

# Virginia Surplus Lines Warning Statement

VIRGINIA FORM SLB-9

DATE \_\_\_\_\_

Applicant/Insured \_\_\_\_\_

Name of Non-Admitted Insurer (If available) \_\_\_\_\_

Policy No. \_\_\_\_\_

## NOTICE TO INSURED

This policy is being procured from or has been placed with an insurer approved by the Commission of Insurance for issuance of surplus lines insurance in this Commonwealth, but not licensed or regulated by the Commission. Additionally, there is no protection under the Virginia Property and Casualty Insurance Guaranty Association, established under Chapter 16 (§ 38.2-1600 et seq.) of this title, against financial loss to claimants or policyholders because of the insolvency of this unlicensed insurer issuing this policy.

\_\_\_\_\_  
(Surplus Lines Broker Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(License Number)

VIRGINIA FORM SL33-9 (9/96)

# NATIONAL FIRE & MARINE INSURANCE COMPANY

## BEHAVIORAL HEALTH HOSPITAL APPLICATION GUIDE

Thank you for choosing National Fire & Marine Insurance Company for your liability insurance needs. The purpose of this guide is to identify the applications necessary for the insurance coverage(s) that you are requesting a premium quote.

Please find below a list of liability coverages offered by National Fire & Marine Insurance Company. You may select any of the additional coverage types listed based on your needs. For every coverage selected, please fill out the corresponding application requirement.

BASIC COVERAGE	APPLICATION REQUIREMENTS
Every submission must include the <b>General Application</b> and the <b>Completed Application Notices and Agreements</b> signature section.	
<input type="checkbox"/> Corporate/Facility Professional Liability	Behavioral Health Hospital Professional Liability Application Claim/Suit Information Application
<input type="checkbox"/> Employed or Contracted Physicians Limited Duty & Scope Professional Liability* Each physician's prior 10 years loss history is required.	Hospital Physicians (Short Form) Application & ISO Code Reference Physicians Claim/Suit Information Application
<input type="checkbox"/> Optional Outside Activities Physicians Professional Liability* Each physician for whom coverage is being requested for services performed outside the hospital/facility.	Hospital Physician (Long Form) Application Hospital Physician Outside Activities Application Physicians Claim/Suit Information Application
<input type="checkbox"/> Employed or Contracted Healthcare Providers Professional Liability	Healthcare Providers Application
<input type="checkbox"/> General Liability	General Liability Application
<input type="checkbox"/> Limited Pollution Short Term Event Liability	Optional Coverages Application
<input type="checkbox"/> Managed Care Professional Liability	Managed Care Application
<input type="checkbox"/> Employee Benefits Professional Liability	Optional Coverages Application
<input type="checkbox"/> Employer's Liability	Optional Coverages Application
<input type="checkbox"/> Excess Professional Liability	Excess Liability Application
<input type="checkbox"/> Excess General Liability	Excess Liability Application
<input type="checkbox"/> Excess Employer's Liability	Excess Liability Application
<input type="checkbox"/> Self-Insured Retention/Captive/Trust/RRG	Self-Insured Retention (SIR) Application
<input type="checkbox"/> Cyber-liability (only required if additional limits desired above the \$100,000 provided at no additional charge)	Cyber-liability, Crisis Management and Reputational Harm Supplemental Application
<input type="checkbox"/> Directors & Officers/Employment Practices Liability Insurance	Executive Liability, Entity Liability, Employment Practices Liability and Third Party Liability Insurance Supplemental Application

In addition to the applications required for each coverage selected above, a copy of the following information, if applicable, must be submitted:

1. A copy of the applicant's certificate/accreditation including any recommendations made; and JCAHO Report.
2. Financial information. Last two (2) years audited financial statements, and annual reports (if one is published) including auditor's opinion.
3. American Hospital Association annual survey.
4. Medical staff bylaws, and rules and regulations.
5. Loss information for all applicable coverages being requested. Recently valued loss runs from insurance carriers covering the last ten (10) full years, including indemnity payments or full indemnity reserves of \$50,000 or more including expenses. All claims must be first dollar/ground up, and if possible, sent electronically.
6. Copy of your current professional liability insurance policy with endorsements.
7. Declarations page of current general liability, helipad, aircraft, watercraft, auto, employer's liability and umbrella/excess liability policies.
8. Organizational chart, including the names of all entities and a brief description of operations.
9. Catalog or list of durable medical equipment that is manufactured, leased, rented or sold to others.

Should you have any questions regarding coverage types or the application instructions, please contact your independent agent or a Customer Service Representative at 800-4MEDPRO.

# NATIONAL FIRE & MARINE INSURANCE COMPANY

## GENERAL APPLICATION

### INFORMATION

(If multiple facilities/locations exist, please complete a separate application for each.)

1. Please print legibly. Policy is based on readability of your brokerage firm/agency name.
2. Please answer all questions. If a question is not applicable, print, "n/a". This application must be completed and signed by an authorized officer of the applicant.
3. If additional space is needed, please use the Supplemental Information section at the end of the application with a reference to the question or an additional form.

### GENERAL INFORMATION

#### A. Applicant Information

Applicant Name. Where ever "Applicant" or "Named Insured" is used in this application, the term means the entity listed above.

Mailing Address \_\_\_\_\_

County \_\_\_\_\_

Street Address (if different) \_\_\_\_\_

Primary Contact Person Name (Officer or Authorized Representative of Applicant) \_\_\_\_\_

Title \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

Website Address \_\_\_\_\_

#### Person responsible for risk management:

Name \_\_\_\_\_

Title \_\_\_\_\_

Phone \_\_\_\_\_

Email \_\_\_\_\_

Requested effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_ 12:01 AM

#### B. Brokerage Firm/Agency Information

Brokerage Firm/Agency Name \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Broker/Agent Name \_\_\_\_\_

Broker/Agent License Number and Type \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

E-mail \_\_\_\_\_

#### C. Type of facility: (Check all that apply.)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> General Acute Care Hospital         | <input type="checkbox"/> Governmental  | <input type="checkbox"/> For Profit     |
| <input type="checkbox"/> Behavioral Health Hospital          | <input type="checkbox"/> Corporation   | <input type="checkbox"/> Not for Profit |
| <input type="checkbox"/> Senior Living/Long-term Care Center | <input type="checkbox"/> Individual    |   |
| <input type="checkbox"/> Other _____                         | <input type="checkbox"/> Partnership   |   |
|  | <input type="checkbox"/> Joint Venture |   |
|  | <input type="checkbox"/> Other _____   |   |

#### D. If licenses or locations are held in other states, please list the states: \_\_\_\_\_

#### E. Are there any plans to build or expand operations during the next 12 months? Yes No

If Yes, please explain and include the timeframe and estimated cost: \_\_\_\_\_

#### F. Has the applicant's license ever been revoked, denied, limited or surrendered? Yes No

If Yes, please explain: \_\_\_\_\_

#### G. Please list all of the applicant's professional association(s) memberships: \_\_\_\_\_

#### H. Have there been any technology systems improvements designed to monitor and/or control quality improvement initiatives (electronic medical records, incident reporting, security, etc.)? Yes No

1. Does the applicant have a business continuity plan in the event of a computer system failure, virus or malfunction?  Yes  No

If Yes, please provide a copy of the plan.

- I. Is there a medical audit system that includes surgical procedures and ties into the physician credentialing process?**  Yes  No
- J. Is there an active peer review process for physicians that is part of the quality management program?**  Yes  No  
If No, please explain: \_\_\_\_\_
- K. Is there a full-time risk manager?**  Yes  No  
If No, what are his/her other responsibilities and how much time is devoted to risk management? \_\_\_\_\_
- L. Is there a formal written risk management program?**  Yes  No  
If Yes, has the program been communicated to administrative and medical staff?  Yes  No
- M. Is the program periodically reviewed for effectiveness and necessary changes made?**  Yes  No
- N. Is there a written incident reporting procedure?**  Yes  No  
1. If Yes, does this procedure require review and appropriate corrective action be taken?  Yes  No  
2. Is follow-up made to assure compliance?  Yes  No
- O. Is there an on-going quality assurance (QA) committee in place?**  Yes  No  
1. If Yes, is the person responsible for risk management a member of this committee?  Yes  No  
2. To whom is the quality assurance committee accountable:  
\_\_\_\_\_  
Name \_\_\_\_\_ Title \_\_\_\_\_
3. What quality indicators are monitored (please list): \_\_\_\_\_  
\_\_\_\_\_
4. Do you monitor infection rates at your facility(ies)?  Yes  No
- P. Have there been other process enhancements or facility improvements the applicant feels has significantly improved patient safety and quality?**  Yes  No  
If Yes, please describe: \_\_\_\_\_ Date implemented (MM/DD/YYYY): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_
- Q. Have all known claims, as well as incidents which may give rise to future claims, been reported to past or current insurers?**  Yes  No
- R. Has there been a recent review of such incidents and other potential claims?**  Yes  No  
If Yes, was this review provided to the applicant's current insurer?  Yes  No  
If Yes, when: \_\_\_\_\_ By whom? \_\_\_\_\_
- S. Please check which type of notice your present professional liability insurer requires before they will formally recognize a claim under their policy:**  
 Summons and complaint or attorney demand letter  
 Written notice from you that a potentially compensable event has occurred
- T. Has any company ever cancelled or refused to offer the applicant insurance coverage?**  Yes  No  
Note: Do **not** answer in the states of Missouri and California.  
If Yes, please explain: \_\_\_\_\_
- U. Do you have a written policy concerning staff training, competency, and performance assessments?**  Yes  No
- V. Are criminal background checks, including sexual offender, performed on all employees and physicians?**  Yes  No
- W. Are drug screens performed on all employees?**  Yes  No
- X. Are job descriptions, orientation programs and performance appraisals job specific and competency based?**  Yes  No  
If No, please explain: \_\_\_\_\_
- Y. Are agency personnel used?**  Yes  No  
If Yes, is orientation provided and documented?  Yes  No
- Z. Do you participate in any alternative work programs (i.e. work release, court mandated community service, etc.)?**  Yes  No
- AA. Please furnish the following information for all owned or leased property operated or occupied by the applicant.**  
A separate summary of locations/exposures is acceptable, providing the information outlined below is furnished.

Address of Property to be Insured	Use/Occupancy	Square Footage	Age	Type of Construction	Number of Stories	Fire Protection*
Patient Care Buildings:						
Other Buildings:						

\*For each building, indicate if there is a: Sprinkler System—Full, Partial or No sprinkler system; Smoke Detector, Heat Detector; Fire Alarm—Central Station or Local Alarm



# NATIONAL FIRE & MARINE INSURANCE COMPANY

## COMPLETED APPLICATION NOTICES AND AGREEMENTS

Please read the following information carefully and return fully executed with the completed application and/or supplemental applications.

### IMPORTANT NOTICE

This insurance may contain claims-made coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date. Please read and review the policy carefully.

### FRAUD NOTICE

#### MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DECEIVE, OR DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.



Initial Here

### PLEASE READ AND SIGN

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on his, her or the facility/entity's behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I or any applicant understands that if payment of premium or first installment is by check, electronic transfer or money order, it shall not be considered "received" by the Company until it has been honored by the bank.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

**This application must be signed by the a President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.**

\_\_\_\_\_  
Signature of Officer or Authorized Representative

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### BEHAVIORAL HEALTH HOSPITAL PROFESSIONAL LIABILITY APPLICATION

**A. Please list all behavioral healthcare facilities locations:**

If More than three, please attach a separate page showing the additional locations.

