 _____ Level II (Comprehensive)
 _____ Level III (Basic)
 _____ Non (Standard)
 _____ Other
27. Is staffing by: _____ Residents _____ Employed Physicians _____ Contracted Physicians
28. Is the Physicians Board certified or eligible? No Yes
 If under contract, to whom is staffing contracted? _____
29. Are contract physicians required to carry Professional Liability Insurance? No Yes
 If "Yes," what are the limits required? \$ _____

30. Does the hospital obtain:
- a. Certificate of Insurance No Yes
 - b. Hold Harmless Agreement No Yes
 - c. Support Facilities:
 - 24-hour X-ray availability No Yes
 - 24-hour Surgery No Yes
 - 24-hour Laboratories No Yes

Radiology

31. Is staffing by: _____ Residents _____ Employed Physician _____ Contracted Physician
32. Is the Physicians Board certified or eligible? No Yes
 If under contract, to whom is staffing contracted? _____

33. Are contract physicians required to carry Professional Liability Insurance? No Yes
 If "Yes," what are the limits of liability required? \$ _____

34. Does the hospital obtain:
- a. Certificate of Insurance No Yes
 - b. Hold Harmless Agreement No Yes

Obstetrics

35. Is the institution a regional referral center for newborns requiring intensive care? No Yes
36. Number of Labor Rooms: _____
37. Number of Delivery Rooms: _____
38. Does the hospital have a separate birthing center? No Yes
39. Is Delivery Room suite separate from surgical suite? No Yes
40. Can Cesarean sections be performed within 30 minutes at all times? No Yes
41. Is anesthesiologist or CRNA available in-house 24-hours a day of obstetrical suite? No Yes
42. Is obstetrician available in-house 24-hours a day for obstetrical suite? No Yes

If the institution has neonatal intensive care unit (NICU), please answer the following:

43. Total number of neonates admitted to NICU in the last 12 months: _____
44. Number of neonates admitted to NICU who were transferred from other facilities: _____
45. Is full-time attending neonatologist on site in NICU 24-hours a day? No Yes
 If the institution does not have NICU, what is the total number of neonates transferred from institution to other facilities in past 12 months: _____

Staffing Privileges

46. Are credentials for new staff members checked and approved prior to granting staffing privileges? No Yes
 By whom: _____
47. How are the applicants' degree(s) and experience verified? _____

48. Are privileges probationary for at least 6 months for all new staffers? No Yes
49. Do you have any staff members who are not licensed or who have restricted licenses or privileges? No Yes
If "Yes," please explain on a separate sheet of paper.

50. Do department heads evaluate the work of their staff members? No Yes
 If yes, are the evaluations done in writing? No Yes
51. Are all staff privileges reviewed each year? No Yes
52. Do you require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? No Yes

Staff Member Malpractice Insurance

53. Are all staff members required to maintain malpractice insurance? No Yes
54. Is this requirement stated in the staff bylaws? No Yes
55. What evidence of compliance is required? _____

If "No," please explain on a separate sheet of paper.

Physical Plant (Attach inspection report if available)

- 56. Number of stories _____
- 57. Sprinklers _____
- 58. Automatic Fire Alarm _____
- 59. Connected to Fire Dept. _____
- 60. Hourly watchmen _____
- 61. Age of buildings _____
- 62. Construction of buildings _____
- 63. Distance to the Fire Dept. _____ Paid _____ Volunteer _____

Automobile Exposures

- 64. State the number and type of vehicles owned or leased by the institution
 - a. Private passenger _____
 - b. Trucks, Pick-ups _____
 - c. Ambulances _____
 - d. Buses, Vans (seating capacity) _____
 - e. Other _____

Primary Insurance

65. List all primary insurances over which the applied - excess/umbrella coverage is to apply

Type of Coverage	Limits (Incl. Agg.)	Carrier	Policy Period	Premium
CGL				\$
Prod/Comp Ops				\$
Automotive				\$
Employers Liab.				\$
Aviation				\$
Helipad				\$
Excess				\$
Other				\$

66. List which primary coverage costs and expenses are included in the above limits:

67. Is primary coverage provided on an occurrence or claims made basis?

Attachment Section

- 1. Please attach loss history for 10 years, including current year and include breakdown of total incurred losses, paid losses, outstanding losses separated by year for Hospital Professional Liability and General Bodily Injury. Additionally, please provide full details of any claim paid or outstanding during the period excess of \$100,000 (paid) and \$25,000 (outstanding).
- 2. Survey information
- 3. Please include copies of the following:
 - a. Your most recent annual report
 - b. A copy of the most recent JCAHO report and response to any contingencies
 - c. Financial Statement
 - d. Current balance of the Self-Insured Trust Fund ¹
 - e. Trust Agreement
 - f. Recent actuarial study supporting the funding of the Self-Insured Trust ¹

¹ These items apply if the applicant has set up a Self-Insured Trust Fund

The hospital hereby makes application for insurance against General Liability and Professional Liability as set forth in this application. It is understood and agreed that the application constitutes agreement and representation made to the company for procuring such insurance and that the information is true and correct.

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states

Applicant Signature: _____ Date: _____
Title: _____

Producer: _____ Date: _____