**Location #1:**

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Distance to nearest hospital: \_\_\_\_\_  
 Date this location opened: \_\_\_\_\_ Estimated number of annual visits at this location: \_\_\_\_\_

**Location #2:**

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Distance to nearest hospital: \_\_\_\_\_  
 Date this location opened: \_\_\_\_\_ Estimated number of annual visits at this location: \_\_\_\_\_

**Location #3:**

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Distance to nearest hospital: \_\_\_\_\_  
 Date this location opened: \_\_\_\_\_ Estimated number of annual visits at this location: \_\_\_\_\_

**B. Please provide the FEIN#(s)** \_\_\_\_\_ **CMS (Medicare) Provider#:** \_\_\_\_\_

**C. Bond and/or Debt Rating:** \_\_\_\_\_ **Rating Company:** \_\_\_\_\_

**D. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Coverage <small>Coverage is provided on a limited duty and scope basis unless otherwise requested.</small>	Requested Per Event Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits (where allowed by state law)	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
<input type="checkbox"/> <b>Professional Liability Facility</b>	\$ _____	\$ _____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Please complete the applicable Physicians and/or Healthcare Providers supplemental application.

**E. Please indicate the certifications/accreditations held by your facility:**

JCAHO     CARF     NCQA     HBIP     Other \_\_\_\_\_

If JCAHO, is the accreditation:     Conditional/Provisional\*     Full

\*If Conditional/Provisional, attach a copy of the Type 1 Recommendations from the last visit.

**F. Medical School Affiliations:**

1. Does the applicant have any formal relationships with a medical school for the purpose of training or educating residents, medical or nursing students, CRNAs or other allied health professionals?  Yes  No

If Yes, please provide the name and location of the school and a description of each program: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2. Indicate by program type, how many students are involved:

Type: \_\_\_\_\_ Number of Students: \_\_\_\_\_      Type: \_\_\_\_\_ Number of Students: \_\_\_\_\_

Type: \_\_\_\_\_ Number of Students: \_\_\_\_\_      Type: \_\_\_\_\_ Number of Students: \_\_\_\_\_

3. Who supervises the students? \_\_\_\_\_

4. Is the applicant required to provide professional liability coverage for the residents or students as part of their residency or training program?  Yes  No

**G. Is there a full time patient advocate?**  Yes  No

**H. What is the applicant's total annual payroll?** \$ \_\_\_\_\_ **Total annual receipts?** \$ \_\_\_\_\_

**I. Is there an on-going continuing education program for:**

Nursing Staff?  Yes  No

Medical Staff?  Yes  No

Allied Health Professionals?  Yes  No

**J. Does the applicant require all foreign medical school graduates to be certified by the Education Council for Foreign Medical School Graduates?**  Yes  No

**K. Does the applicant provide service to any prison/detention centers on or off premises?**  Yes  No

If Yes, please explain: \_\_\_\_\_

**L. Does the applicant provide ancillary services to non-patients and non-owned entities?** (i.e. DME, pharmacy, wellness center, blood bank, etc.)  Yes  No

If Yes, please describe: \_\_\_\_\_

**M. Indicate if the applicant does, or will, conduct or provide any of the following services:**

1. Research activities for pharmaceuticals, surgery, biomedical equipment or psychotherapy  Yes  No  
If Yes, complete a separate research supplemental questionnaire.

2. Full body scans to non-patients.  Yes  No  
If Yes, indicate the number of procedures anticipated for the next 12 months: \_\_\_\_\_

3. Alternative/complementary medicine.  Yes  No  
If Yes, indicate the type of alternative medicine provided: \_\_\_\_\_

**N. Are any changes planned to the services offered by the applicant in the next 12 months?**  Yes  No  
If Yes, please describe. Please include additional services as well as services to be discontinued. \_\_\_\_\_

**O. Have any services been discontinued during the last 24 months?**  Yes  No  
If Yes, please describe. \_\_\_\_\_

**P. Does the applicant engage in telemedicine** (i.e. radiology, cardiology, ophthalmology, remote monitoring for home patients, dermatology, etc.)?  Yes  No  
If Yes, please describe. \_\_\_\_\_

**Q. Medical Staff—Physicians:**

1. Indicate the total number of medical staff: \_\_\_\_\_

2. Indicate the total number of staff physicians: \_\_\_\_\_

3. a. Are credentials for all new staff physicians checked and approved prior to granting privileges?  Yes  No  
b. Are privileges probationary for at least 6 months for all new staff physicians?  Yes  No

4. Are all staff physicians licensed and privileged without restrictions?  Yes  No  
If No, please provide details: \_\_\_\_\_

5. Is a new staff physician's work evaluated by the department chief?  Yes  No  
If Yes, is it done in writing?  Yes  No

6. How often are privileges reviewed? \_\_\_\_\_

7. Is an ongoing quality assurance review maintained on all staff physicians' clinical work?  Yes  No

8. Is clinical staff reappointed at least every two years, with reappointment based on evaluation of clinical practice by the department chief?  Yes  No  
If Yes, is it done in writing?  Yes  No

9. Does the applicant perform drug and alcohol testing for all physicians for credentialing and privileging purposes?  Yes  No

10. Are each of the physicians practicing at the applicant's facility board-certified?  Yes  No  
If No, how many are not board-certified? \_\_\_\_\_

11. Are all privileges granted to staff physicians in writing?  Yes  No

12. a. 1) Are staff physicians required to carry professional liability insurance?  Yes  No  
If Yes, what are the liability limits? \$ \_\_\_\_\_ Per Event / \$ \_\_\_\_\_ Annual Aggregate  
b. Are they insured with a carrier rated less than A- by AM Best?  Yes  No

13. Does the applicant collect certificates of insurance from all staff physicians as evidence of compliance?  Yes  No

14. Has the license of any staff physician been restricted, revoked or suspended during the last five years?  Yes  No  
If Yes, please explain: \_\_\_\_\_

15. Have you made reports to the National Practitioner Data Bank regarding any peer review action, suspension or professional liability payment involving any member of the medical/dental staff during the last five years?  Yes  No
16. Does the applicant supervise anyone other than its own employees?  Yes  No  
If Yes, please describe the responsibility of each individual, relationship to each individual and also indicate by type of medical professional, the number of individuals the applicant supervises:
- 

**R. Pharmaceutical Services:**

1. Does a full-time registered pharmacist direct the pharmacy?  Yes  No  
If No, please explain: \_\_\_\_\_
2. Is the pharmacy staffed in whole or in part by a contract group?  Yes  No  
If Employees, skip to next question.  
If contract group, what is the name of the group? \_\_\_\_\_  
Name of group's insurance carrier: \_\_\_\_\_
3. Does the group provide a hold harmless agreement in favor of the hospital?  Yes  No
4. Does the group annually provide the applicant with a certificate of insurance for professional liability?  Yes  No
5. What are the minimum professional liability limits that is required for the group to carry?  
\$\_\_\_\_\_ Per Medical Incident / \$\_\_\_\_\_ Annual Aggregate
6. Do the limits apply on an individual or shared limits basis?  Individual Limits  Shared Limits

**S. Anesthesia Services:**

1. Number of employed and contracted: Anesthesiologists: \_\_\_\_\_ CRNA's: \_\_\_\_\_
2. Are the anesthesiologists required to be board certified/eligible in anesthesiology?  Yes  No
3. Does the applicant require certificates of insurance by those performing anesthesia?  Yes  No
4. What is the ratio of CRNAs to anesthesiologists? \_\_\_\_\_
5. Are CRNAs supervised by a physician?  Yes  No
6. Is anesthesia administered without the direct supervision of an anesthesiologist?  Yes  No
- 
7. Is an anesthesiologist or CRNA on site 24/7?  Yes  No  
If No, is an anesthesiologist or CRNA on-call when one is not on site?  Yes  No  
If Yes, what is the maximum amount of time for arrival for the on-call physician? \_\_\_\_\_
8. Does an informed consent discussion take place between the patient and the anesthesiologist or CRNA that includes anesthesia contemplated, possible risks and alternatives?  Yes  No
9. Does the anesthesia equipment have oxygen analyzers?  Yes  No  
If No, please explain: \_\_\_\_\_
10. Does the anesthesia equipment have disconnect alarms?  Yes  No  
If No, please explain: \_\_\_\_\_
11. Who owns and maintains the anesthesia equipment? \_\_\_\_\_

**T. Please indicate the % of the following services that are being provided by your facility. (Total % should equal 100%)**

\_\_\_\_\_ **Alcohol and other drugs/addictions**

\_\_\_\_\_ **Mental Health, Psychosocial Rehabilitation**

\_\_\_\_\_ **Family Services** (programs designed to help maintain or improve the quality of life for children, adolescents, or other family members individually or in their relationships with their families, their environments, or other individuals; services can include family counseling, educational programs, etc.)

\_\_\_\_\_ **Integrated AOD/Mental Health** (programs designed to provide alcohol, drug, addictions and other mental health services)

\_\_\_\_\_ **Integrated DD/Mental Health** (programs designed to provide services to persons whose primary diagnosis is intellectual or other developmental disabilities, and who are at risk for or exhibiting behavioral disorders, or have identified mental health needs.)

**U.**

	# of outpatient visits (if applicable)	# of licensed beds (if applicable)	# of occupied beds (if applicable)	Average length of stay
Substance Abuse Counseling				
Substance Abuse Skilled Medical*				
Mental Health Counseling				
**"Skilled" - medical treatment for chemical dependency				



**BB. Are patients allowed to self medicate while at the facility?**  Yes  No

**CC. Is informed consent secured for all treatments?**  Yes  No

**DD. Are guidelines in place to determine whether a patient is capable of giving consent for treatment?**  Yes  No

**EE. Identify any outstanding deficiencies, problems, failures or user errors in safety management, life safety management, equipment management or utilities management as cited in any recent inspections.**

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

**FF. Are all patient areas visible from a nursing station?**  Yes  No

**GG. Are all patient areas compliant with the standards for psychiatric wards and suicide prevention (physical environment)?**  Yes  No

**HH. Are all patients segregated by:**

1. Gender?  Yes  No

2. Age?  Yes  No

**II. Are patients constantly monitored in:**

1. common areas?  Yes  No

2. when mixed?  Yes  No

**JJ. Are patients discharged with antipsychotic medicines?**  Yes  No

If Yes, please provide the percentage \_\_\_\_\_%

**KK. Are patients discharged on multiple antipsychotic medicines?**  Yes  No

If Yes, please provide the percentage \_\_\_\_\_%

**LL. Are patients searched upon return to an inpatient area/facility?**  Yes  No

**MM. Are contraband controls in place?**  Yes  No

**NN. Are all inpatients facilities locked and secured?**  Yes  No

**OO. Do all exit doors require a magnetic key?**  Yes  No

**PP. Please identify any other measures used to address: escapes, leaving without authorization, unauthorized visitors, etc.**

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

**QQ. Are any precautions taken to warn identified third parties of threats made against them by patients?**  Yes  No

**RR. Are credentials of each physician reviewed by a medical staff committee and approved by the governing body prior to granting privileges?**  Yes  No

**SS. Does the applicant have any physicians on staff that do not maintain staff privileges at a hospital?**  Yes  No

If yes, please explain: \_\_\_\_\_

# NATIONAL FIRE & MARINE INSURANCE COMPANY

## CLAIM/SUIT INFORMATION APPLICATION

Please complete the questions below for all of the applicant's **(1) Open and; (2) Closed Claims with an indemnity payment or indemnity reserve of \$50,000 or more including expenses.** All claims must be first dollar/ground up, and if possible, sent electronically. Only provide the claims information on those claims that are not being handled directly by National Fire & Marine Insurance Company.

Note: Additional documentation (office/hospital records) may be requested at the underwriting department's discretion.  
All fields must be completed.

**1. Claim Number:** \_\_\_\_\_

**2. Patient/Claimant Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last Name, First Name

**3. Date of treatment and/or surgery which led to the allegations against you.** \_\_\_\_\_  
MM      YYYY

**4. Date claim/incident notice received:** \_\_\_\_\_  
MM      YYYY

**5. Has this claim/incident been reported to your current or former insurer?**  Yes  No  
If Yes, provide the date the claim was reported to your current or former insurer:  
*Please provide a copy of the report(s).* \_\_\_\_\_  
MM      YYYY

**6. Name of doctor(s), health care provider(s) or other hospital(s), if any, involved in the claim or suit:** \_\_\_\_\_  
\_\_\_\_\_

**7. Defending insurance carrier name:** \_\_\_\_\_  
\_\_\_\_\_

**8. Was a claim made or a suit filed?**  Yes  No

**9. Indicate case value established by carrier, if known:** \$ \_\_\_\_\_

**10. Disposition or current status of claim or suit:**  Open  Closed

**If closed,** date of closing/settlement or award: \_\_\_\_\_  
MM      YYYY

**If closed,** was payment made?  Yes  No  
If No, was claim or suit withdrawn?  Yes  No

If Yes, indicate total amount of settlement or award: \$ \_\_\_\_\_

Was the matter closed with your consent?  Yes  No

**If Open,** has settlement been offered?  Yes  No

**If Open,** has trial date been set?  Yes  No

Trial date: \_\_\_\_\_  
MM      YYYY

**11. Nature of allegations in the claim or suit:**  
Condition treated: \_\_\_\_\_  
Treatment provided: \_\_\_\_\_  
Alleged negligence: \_\_\_\_\_  
Alleged injury: \_\_\_\_\_

**12. Please provide a narrative description of the medical facts:** (must include but not be limited to the type of treatment and/or surgery, including applicant's involvement). If additional space is needed, please attach a separate piece of paper.

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

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### HOSPITAL PHYSICIANS (SHORT FORM) APPLICATION

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Coverage <small>Coverage is provided on a limited duty and scope basis unless otherwise requested.</small>	Requested Per Event Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits (where allowed by state law)	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
<input type="checkbox"/> <b>Professional Liability Employed or Contracted Physicians</b> (Physician, Surgeons, Residents, Interns, Fellows, Dentists and Oral Surgeons)	\$	\$	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

**B. Schedule of Medical Professionals—Physicians, Surgeons, Dentists and Oral Surgeons**

Please provide the information below for each physician, surgeon, resident, intern, fellow, dentist and oral surgeon for whom coverage is to be provided under this policy. If additional space is needed, please use an additional piece of paper and include all information requested in the Schedule of Medical Professionals, below.

***PLEASE COMPLETE THE PHYSICIANS CLAIM/SUIT INFORMATION APPLICATION TO PROVIDE THE PREVIOUS 10 YEARS LOSS HISTORY FOR EACH PHYSICIAN.***

Coverage is provided on a limited duty and scope basis unless otherwise requested. If coverage for Outside Activities is being requested, please complete the Hospital Physicians Application, the Hospital Physicians Outside Activities Application and Physicians Claim/Suit Information Application for each. Coverage is designed to provide retroactive dates equal to the start date with the applicant unless otherwise requested. If an individual application is requested and received by the Company that conflicts with the information below, the provider will be subject to re-classification and re-rating based on the information contained in the application.

- Employee Status: (C)ontract; (E)mployed; (F)aculty; (R)esident  
 Limits: (SH) Shared limits with the facility, restricted to the named insured's operations.  
 (SE) Separate limits, restricted to the named insured's operations.

#### SCHEDULE OF MEDICAL PROFESSIONALS—PHYSICIANS, SURGEONS, DENTISTS AND ORAL SURGEONS

Name of Medical Professional <small>Last Name, First Name, Middle Name</small>	Status <small>(C) (E) (F) (R)</small>	State	County	Indicate: <small>Physician, Surgeon, Dentist or Oral Surgeon</small>	Specialty ISO Code-List all that apply. (Please see ISO Code Reference)	Surgery Type: No surgery, Minor, or Major	Retro Date *	Hire Date	Number of hours per week if less than 40	License #	Limits (SH) (SE)

\*If prior acts coverage is desired for services provided prior to the hire date with the applicant, please submit an individual application for each medical professional for whom prior acts coverage is being requested.

#### SCHEDULE OF TERMINATED-INACTIVE PHYSICIANS

**C. Schedule of Terminated-Inactive Physicians**

**If coverage is sought for inactive physicians who are sharing limits or who have been previously provided ongoing incurred but not reported coverage, please complete the Schedule of Terminated-Inactive Physicians below.** If coverage for inactive physicians is not being requested, skip to the next question. Coverage is provided on a shared limit basis unless otherwise requested. If additional space is needed, use an additional piece of paper.

Name of Medical Professional <small>Last Name, First Name, Middle Name</small>	MD or DO	State	County	Specialty ISO Code List all that apply. (Please see ISO Code Reference)	License Number	Retro Date	Hire Date	Termination Date

ISO CODE REFERENCE		
SPECIALTY	ISO CODE	
	M.D.	D.O.
Allergy—No Surgery	80254	84254
Anesthesiology	80151	84151
Colon & Rectal Surgery	80115	84115
Cardiology (including Swan-Ganz) - No Surgery	80255	84255
Cardiology (including left heart catheterization, angioplasty, electrophysiological studies [left heart])	80422	84422
Cardiovascular Surgery	80150	84150
Cosmetic Surgery	80136	84136
Dermatology—No Surgery	80256	84256
Dermatology—Performing any of the following procedures: liposuction: tumescent technique only, deep chemical peels	80282	84282
Dermatology—Skin flaps/grafts, cosmetic, assisting in major surgery—own patients	80294	84294
Emergency Medicine (including major surgery)	80157	84157
Endocrinology—No Surgery	80238	84238
Family/General Practice—No Surgery/No obstetrics	80420	84420
Family/General Practice—Performing any of the following procedures: Vasectomies—own patients only; Lumbar Epidural Steroid Nerve Blocks	80421	84421
Family/General Practice—Performing any of the following procedures: Prenatal practice with delivery or to term; no delivery, Tubal Ligations, Colonoscopy	80273	84273
Family/General Practice—including deliveries	80273	84273
General Surgery—No bariatric	80143	84143
General Surgery—Bariatric	80148	84148
Forensic Medicine—No Surgery	80240	84240
Gastroenterology—No Surgery	80241	84241
Gastroenterology—Performing any of the following procedures: Colonoscopy, Endoscopic Biopsy, Upper GI Endoscopy - ERCP, Gastrostomy (PEG tube replacement), Upper GI Endoscopy - Duodenoscopy	80274	84274
Geriatrics—No Surgery	80243	84243
Gynecology—No Surgery	80244	84244
Gynecology—Major Surgery	80167	84167
Hand Surgery	80169	84169
Head & Neck Surgery	80170	84170
Hematology/Oncology—No Surgery	80245	84245
Infectious Disease-No Surgery	80246	84246
Internal Medicine—No Surgery	80257	84257
Internal Medicine—Performing any of the following procedures: Gastrointestinal Endoscopy, Biopsy: Endoscopic	80284	84284
Internal Medicine—Performing any of the following procedures: Colonoscopy	80284	84284
Neonatology—No Surgery	80471	84471
Nephrology—No Surgery	80260	84260
Neurology—No Surgery	80261	84261
Neurology—Performing any of the following procedures: Lumbar Epidural Steroid-Nerve Blocks, Myelography, Angiography, Arteriography	80288	84288
Neurosurgery— Neurosurgeons (Craniotomy, Laminectomy, Spinal Fusions)	80152	84152
Nuclear Medicine—No Surgery	80262	84262
Nutrition—No Surgery	80248	84248
Obstetrics/Gynecology	80153	84153

**ISO CODE REFERENCE**

SPECIALTY	ISO CODE	
	M.D.	D.O.
Occupational Medicine—No Surgery	80233	84233
Ophthalmology—No Surgery	80263	84263
Ophthalmology—Performing any of the following procedures: Ectropion/Entropion repair, Excision of growths in area of eyes and lids	80289	84289
Ophthalmology—Performing any of the following procedures: Cataract surgery, Blepharoplasty, Lasik/Refractive surgery	80114	84114
Orthopedic Surgery—Exclude back	80176	84176
Orthopedic Surgery—Include back	80154	84154
Otorhinolaryngology—No Surgery	80265	84265
Otorhinolaryngology—Performing any of the following procedures: Endoscopic biopsy, lymph node excision, hair transplants (follicular unit transplantation)	80291	84291
Otorhinolaryngology—Assisting in surgery on other than own patients	80117	84117
Otorhinolaryngology—Performing any of the following procedures: Rhinoplasty, Reconstructive Blepharoplasty, Tonsillectomy & Adenoidectomy, Reconstructive Cleft Plate surgery, Mastoidectomy	80159	84159
Pain Management	80295	84295
Pathology—No Surgery	80266	84266
Pediatrics—No Surgery	80267	84267
Pediatrics—Performing any of the following procedures: Colonoscopy, Upper GI Endoscopy - ERCP, Upper GI Endoscopy - Esophagoscopy, Pulmonary Artery Catheterization	80293	84293
Physiatry-No Surgery	80235	84235
Plastic Surgery	80156	84156
Psychiatry—No Surgery (including child)	80249	84249
Radiology—Diagnostic	80280	84280
Radiology—Therapy	80425	84425
Rheumatology—No Surgery	80252	84252
Thoracic Surgery	80144	84144
Traumatic Surgery	80171	84171
Urgent Care—No Surgery/No ER	80102	84102
Urology	80145	84145
Vascular Surgery	80146	84146

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### PHYSICIANS CLAIM/SUIT INFORMATION APPLICATION

For **each physician** complete this form for **each claim**.

Please complete the questions below for all **Open and; (2) Closed Claims covering the past ten (10) years**. All claims must be first dollar/ground up, and if possible, sent electronically. Only provide the claims information on those claims that are not being handled directly by National Fire & Marine Insurance Company.

Note: Additional documentation (office/hospital records) may be requested at the underwriting department's discretion.  
All fields must be completed.

**1. Claim Number:** \_\_\_\_\_

**2. Patient/Claimant Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_  
Last Name, First Name

**3. Date of treatment and/or surgery which led to the allegations against you.** \_\_\_\_\_  
MM YYYY

**4. Date claim/incident notice received:** \_\_\_\_\_  
MM YYYY

**5. Has this claim/incident been reported to your current or former insurer?**  Yes  No

If Yes, provide the date the claim was reported to your current or former insurer:  
*Please provide a copy of the report(s).*

\_\_\_\_\_ MM YYYY

**6. Name of doctor(s), health care provider(s) or other hospital(s), if any, involved in the claim or suit:** \_\_\_\_\_

**7. Defending insurance carrier name:** \_\_\_\_\_

**8. Was a claim made or a suit filed?**  Yes  No

**9. Indicate case value established by carrier, if known:** \$ \_\_\_\_\_

**10. Disposition or current status of claim or suit:**  Open  Closed

**If closed**, date of closing/settlement or award: \_\_\_\_\_  
MM YYYY

**If closed**, was payment made?  Yes  No

If No, was claim or suit withdrawn?  Yes  No

If Yes, indicate total amount of settlement or award: \$ \_\_\_\_\_

Was the matter closed with your consent?  Yes  No

**If Open**, has settlement been offered?  Yes  No

**If Open**, has trial date been set?  Yes  No

Trial date: \_\_\_\_\_  
MM YYYY

**11. Nature of allegations in the claim or suit:**

Condition treated: \_\_\_\_\_

Treatment provided: \_\_\_\_\_

Alleged negligence: \_\_\_\_\_

Alleged injury: \_\_\_\_\_

**12. Please provide a narrative description of the medical facts:** (must include but not be limited to the type of treatment and/or surgery, including applicant's involvement).

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

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### HOSPITAL PHYSICIAN (LONG FORM) APPLICATION

- A. If additional space is needed, please complete in the Supplemental Information section with a reference to the question.  
 B. Additional documentation may be requested by the Company as necessary. For example: A copy of your most recent professional liability policy, including all endorsements, declarations page, etc.  
 C. Please print legibly. Please answer all questions; if a question is not applicable, print, "N/A."

#### GENERAL INFORMATION

- A. Last Name:** \_\_\_\_\_  
**First Name:** \_\_\_\_\_  
**Middle Name:** \_\_\_\_\_ **Suffix:** \_\_\_\_\_
- B. Employment Status:**  
 Employee     Contractor     Other: \_\_\_\_\_    Date joined: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM      DD      YYYY
- C. Residence Address:**  
 Number and Street: \_\_\_\_\_ Apartment # \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 County: \_\_\_\_\_

#### EDUCATIONAL BACKGROUND

- A. Medical School:**  
 \_\_\_\_\_  
 Name of School \_\_\_\_\_ Degree \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Completed From: \_\_\_\_\_ / \_\_\_\_\_ To: \_\_\_\_\_ / \_\_\_\_\_  
MM      YYYY      MM      YYYY  
 Country: \_\_\_\_\_
- B. If a foreign medical school graduate, are you certified by the Educational Commission for Foreign Medical Graduates or have you completed the Fifth Pathway Program?**  Yes  No  
 If No, please explain: \_\_\_\_\_  
 \_\_\_\_\_
- C. Residency: List all residency training programs.** Please enter each specific specialty.
1. Name of Hospital/Facility/Program: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Specialty type: \_\_\_\_\_  
 Completed:  Yes  No  Still in training    From (MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_ To (MM/YYYY):: \_\_\_\_\_ / \_\_\_\_\_
2. Name of Hospital/Facility/Program: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Specialty type: \_\_\_\_\_  
 Completed:  Yes  No  Still in training    From (MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_ To (MM/YYYY):: \_\_\_\_\_ / \_\_\_\_\_
- D. Have you participated in any additional training?** (i.e. Fellowship, etc.)  Yes  No  
 If Yes, please provide the following information:
1. Name of Hospital/Facility/Program: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Specialty type: \_\_\_\_\_  
 Completed:  Yes  No  Still in training    From (MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_ To (MM/YYYY):: \_\_\_\_\_ / \_\_\_\_\_
2. Name of Hospital/Facility/Program: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Specialty type: \_\_\_\_\_  
 Completed:  Yes  No  Still in training    From (MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_ To (MM/YYYY):: \_\_\_\_\_ / \_\_\_\_\_
- E. Are you entering practice for the first time?**  Yes  No
- F. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 credit hours:** \_\_\_\_\_
- G. Have you completed a risk management education course within the last twelve (12) months?**  Yes  No

**PRACTICE INFORMATION**

**A. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including but not limited to, Telemedicine or Internet Medicine?**  Yes  No

If this is covered by another professional liability insurance policy, complete Question F of the Additional Professional Information section.

If Yes, which state(s): \_\_\_\_\_

**B. States in which you hold a license to practice medicine:** Please check the appropriate box to indicate the status of your license.  
(Exclude state abbreviation from license number) Active Inactive Temporary Pending

- |                                  |                          |                          |                          |                          |
|----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. State: _____ License #: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. State: _____ License #: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. State: _____ License #: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. State: _____ License #: _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**C. Do you have previous practice location(s)?**  Yes  No

If Yes, list all location(s) within the past ten (10) years. If your requested retroactive date is greater than 10 years, provide locations back to the retroactive date. Please list the most recent location first.

- Name of Practice: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
Specialty type: \_\_\_\_\_ From (MM/YYYY): \_\_\_\_ / \_\_\_\_ To (MM/YYYY):: \_\_\_\_ / \_\_\_\_
- Name of Hospital/Facility/Program: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
Specialty type: \_\_\_\_\_ From (MM/YYYY): \_\_\_\_ / \_\_\_\_ To (MM/YYYY):: \_\_\_\_ / \_\_\_\_

**D. Please explain the following gaps if they occurred in the last ten (10) years:**

- Gaps greater than 1 year between your medical school, residency, other training or first time in practice: \_\_\_\_\_
- Gaps greater than 6 months between practice locations: \_\_\_\_\_

**E. To which medical societies or associations do you belong?** \_\_\_\_\_

Note: All percentages requested below for specialties, procedures and surgical activities are of your total practice.

**Please enter complete name of specialty/sub-specialty. Combined percentages must equal 100%.**

**F. What is your present specialty?** \_\_\_\_\_ % of total practice  
**What is your sub-specialty?** \_\_\_\_\_ % of total practice

**G. Are you permanently retired from the practice of clinical medicine?**  Yes  No

**H. American Board Certified?**  Yes  No \_\_\_\_\_ / \_\_\_\_\_ (MM/YYYY)  
Specialty Board Date most recently certified.  
\_\_\_\_\_ / \_\_\_\_\_ (MM/YYYY)  
Specialty Board Date most recently certified.

If not American Board Certified, are you board eligible?  Yes  No If Yes, when do you take your boards? \_\_\_\_\_ / \_\_\_\_\_ (MM/YYYY)

If not American Board Certified, have you ever taken a specialty board examination and failed to pass?  Yes  No

If Yes, how many times? \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

**I. Indicate the state and county where you practice, and average weekly hours at that location:**

State/County: \_\_\_\_\_ Hours: \_\_\_\_\_ State/County: \_\_\_\_\_ Hours: \_\_\_\_\_

**J. Indicate the estimated average weekly numbers, under each of the following categories, for which you require National Fire & Marine Insurance Company Coverage:**

Hours per week: \_\_\_\_\_ Patients seen per week: \_\_\_\_\_  None Unscheduled walk-in patients per week: \_\_\_\_\_  None

**K. Please indicate the percentage of your total practice performing the following surgical activities:**

- |                          |   |   |                   |
|--------------------------|---|---|-------------------|
| _____ % Cardiac          | _____ % Obstetrics                      | _____ % Otolaryngology                      | _____ % Traumatic |
| _____ % Gynecology       | _____ % Ophthalmology                   | _____ % Plastic (cosmetic enhancement only) | _____ % Urology   |
| _____ % Hand             | _____ % Orthopedic (including back)     | _____ % Plastic (reconstruction only)       | _____ % Vascular  |
| _____ % Neurosurgery     | _____ % Orthopedic (not including back) | _____ % Thoracic                            |                   |
| _____ % Other (describe) | _____                                   |   |                   |

**L. Please check any of the following procedures you will perform:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abdominoplasty—Tummy Tuck                                      | <input type="checkbox"/> D & C  | <input type="checkbox"/> Pacemakers—Epicardial                       |
| <input type="checkbox"/> Abortions—elective ____% of total practice                     | <input type="checkbox"/> Disectomy  | <input type="checkbox"/> Pacemakers—Endocardial                      |
| <input type="checkbox"/> Abortions—Therapeutic ____% of total practice                  | <input type="checkbox"/> Open   | <input type="checkbox"/> Pacemakers—Temporary                        |
| <input type="checkbox"/> Acupuncture—Therapeutic/Local Anesthetic                       | <input type="checkbox"/> Other Than Open  | <input type="checkbox"/> Peritoneoscopy                              |
| <input type="checkbox"/> Anesthesia General/Spinal/Caudal                               | <input type="checkbox"/> Electromagnetic Therapy  | <input type="checkbox"/> Phlebography                                |
| <input type="checkbox"/> Angiography  | <input type="checkbox"/> Electroconvulsive/Shock Therapy                                    | <input type="checkbox"/> Pneumoencephalography                       |
| <input type="checkbox"/> Angioplasty  | <input type="checkbox"/> Embolization   | <input type="checkbox"/> Polypectomy                                 |
| <input type="checkbox"/> Arteriography  | <input type="checkbox"/> ERCP   | Prenatal / Gynecological Practice                                    |
| <input type="checkbox"/> Arthroscopy  | <input type="checkbox"/> Face Lifts   | <input type="checkbox"/> Prenatal Practice—1st & 2nd Trimester       |
| <input type="checkbox"/> Assisting in major surgery-own patients only                   | <input type="checkbox"/> Face Lifts Mini (done with laser) _% of total practice             | <input type="checkbox"/> Prenatal Practice—1st & 2nd Trimester       |
| <input type="checkbox"/> Assisting in major surgery-own & other than own patients       | <input type="checkbox"/> Gastrointestinal Endoscopy   | <input type="checkbox"/> Prenatal Practice—to term, no delivery      |
| <input type="checkbox"/> Bariatric Surgery—Laparoscopic                                 | <input type="checkbox"/> Gynecology—Major Surgery   | <input type="checkbox"/> Normal Deliveries—total per year ____       |
| <input type="checkbox"/> Bariatric Surgery—Non-Laprosopic                               | <input type="checkbox"/> Hair Transplants—Follicular Unit Transplantations                  | <input type="checkbox"/> Cesarean Deliveries—total per year ____     |
| <input type="checkbox"/> Biopsy—Endoscopic  | <input type="checkbox"/> Hair Transplants—Other   | <input type="checkbox"/> Prolotherapy                                |
| <input type="checkbox"/> Blepharopigmentation ____% of total practice                   | <input type="checkbox"/> HVLA on the cervical spin on patients younger than 18 years of age | <input type="checkbox"/> Radial/Laser Keratotomy                     |
| <input type="checkbox"/> Blepharoplasty—cosmetic ____% of total practice                | <input type="checkbox"/> Intrathecal Pumps  | <input type="checkbox"/> Radiation/X-Ray Therapy                     |
| <input type="checkbox"/> Blepharoplasty-reconstruction ____% of total practice          | <input type="checkbox"/> Kyphoplasty  | <input type="checkbox"/> Rectal Ozone Therapy                        |
| <input type="checkbox"/> Botox ____% of total practice                                  | <input type="checkbox"/> Laporoscopic Cholecystectomy                                       | <input type="checkbox"/> Rhinoplasty ____% of total practice         |
| <input type="checkbox"/> Brachioplasty  | <input type="checkbox"/> Laparoscopy  | <input type="checkbox"/> Sigmoidoscopy—60 cm or less                 |
| <input type="checkbox"/> Breast Implants-Cosmetic ____% of total practice               | <input type="checkbox"/> Laser Surgery  | <input type="checkbox"/> Sigmoidoscopy—greater than 60 cm            |
| <input type="checkbox"/> Breast Implants-Reconstruction ____% of total practice         | <input type="checkbox"/> Laser Therapy (Endoscopic)   | <input type="checkbox"/> Silicone Injections ____% of total practice |
| <input type="checkbox"/> Breast Reduction—Cosmetic                                      | <input type="checkbox"/> Laser Therapy (Non-Endoscopic)                                     | Skin Flaps/Grafts  |
| <input type="checkbox"/> Bronchoscopy   | <input type="checkbox"/> Lipoinjection ____% of total practice                              | <input type="checkbox"/> Cosmetic ____% of total practice            |
| <input type="checkbox"/> Bronco-esophagology  | Liposuction   | <input type="checkbox"/> Reconstruction ____% of total practice      |
| <input type="checkbox"/> Buttock Implants   | <input type="checkbox"/> Other Than Tumescant Technique                                     | <input type="checkbox"/> Spinal Cord Stimulators                     |
| <input type="checkbox"/> Calf Implants  | <input type="checkbox"/> Tumescant Technique Only ____% of total practice                   | <input type="checkbox"/> Thigh Lift                                  |
| <input type="checkbox"/> Cataract Surgery   | <input type="checkbox"/> Lithotripsy  | <input type="checkbox"/> Tubal Ligations                             |
| <input type="checkbox"/> Catheterization—Left Heart                                     | <input type="checkbox"/> Lymphangiography   | <input type="checkbox"/> Upper GI Endoscopy                          |
| <input type="checkbox"/> Catheterization-Right Heart (other than CVP lines)/ Swanz Ganz | <input type="checkbox"/> Mammograms   | <input type="checkbox"/> Vasectomies—own patients                    |
| <input type="checkbox"/> Cheek/Chin/Lip Implants  | <input type="checkbox"/> Myelography  | <input type="checkbox"/> Vasectomies-own & other than own patients   |
| <input type="checkbox"/> Chelation Therapy  | Nerve Blocks  | <input type="checkbox"/> Weight Control Medication                   |
| <input type="checkbox"/> Chemical Peels—Superficial/Medium                              | <input type="checkbox"/> Facet  | ____% of total practice  |
| <input type="checkbox"/> Chemical Peels—Deep ____% of total practice                    | <input type="checkbox"/> Lumbar Epidural Steroid  | <input type="checkbox"/> Other Medical Techniques, List              |
| <input type="checkbox"/> Cleft Lip Surgery—Reconstructive                               | <input type="checkbox"/> Myofascial   | Procedures (do not restate your specialty):                          |
| <input type="checkbox"/> Cleft Palate Surgery—Reconstructive                            | <input type="checkbox"/> Occipital  | _____  |
| <input type="checkbox"/> Colonoscopy  | <input type="checkbox"/> Paraspinal/Paravertebral   | _____  |
| <input type="checkbox"/> Cryosurgery (Cervical)   | <input type="checkbox"/> Peripheral   | _____  |
| <input type="checkbox"/> Cryosurgery (non-external lesions)                             | <input type="checkbox"/> Sciatic  | _____  |
|   | <input type="checkbox"/> Triggerpoint Injection   | _____  |
|   | <input type="checkbox"/> Oxidation Therapy  | _____  |

**M. In the last 10 years,**

- Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity?  Yes  No  
If Yes, list procedures/activities, reason for discontinuing, and date discontinued: \_\_\_\_\_ / \_\_\_\_\_  
MM YYY
- Have you performed weight control surgery or prescribed weight control medication?  Yes  No
  - If Yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?  
 <1%  1% - 10%  11% - 50%  >50%  Never prescribed weight control medication
  - If Yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?  
 <1%  1% - 10%  11% - 50%  >50%  Never prescribed weight control surgery

**N. Do you work in an emergency room on a scheduled basis? (If Yes, answer 1 and 2 below.)**

- Indicate average number of of hours per month devoted to in-hospital emergency room care. (Do not include on-call hours.) \_\_\_\_\_ hrs
- On average how many of the above hours are you working in order to fulfill staff privilege requirements? \_\_\_\_\_ hrs  
(If you have emergency room activities which are covered by another professional liability insurance policy, please complete Question F of the Additional Professional Information section).

**O. Please use the space below for any comments you feel will help National Fire & Marine Insurance Company better understand any special circumstances concerning your practice:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL PROFESSIONAL INFORMATION**

Please fully explain any, "Yes," answer in the Supplemental Information section with a reference to the question. (For questions A through E, please complete Question F, if you are covered by other insurance for these activities.)

**A. Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes.** \_\_\_\_\_ %  None

**B. Indicate the percentage of your practice devoted to working in a nursing home facility.** \_\_\_\_\_ %  None

**C. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved.**  Yes  No  
If Yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

**D. Do you practice as a medical director?**  Yes  No  
Type and name of facility: \_\_\_\_\_  
If Yes, what percentage of your practice is devoted to this activity? \_\_\_\_\_ %  
Briefly describe your responsibilities: \_\_\_\_\_

**E. Do you devise or review plant/employer safety standards?**  Yes  No  
What products are manufactured by the company? \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Location: \_\_\_\_\_

**F. Will you be performing activities which will be covered by another professional liability policy?**  Yes  No  
If Yes, are you a(n):  Employee  Independent Contractor  Resident/Fellow  Faculty  
Practice Name: \_\_\_\_\_  
Location: \_\_\_\_\_  
Name of Insurer: \_\_\_\_\_

**G. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked suspended, restricted, subject or a reprimand, placed on probation or voluntarily surrendered?**  Yes  No  
If Yes, please indicate the date(s) and explain: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM YYYY

**Note: Missouri and California residents, do NOT answer Question J below.**

**H. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had an involuntary deductible or surcharge assessed against your policy?**  Yes  No  
If Yes, please indicate the date(s) and explain: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM YYYY

**I. Have you ever been accused of sexual misconduct of any kind?**  Yes  No  
If Yes, please indicate the date(s) and explain: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
MM YYYY

**L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)?**  Yes  No

If Yes, state condition(s) and date(s) and identify your treating physician(s) in the space below. In the event of any such impairment, **a statement from your physician attesting to your fitness to practice your specialty must accompany this application.**

Type(s) of illness: \_\_\_\_\_

Date(s) of treatment(s): From: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ To: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Currently in treatment  
MM DD YYYY MM DD YYYY

Name of treating physician(s): \_\_\_\_\_

Address(es): \_\_\_\_\_

**LOSS INFORMATION (Important! Please fully complete.)**

Please complete the **Loss Information Supplement** for each written request, incident, claim or suit (A, B or C) below that has **NOT** been covered by a National Fire & Marine Insurance Company policy.

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

**A. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?**

If Yes, how many? \_\_\_\_\_  None

**B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes but is not limited to, the following:**

Amputation, Death, Loss of major organ function, Loss of vision, Permanent neurological injury.

If Yes, how many? \_\_\_\_\_  None



## NATIONAL FIRE & MARINE INSURANCE COMPANY

### HOSPITAL PHYSICIAN OUTSIDE ACTIVITIES APPLICATION

- A. Complete this supplemental application for all activities outside the primary applicant's hospital/facility.  
 B. Additional documentation may be requested by the Company as necessary. For example: A copy of your most recent professional liability policy, including all endorsements, declarations page, etc.  
 C. Please print legibly. Please answer all questions; if a question is not applicable, print, "N/A."

#### GENERAL INFORMATION

A. Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Middle Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

B. **Practice Locations:** (Please list primary location first. Combined percentage for all locations must total 100% and cannot be of equal values).

**1. Type of Facility:**

- Office    Hospital    Nursing Home    Prison/Correctional Facility    Weight Loss Clinic    Other: \_\_\_\_\_

\_\_\_\_\_ # Hours \_\_\_\_\_  
 Practice/Hospital Name \_\_\_\_\_ County \_\_\_\_\_

Street Address \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Start Date (MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_

**2. Type of Facility:**

- Office    Hospital    Nursing Home    Prison/Correctional Facility    Weight Loss Clinic    Other: \_\_\_\_\_

\_\_\_\_\_ # Hours \_\_\_\_\_  
 Practice/Hospital Name \_\_\_\_\_ County \_\_\_\_\_

Street Address \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Start Date (MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_

**3. Type of Facility:**

- Office    Hospital    Nursing Home    Prison/Correctional Facility    Weight Loss Clinic    Other: \_\_\_\_\_

\_\_\_\_\_ # Hours \_\_\_\_\_  
 Practice/Hospital Name \_\_\_\_\_ County \_\_\_\_\_

Street Address \_\_\_\_\_ Suite \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Start Date (MM/YYYY): \_\_\_\_\_ / \_\_\_\_\_

C. **Please list all activities for which you are requesting coverage:** \_\_\_\_\_

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

#### ADDITIONAL PROFESSIONAL INFORMATION

Please fully explain any, "Yes," answer in Section X, Supplemental Information with a reference to the question. (For questions A through G, please complete Question H, if you are covered by other insurance for these activities.)

A. **Indicate the average hours per week devoted to treating or reviewing treatment of federal prison inmates.** \_\_\_\_\_ Hrs.  None

B. **Indicate the average hours per week devoted to treating non-federal prison inmates.** \_\_\_\_\_ Hrs.  None

C. **Indicate the percentage of your practice devoted to being a team physician for any professional or collegiate athletes.** \_\_\_\_\_ %  None

D. **Indicate the percentage of your practice devoted to working in a nursing home facility.** \_\_\_\_\_ %  None

E. **Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved.**  Yes  No

If Yes, include a copy of the indemnification agreement provided by the pharmaceutical company.

F. **Do you practice as a medical director?**  Yes  No

Type and name of facility: \_\_\_\_\_

If Yes, what percentage of your practice is devoted to this activity? \_\_\_\_\_ %

Briefly describe your responsibilities: \_\_\_\_\_

G. **Do you devise or review plant/employer safety standards?**  Yes  No

What products are manufactured by the company? \_\_\_\_\_



## NATIONAL FIRE & MARINE INSURANCE COMPANY

### HEALTHCARE PROVIDERS SUPPLEMENTAL APPLICATION

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits (where allowed by state law)	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
<input type="checkbox"/> <b>Professional Liability Employed or Contracted Healthcare Providers</b> (CRNAs, Nurse Midwives, CRNPs, Podiatrists, Physician Assistants and Surgical Assistants)	\$	\$	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

**B. When hiring allied professionals, are credentials checked and verified?**  Yes  No

If No, please explain: \_\_\_\_\_

**C. Provide the number of allied professionals working at your facility in the chart below.**

ALLIED PROFESSIONALS	NUMBER EMPLOYED	NUMBER CONTRACTED
<b>AIDES</b>		
<b>CHIROPRACTORS</b>		
<b>DENTAL HYGIENISTS/TECHNICIANS</b>		
<b>DIETICIANS</b>		
<b>EMT'S/PARAMEDICS</b>		
<b>LABORATORY TECHNICIANS</b>		
<b>LPN'S</b>		
<b>MEDICAL TECHNICIANS</b>		
<b>PERFUSIONISTS</b>		
<b>PHARMACISTS</b>		
<b>PSYCHOLOGISTS</b>		
<b>RADIOLOGY/X-RAY TECHNICIANS/THERAPISTS</b>		
<b>RESPIRATORY THERAPISTS</b>		
<b>RN'S</b>		
<b>SURGICAL ASSISTANTS</b>		

**D. Medical Staff Mid-Level Providers**

1.
  - a. Are credentials for all new staff providers verified and approved prior to granting privileges?  Yes  No
  - b. Are privileges probationary for at least 6 months for all new staff providers?  Yes  No
  - c. Does an identical credentialing and privileging process apply to:
    - 1) mid-level providers (i.e. CRNA's, Certified Nurse Midwives, Physician Assistants, etc.)?  Yes  No
    - 2) physicians' employees on premises (private scrubs, first assistants, nurse practitioners, etc.)?  Yes  No
  - d. Are physicians' employees working on the premises required to meet the identical standards of employed staff (i.e. education, training, licensure, certification, etc.)?  Yes  No
2. Are all staff members licensed and privileged without restrictions?  Yes  No  
 If No, please provide details: \_\_\_\_\_
3. How often are privileges reviewed? \_\_\_\_\_
4. Are all privileges granted to mid-level providers in writing?  Yes  No
5. Are mid-level providers required to carry professional liability insurance?  Yes  No
  - a. If Yes, what are the liability limits? \$ \_\_\_\_\_ Per Event / \$ \_\_\_\_\_ Annual Aggregate
  - b. Are they insured with a carrier rated less than A- by AM Best?  Yes  No  
 If Yes, please explain: \_\_\_\_\_



## NATIONAL FIRE & MARINE INSURANCE COMPANY

### GENERAL LIABILITY SUPPLEMENTAL APPLICATION

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event / Medical Incident or Per Occurrence Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
<input type="checkbox"/> <b>General Liability**</b>	\$ _____	\$ _____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*\* Fire and water damage liability is automatically provided at a \$50,000 limit. If higher limits are desired, please contact your agent.

**B. Please indicate below which of the following apply and specify the corresponding projected number or amount of receipts for the next 12 months.**

1.  Child Daycare Center     Adult Daycare Center     None
  - a) Number of Children/Adults per week: \_\_\_\_\_ Children    \_\_\_\_\_ Adults
  - b) Are references checked prior to hiring on all employees and on all volunteers?  Yes  No
  - c) Are these services offered to:     Employees Only     Open to the Public
  - d) What is the staff to participant ratio? \_\_\_\_\_ Staff    \_\_\_\_\_ Children/Adults Participants
  
2. **Habitational Risk:**     Apartment     Dwelling     Hotel     None     Other, please describe: \_\_\_\_\_
  - a) Number of Units: \_\_\_\_\_ Units    Year Built: \_\_\_\_\_
  - b) Are there at least two exits located remotely from each other?  Yes  No
  - c) For apartment buildings and hotels, are there lighted emergency exit signs?  Yes  No
  
3. **Paid Parking:**     Yes  No    Receipts/Year: \$ \_\_\_\_\_
  
4. **Restaurant:**     Yes  No    Receipts/Year: \$ \_\_\_\_\_
  - a) Is the restaurant staff contracted or employed?     Contracted     Employed
  - b) If contracted, do you require them to carry a general liability (GL) insurance policy with a limit of \$1,000,000 per occurrence?  Yes  No
  - c) Are certificates of insurance obtained annually to verify coverage is in place?  Yes  No
  - d) Is the hospital added as an additional insured on their GL policy?  Yes  No
  - e) Does the restaurant comply with all state and local codes and regulations?  Yes  No  
If No, please explain: \_\_\_\_\_
  - f) Did any inspector who visited the restaurant during the last 12 months indicate any violations or make any recommendations for change?  Yes  No  
If Yes, please provide a copy of the violation/recommendation and indicate the corrective action(s) taken.
  
5. **Special Athletic or Fund Raising Events:**    Receipts/Year: \$ \_\_\_\_\_  
Describe planned events for the upcoming year and indicate if alcohol will be served: \_\_\_\_\_
  
6. **Swimming Pool:**     Yes  No    How deep is the pool? \_\_\_\_\_
  - a) Is it open to the public?     Yes  No    If Yes, Receipts/Year: \$ \_\_\_\_\_
  - b) Is there a diving board?     Yes  No    If Yes, is there a lifeguard on duty at all times?  Yes  No

**C. Is there a heliport/helipad on the premises?**     Yes  No

1. If Yes, is it FAA approved?     Yes  No
2. What is the estimated number of landings per year?     0-365     366-1000     1001—Up
3. Is there a separate insurance policy in place covering this heliport/helipad exposure?  Yes  No
4. If yes, what are the limits? \$ \_\_\_\_\_ Per Event / \$ \_\_\_\_\_ Annual Aggregate  
*Please provide a copy of the Declarations and Loss Runs.*

**D. Provide the number and type of owned, non-owned, leased or chartered watercraft:** \_\_\_\_\_

1. Give a brief explanation of watercraft use: \_\_\_\_\_
2. Are any of the watercraft over 26 feet?  Yes  No  
If Yes, provide a description of the craft and its length: \_\_\_\_\_
3. Is there a separate insurance policy in place covering this watercraft exposure?  Yes  No
4. If yes, what are the limits? \$ \_\_\_\_\_ Per Event / \$ \_\_\_\_\_ Annual Aggregate  
*Please provide a copy of the Certificate of Insurance.*

**E. Do you lease space to others?**  Yes  No

1. If Yes, indicate the address, square footage and the occupancy/use of the space. \_\_\_\_\_
2. Does the lease require the tenant to carry a general liability (GL) insurance policy with a limit of \$1,000,000 per occurrence?  Yes  No
3. Are certificates of insurance obtained annually to verify coverage is in place?  Yes  No
4. Is the hospital added as an additional insured on their GL policy?  Yes  No

**F. Is there an employee or contract security service?**  Yes  No

If Yes, do they carry guns?  Yes  No

**G. Are the management services of your facility provided by a management company?**  Yes  No

1. If Yes, please provide the name and address of the hospital management company and indicate the operational positions provided:  
\_\_\_\_\_
2. If contracted, do you require them to carry a general liability (GL) insurance policy with a limit of \$1,000,000 per occurrence?  Yes  No
3. Are certificates of insurance obtained annually to verify coverage is in place?  Yes  No

**H. Do you rent or lease equipment from others?**  Yes  No

If Yes, who is responsible for the maintenance of the equipment? \_\_\_\_\_

**I. Is there a preventative maintenance and corrective maintenance program in place for medical equipment at the facility?**  Yes  No

If Yes, do you adhere to each manufacturer's established guidelines and standards for all medical equipment?  Yes  No

**J. Do you manufacture, produce, modify, customize, service or assemble any durable medical equipment or any other products?**  Yes  No

1. If Yes, please describe and *provide a copy of your brochures*: \_\_\_\_\_
2. Do you sell, rent or lease any medical equipment to others?  Yes  No  
*Please provide a copy of your equipment list or catalog of products available.*
3. Is there a preventative maintenance plan in place on this equipment?  Yes  No
4. If Yes, is it performed by a qualified biomedical technician?  Yes  No

**K. Environmental Exposures:**

1. Is there a hazardous waste management/environmental safety program?  Yes  No
2. Is there a program in place for monitoring the facility's environmental exposures on an ongoing basis?  Yes  No  
*Submit the following items:*  
A) *Copies of any governmental sanctions or citations.*  
B) *Documentation of any voluntary cleanup from releases or spills (over \$50,000) whether or not reported to your insurance carrier.*
3. Do you have written spill prevention and spill control programs in place?  Yes  No

**L. Do you use an advertising agency?**  Yes  No

1. If Yes, what professional liability limits do you require them to carry? \$ \_\_\_\_\_ Per Event / \$ \_\_\_\_\_ Annual Aggregate
2. Are certificates of insurance obtained annually to verify coverage is in place?  Yes  No
3. Is the hospital added as an additional insured on the Agency's policy?  Yes  No
4. Is there a hold harmless agreement in the contract in favor of the hospital?  Yes  No

**M. Do you have any other contracts in place not previously discussed in this application?**  Yes  No

If Yes, what services are provided? \_\_\_\_\_  
\_\_\_\_\_

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### OPTIONAL COVERAGES SUPPLEMENTAL APPLICATION

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Event Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
<input type="checkbox"/> <b>Limited Pollution Short Term Event Liability</b>	<input type="checkbox"/> \$100,000/\$100,000 <input type="checkbox"/> \$200,000/\$200,000 <input type="checkbox"/> \$300,000/\$300,000		<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Employer's Liability</b>	\$ _____	\$ _____	<input type="checkbox"/> Occurrence ONLY	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Employee Benefits Liability</b>	\$ _____	\$ _____	<input type="checkbox"/> Claims-Made ONLY Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

**EMPLOYEE BENEFITS LIABILITY**

Not requesting this coverage (Skip to next section)

**A. Is liability for the applicant's employee benefits program self-insured?**

Yes  No

If Yes, please describe: \_\_\_\_\_

**B. Is the applicant's employee benefits program self-administered?**

Yes  No

If Yes, please describe: \_\_\_\_\_

**EMPLOYER'S LIABILITY**

Not requesting this coverage (Skip to next section)

**A. Are any of the applicant's facilities in a monopolistic state and require primary employer's liability coverage?**

Yes  No

**B. Is excess employer's liability coverage requested?**

Yes  No

**C. Is the applicant subject to:**     Jones Act     FELA     Stop Gap     Other: \_\_\_\_\_

**DAMAGE TO PREMISES RENTED TO AN INSURED BUSINESS**

Not requesting this coverage (Skip to next question)

**If requested, please identify the Per Occurrence Limit:**

- \$50,000 Per Occurrence Limit
- \$100,000 Per Occurrence Limit
- \$250,000 Per Occurrence Limit

**MEDICAL PAYMENTS**

Not requesting this coverage (Skip to next question)

**If requested, please identify the Per Person Limit:**

- \$1,000 Per Person Limit
- \$2,500 Per Person Limit
- \$5,000 Per Person Limit
- \$10,000 Per Person Limit

**PATIENTS' PROPERTY LIABILITY**

Not requesting this coverage (Skip to next question)

**If requested, please identify the Per Patient Limit and Deductible:**

- |  |   |
|--|---|
| <input type="checkbox"/> \$1,000 Per Patient Limit | <input type="checkbox"/> \$250 Deductible |
|  | <input type="checkbox"/> \$500 Deductible |
| <input type="checkbox"/> \$2,000 Per Patient Limit | <input type="checkbox"/> \$250 Deductible |
|  | <input type="checkbox"/> \$500 Deductible |
| <input type="checkbox"/> \$5,000 Per Patient Limit | <input type="checkbox"/> \$250 Deductible |
|  | <input type="checkbox"/> \$500 Deductible |

**LIMITED POLLUTION SHORT TERM EVENT LIABILITY**

**A. Environmental Exposures**

1. Is the limited pollution short-term event coverage option desired?  Yes  No  
 If No, skip to the next section.  
 Pollution Liability: Coverage is excluded from our standard coverage with exception for a very limited grant for bodily injury and property damage. A limited endorsement of coverage is available, including an option for underground storage tanks.
2. If Yes, do you want the limited pollution short-term event coverage option with underground storage tanks?  Yes  No  
 If Yes, complete the all of the questions in Question B.
3. Is preventative maintenance on all above ground and underground tanks performed by outside contractors?  Yes  No  
 If No, please explain: \_\_\_\_\_
4. How often are tanks tested? \_\_\_\_\_

**B. Underground Tanks:** If the limited pollution short-term event option with underground tanks is desired, please provide the information requested below for each underground tank. If you have more than two tanks, attach a separate page indicating the information for each question below.

**UNDERGROUND TANKS**

	Tank 1	Tank 2
<b>Registration Number or Identifier</b>		
<b>Age</b>		
<b>Contents</b>		
<b>Capacity in Gallons</b>		
<b>Construction Type</b>	<input type="checkbox"/> Fiberglass Steel Coats <input type="checkbox"/> Fiberglass Lined Steel Tank <input type="checkbox"/> Cathodically Protected Steel <input type="checkbox"/> Unprotected <input type="checkbox"/> Fiberglass <input type="checkbox"/> Other: (describe) _____	<input type="checkbox"/> Fiberglass Steel Coats <input type="checkbox"/> Fiberglass Lined Steel Tank <input type="checkbox"/> Cathodically Protected Steel <input type="checkbox"/> Unprotected <input type="checkbox"/> Fiberglass <input type="checkbox"/> Other: (describe) _____
<b>Single or Double Wall Construction</b>	<input type="checkbox"/> Single <input type="checkbox"/> Double	<input type="checkbox"/> Single <input type="checkbox"/> Double
<b>Is the tank in a vault?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is there a leak detection system in place?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate type: <input type="checkbox"/> Automatic Tank Guaging <input type="checkbox"/> Intersital Monitoring (liquid/vapor monitoring within the wall of the tank) <input type="checkbox"/> Vapor Monitoring Systems (alarms) <input type="checkbox"/> Ground Water Monitoring <input type="checkbox"/> Other: (describe) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, indicate type: <input type="checkbox"/> Automatic Tank Guaging <input type="checkbox"/> Intersital Monitoring (liquid/vapor monitoring within the wall of the tank) <input type="checkbox"/> Vapor Monitoring Systems (alarms) <input type="checkbox"/> Ground Water Monitoring <input type="checkbox"/> Other: (describe) _____
<b>When was the last tightness test performed? Did the tank pass or fail? If it failed, provide details in the comments section on the next page.</b>	Date: _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Date: _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail
<b>Is the tank equipped with spill protection? Over-fill protection?</b>	<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
<b>Are the tanks in compliance with all governmental regulations for leak detection, overflow protection and corrosion protection? If No, provide details in the comments section on the next page.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Underground Tanks Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### EXCESS LIABILITY SUPPLEMENTAL APPLICATION

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Claim / Medical Incident or Per Occurrence Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits (where allowed by state law)	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
<input type="checkbox"/> <b>Excess Professional Liability</b>	\$ _____	\$ _____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Excess General Liability</b>	\$ _____	\$ _____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Excess Auto/Emergency Vehicles</b>	\$ _____	\$ _____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> <b>Excess Employer's Liability</b>	\$ _____	\$ _____	<input type="checkbox"/> Occurrence ONLY	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

**B. Have excess liability limits been increased within the last five years?**  Yes  No

If Yes, indicate the type of coverage, prior limit and when it was increased: \_\_\_\_\_

**C. Provide the number and type of owned, non-owned, leased or chartered aircraft:** \_\_\_\_\_

**D. Give a brief explanation of the use of each aircraft and indicate the passenger capacity:** \_\_\_\_\_

Is there an insurance policy in place that covers each aircraft?  Yes  No

If Yes, what are the liability limits? \$ \_\_\_\_\_ Per Event / \$ \_\_\_\_\_ Annual Aggregate

If No, please explain: \_\_\_\_\_

**E. Indicate the number and type of autos owned or leased by the hospital:** *Please provide a copy of the Schedule of Vehicles from each of the current primary auto policies.*

TYPE	NUMBER	PASSENGER CAPACITY OF EACH
<input type="checkbox"/> Ambulance—Emergency Use	_____	_____
<input type="checkbox"/> Ambulance—Non-Emergency Use	_____	_____
<input type="checkbox"/> Public Service Auto/Bus	_____	_____
<input type="checkbox"/> Private Passenger	_____	_____
<input type="checkbox"/> Trucks/Truck Tractors	_____	_____

**F. Are each of the above vehicles insured on current underlying policies?**  Yes  No

If No, please explain: \_\_\_\_\_

**G. Do you provide valet service to your patients?**  Yes  No

**H. What criteria do you use to determine if an individual will be allowed to drive your vehicles?**

**I. Do you check motor vehicle records (MVRs) annually on each individual driving your vehicles?**  Yes  No

**J. If you own or lease ambulances, public service autos or busses, please answer the following questions:**

Describe the type of training required before employees can drive these vehicles: \_\_\_\_\_

Describe your vehicle maintenance program: \_\_\_\_\_

Are drivers required to do vehicle checks?  Yes  No  
If Yes, how frequently are checks required and what items are contained on the checklist? \_\_\_\_\_

Are the vehicle checks documented in writing?  Yes  No

**EXCESS EMPLOYER'S LIABILITY**

Not requesting this coverage (Skip to next section)

**A. Are any of the applicant's facilities in a monopolistic state and require primary employer's liability coverage?**  Yes  No

**B. Is excess employer's liability requested?**  Yes  No

**C. Is the applicant subject to:**  Jones Act  FELA  Stop Gap  Other: \_\_\_\_\_

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### CYBER-LIABILITY, CRISIS MANAGEMENT AND REPUTATIONAL HARM SUPPLEMENTAL APPLICATION

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Cyber Suite Coverages	Requested Limits of Liability	Retroactive Date	Retention
<input type="checkbox"/> <b>Coverages A through G</b> (A) Multimedia Liability, (B) Security and Privacy, (C) Privacy Regulatory Defense and Penalties, (D) Privacy Breach Response Costs, Customer Notification Expenses, Customer Support and Credit Monitoring Expenses, (E) Network Asset Protection, (F) Cyber Extortion, (G) Cyber Terrorism	<input type="checkbox"/> \$500,000 <input type="checkbox"/> \$3,000,000 <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$4,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000	<input type="checkbox"/> Retroactive Date for Coverages A, B, C and H: _____	<input type="checkbox"/> Retention Amount: \$ _____  <input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>Coverage H</b> Regulatory Proceeding	<input type="checkbox"/> \$500,000 <input type="checkbox"/> \$3,000,000 <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$4,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000		
<b>Coverages I through K</b> Crisis Management Coverages (I) Evacuation Expense Reimbursement, (J) Disinfection Expense Reimbursement, and (K) Public Relations Expense Reimbursements	\$100,000		
<b>Coverage L</b> Crisis Management Coverage E-Discovery Claim Expenses/E-Discovery Regulatory Investigation Expense	\$100,000	Subject to same retroactive date requested above.	
<b>Coverage M</b> Data Protection Reputational Harm	\$100,000		

#### GENERAL INFORMATION

**A. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:**

Name \_\_\_\_\_ Title \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_

**B. Does the applicant own any physician groups?**  Yes  No  
 If yes, please provide the date(s) acquired or incepted: \_\_\_\_\_

**C. What is the applicant's total annual operating revenues? Please provide the following:**

Anticipated revenue? \$ _____	Current year? \$ _____	One year ago? \$ _____
1. Total Billings:		\$ _____
2. Annual Medicare revenue:		\$ _____
3. Annual Medicaid revenue:		\$ _____
4. Commercial insurance revenue:		\$ _____

**D. In-Patient Exposure vs. Outpatient Exposure:**

In-Patient

1. Number of In-Patient Beds: \_\_\_\_\_
2. Estimated percentage of Medicare Admissions as a percentage of total admissions: \_\_\_\_\_%
3. Billings as a percentage of Medicare Bills:
  - a. Hospital: \_\_\_\_\_%
  - b. Skilled Nursing: \_\_\_\_\_%
  - c. Other: \_\_\_\_\_%

Outpatient

4. Estimated percentage of bills to Medicare Outpatient Services as a percentage of total outpatient services: \_\_\_\_\_%

**E. Has the applicant acquired any entities in the past five years?**  Yes  No  
 If yes, please provide specific details, including size, dates, what specialty/specialties were involved and what the Medicare/Medicaid billings were as a percentage of the total practice for each of the past five years. Please attach a separate sheet of paper, if necessary.

\_\_\_\_\_

\_\_\_\_\_

**F. Please complete the Schedule of Current Liability Policies and Coverages.** For each policy below, please provide a copy of the policy, including the declarations page, and the loss runs for the last ten years.

**SCHEDULE OF CURRENT LIABILITY POLICIES AND COVERAGES**

COVERAGE	CARRIER	POLICY NUMBER	POLICY PERIOD	LIMITS OF LIABILITY	RETROACTIVE DATE	EXPIRING PREMIUM
Cyber-Liability				\$		\$
Regulatory Proceeding				\$		\$
Crisis Management				\$		\$
Reputational Harm				\$		\$

**BILLING COMPLIANCE INFORMATION**

**A. Does the applicant handle all billings in-house?**  Yes  No

If no, please list the amount done centrally and amount done by third party billing service(s) and any ownership percentage in the third party billers used:

\_\_\_\_\_

**B. Does the applicant have a compliance program in place for both HIPAA and billing errors?**  Yes  No

If yes, when was it implemented and provide detail on any compliance software being utilized:

\_\_\_\_\_

Does it include the oversight of Medicaid Billing?  Yes  No

**C. Does the applicant have a Medical Billings Compliance Officer?**  Yes  No

If yes, please provide the following information:

Name \_\_\_\_\_ Title \_\_\_\_\_

Experience and qualifications: \_\_\_\_\_

**D. Does the applicant's organization currently use non-credentialed staff to perform medical billing procedures?**  Yes  No

If yes, please provide the following:

1. Number of non-credentialed staff: \_\_\_\_\_

2. Name of the positions the non-credentialed staff hold: \_\_\_\_\_

3. Are coders regularly educated?  Yes  No

4. Does the applicant have written policies and procedures for coders?  Yes  No

If yes, are they updated yearly?  Yes  No

5. The approximate split between the billings processed by credentialed and non-credentialed staff: \_\_\_\_\_%

**E. Please identify whether all of the activities listed are included in the compliance program:**

1. Specifically drafted policies and procedures  Yes  No

2. Education and training  Yes  No

3. Internally conducted audits  Yes  No

4. Third party audits  Yes  No

5. Review of Medicare/Medicaid billing  Yes  No

6. Outside coding consultant  Yes  No

7. Outside legal counsel  Yes  No

8. Other (please describe): \_\_\_\_\_  Yes  No

**F. Does the organization have a written repayment policy for billing errors that are found?**  Yes  No

**G. If the applicant has any other CMS (Medicare) Provider number than that listed on the Hospital Professional Liability Supplemental Application, please provide:** \_\_\_\_\_

If other Medicare Provider number is applicable, please provide the corresponding entity name: \_\_\_\_\_

**NETWORK SECURITY AND PRIVACY INFORMATION**

**A. Does the applicant enforce a security policy that must be followed by all employees, contractors, or any other person with access to the applicant's networks?**  Yes  No

**B. Does the applicant's virus or malicious code control program address the following:**

1. anti-virus on all systems?  Yes  No

2. filtering of all content for malicious code?  Yes  No

3. controls on shared drives and folders?  Yes  No

4. CERT or similar vendor neutral threat notification services?  Yes  No

5. removal of spyware and similar parasitic code?  Yes  No

- C. **Does the applicant test its security at least yearly to ensure effectiveness of the technical controls as well as its procedures for responding to security incidents (e.g. hacking, viruses, and denial of service attacks)?**  Yes  No  
Does this include a network penetration test?  Yes  No
- D. **Is all remote access to the applicant's network authenticated, encrypted, and from systems that are at least as secure as the applicant's?**  Yes  No
- E. **Does the applicant require all third parties entrusted with sensitive or non-public personal information to contractually agree to protect such information using safeguards at least equivalent to the applicant's own?**  Yes  No  
If yes, does the applicant audit the third party's compliance with the foregoing safeguards?  Yes  No
- F. **Does the applicant retain non-public personal information and others' sensitive information only for as long as needed and when no longer needed, irreversibly erase or destroy them using a technique that leaves no residual information?**  Yes  No
- G. **Does the applicant employ physical security controls to prevent unauthorized access to computer, networks, and data?**  Yes  No
- H. **Does the applicant control and track all changes to its network to ensure that it remains safe?**  Yes  No
- I. **How long does it take to restore the applicant's operations after a computer attack or other loss/corruption of data?**  
 12 hrs or less     12-24 hrs     More than 24 hrs
- J. **Is all sensitive and confidential information that is transmitted within and from the organization encrypted using industry-grade mechanisms?**  Yes  No
- K. **Is all sensitive and confidential information stored on the applicant's databases, servers and data files encrypted?**  Yes  No

**LOSS INFORMATION**

After the applicant's inquiry, has the applicant or any member of its staff or any person or entity for whom the applicant performs billing services, ever:

- A. **Been investigated or sanctioned by any local, state or federal government agency or private payer regarding the delivery of health care services or reimbursement thereof?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- B. **Had to refund amounts to public and/or private payers?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- C. **Been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- D. **Been accused of errors by any government agency or commercial payer?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- E. **Has the applicant received any complaints, claims or been subject to litigation involving matters of privacy, injury, identity theft, denial or service attacks, computer virus infections, theft of information, damage to third party networks, or the applicant's customer's ability to rely on the applicant's network?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- F. **Has insurance of the type for which the applicant is now applying ever been declined, cancelled or had the renewal thereof refused to the proposed insured?** Note: Do **not** answer in the states of Missouri and California.  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- G. **Does the applicant have knowledge of any claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the requested policy?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- H. **Has the applicant ever received a letter or subpoena from any government entity outlining the intent to audit the applicant?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_
- I. **In the last five (5) years, has the applicant experienced any claims, or is the applicant aware of any circumstances that may give rise to a claim that would have been covered by this policy?**  Yes  No  
If yes, please provide specific details: \_\_\_\_\_

**NATIONAL FIRE & MARINE INSURANCE COMPANY**

**EXECUTIVE LIABILITY, ENTITY LIABILITY, EMPLOYMENT PRACTICES LIABILITY  
AND THIRD PARTY LIABILITY INSURANCE SUPPLEMENTAL APPLICATION**

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

**COVERAGES, LIMITS AND DEDUCTIBLES**

Coverage	Requested Limits of Liability	Pending or Prior Date	Retention
<input type="checkbox"/> <b>Coverages A through C</b> Executive Liability, Executive Indemnification and Entity Liability	<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$4,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000 <input type="checkbox"/> \$3,000,000	<input type="checkbox"/> Pending or Prior Date: _____	<input type="checkbox"/> Retention Amount: \$ _____ <input type="checkbox"/> Other: _____
<b>Antitrust Violation Claims</b> This coverage will be provided as a sublimit of Coverages A, B & C, if selected above.	\$1,000,000		
<input type="checkbox"/> <b>Coverage D</b> Employment Practices Liability	<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$4,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000 <input type="checkbox"/> \$3,000,000	<input type="checkbox"/> Pending or Prior Date: _____	<input type="checkbox"/> Retention Amount: \$ _____ <input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>Coverage E</b> Third Party Liability	<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$4,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$5,000,000 <input type="checkbox"/> \$3,000,000	<input type="checkbox"/> Pending or Prior Date: _____	<input type="checkbox"/> Retention Amount: \$ _____ <input type="checkbox"/> Other: _____
<b>Internal Revenue Code of 1986 Sublimit</b> This coverage will be provided as a sublimit of the Maximum Aggregate for all coverages.	\$50,000		
<b>Excess Benefit Transaction Sublimit</b> This coverage will be provided as a sublimit of the Maximum Aggregate for all coverages.	\$10,000		

**NOTICE**

The policy for which this application is made, subject to its terms, applies only to any claim made (as applicable in the Coverage section for which this application is made) against any of the insureds during the policy period. The limit of liability available to pay damages or settlements shall be reduced and may be exhausted by amounts paid for defense costs. Payment of defense costs shall be applied to the retention. Submission of this application does not guarantee coverage.

In no event will the Company be liable for defense costs or other loss in excess of the applicable limits of liability. Read the entire application carefully before signing.

**GENERAL INFORMATION**

**A. Authorized individual (Executive Officer) to receive notices and information regarding the proposed coverage sections:**

Name \_\_\_\_\_ Title \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_

**B. Individual responsible for Human Resources or employment law matters:**

Name \_\_\_\_\_ Title \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_

**C. Does the applicant have any subsidiaries, affiliates or control over any other entity or organization to be covered?**       Yes  No  
 If yes, please provide a description of the operations, ownership/relationship to the above named applicant, and the tax status of each such entity (if an additional space is needed, please attach a separate sheet with all of the requested information):  
 \_\_\_\_\_

**D. Is the applicant publicly-held or a public reporting company under the Securities Exchange Act of 1934?**       Yes  No  
 If yes, coverage is not available.

**E. In the last 18 months, has the applicant transacted or attempted a private debt or equity offering of securities?**       Yes  No

**F. Within the next 18 months, does the applicant anticipate any:**

- private debt equity offering of securities?       Yes  No
- public offering of securities?       Yes  No

- G. Has the applicant contemplated within the last eighteen (18) months, been involved with any actual, negotiated, or attempted merger, acquisition, divestment or reorganization, or arrangement with creditors under any federal or state law?**  Yes  No
- H. Does the applicant contemplate transacting any mergers or acquisitions in the next 12 months?**  Yes  No
- I. Please complete the Schedule of Current Liability Policies and Coverages.** For each policy below, please provide a copy of the policy, including the declarations page and the loss runs for the last ten years.

**SCHEDULE OF CURRENT LIABILITY POLICIES AND COVERAGES**

COVERAGE	CARRIER	POLICY NUMBER	POLICY PERIOD	LIMITS OF LIABILITY	RETROACTIVE/PENDING OR PRIOR DATE	EXPIRING PREMIUM
Directors & Officers				\$		\$
Employment Practices Liability				\$		\$

- J. Is any of the applicant's medical malpractice/health care professional liability exposure self-insured or insured by means of a funded trust, captive, subsidiary or reciprocal risk sharing arrangement or pool?**  Yes  No  
 If yes, please describe that insurance program by separate attachment, state how the program is administered and attach a copy of the most recent actuarial study. If a funded trust, captive or subsidiary is used:
- Does the funded trust, captive or subsidiary provide insurance other than to the applicant?  Yes  No
  - Is the program funded in accordance with annually determined actuarial requirements?  Yes  No

If any of the questions, K through M, below are answered, yes, please complete the Claim/Wrongful Act/ Incident Supplemental Application.

- K. Has any insurer made payments to or on behalf of any person or entity proposed for this insurance at any time in the last 5 years?**  Yes  No
- L. Has the applicant given written notice under the provisions of any current or prior policy providing similar insurance of any specific facts or circumstances which might give rise to a claim under such insurance?**  Yes  No

California and Missouri applicants, do NOT answer question M. below.

- M. Has any insurer ever cancelled or non-renewed any similar insurance?**  Yes  No

**FINANCIAL INFORMATION**

- A. Describe the following financial information of the applicant for the most recent fiscal year-end:**
- Fiscal year ending: \_\_\_\_\_
  - Total Assets: \$ \_\_\_\_\_
  - Income/Loss: \$ \_\_\_\_\_ Check one:  Net Income; or  Net Loss
  - Equity: \$ \_\_\_\_\_
- B. Do the current liabilities exceed current assets?**  Yes  No  
 If yes, please explain: \_\_\_\_\_
- C. Do long-term liabilities exceed 45% of total assets?**  Yes  No  
 If yes, please explain: \_\_\_\_\_
- D. Will more than 50% of the total long-term liabilities mature within the next 18 months?**  Yes  No  
 If yes, please explain: \_\_\_\_\_
- E. Has any auditor in the last 2 fiscal years rendered a "going concern" opinion for the financial statements of the applicant?**  Yes  No  
 If yes, please explain: \_\_\_\_\_

**EXPERIENCE AND COMPLIANCE**

- A. Has the applicant been investigated or sanctioned by any local, state or federal government agency or private payer regarding the delivery of health care services or reimbursement thereof?**  Yes  No
- B. Does the applicant have a compliance program in effect, including but not limited to compliance for billing, HIPAA and EMTALA regulations?**  Yes  No
- C. Does the applicant have a compliance officer/manager?**  Yes  No
- If yes, please provide his or her name, qualifications and to whom he/she reports: \_\_\_\_\_
  - If no, who ensures compliance? \_\_\_\_\_
- D. Does the applicant use an outside compliance consultant?**  Yes  No  
 If yes, who? \_\_\_\_\_
- E. Does the applicant have legal counsel for compliance issues?**  Yes  No  
 If yes, who? \_\_\_\_\_

**DIRECTORS & OFFICERS AND INSURED ORGANIZATION COVERAGE INFORMATION**

- A. Do the directors and officers, as a whole, directly or indirectly own or control the voting rights of more than 5% of the outstanding securities of the applicant?**  Yes  No
- B. Does the applicant act as a general partner in any partnership?**  Yes  No  
If yes, please explain: \_\_\_\_\_
- C. Does the applicant have any direct or indirect insurance operations?**  Yes  No  
If yes, please explain: \_\_\_\_\_
- D. Please provide the applicant's accreditation(s):**  JCAHO  NCQA  Other: \_\_\_\_\_
- E. Is the coverage requested for outside service positions on any for-profit or public corporate boards or other joint venture?**  Yes  No  
If yes, please explain: \_\_\_\_\_  
*If yes, please submit the following for the outside company:*
  - 1. Name;
  - 2. Audited Financial Statement;
  - 3. Schedule of primary Directors & Officers; and,
  - 4. Schedule of proposed insured persons and their capacity.
- F. Does the applicant control more than twenty percent (20%) of the market share in any given geographical area of providers in any given field of practice or health care services?**  Yes  No  
If yes, please provide market share percentages by separate attachment.
- G. Prior Activities:**
  - 1. Within the last five years, has any person or entity proposed for this insurance been the subject of or involved in any litigation, administrative proceeding, demand letter or formal or informal governmental investigation or inquiry, including and not limited to violations of any federal or state securities laws, or anti-trust copyright or patent litigation?  Yes  No  
If yes, please complete the Claim/Wrongful Act/Incident Supplemental Application.
  - 2. Is any person or entity proposed for this insurance aware of any wrongful act, facts, incidents, or any circumstance which may result in claims being made against the applicant(s)?  Yes  No  
If yes, please explain: \_\_\_\_\_

**EMPLOYMENT PRACTICES COVERAGE SECTION INFORMATION**

- A. What is the total number of employees, including providers/doctors?**  
**Full time:** \_\_\_\_\_ **Part time:** \_\_\_\_\_ **Temporary:** \_\_\_\_\_
- B. What is the total number of providers/doctors?**  
**Employed:** \_\_\_\_\_ **Contracted:** \_\_\_\_\_
- C. Have any officers or senior management voluntarily or involuntarily left the employment of the applicant within the last 18 months?**  Yes  No  
If yes, please provide details: \_\_\_\_\_
- D. Does the applicant anticipate in the next twelve (12) months, or transacted in the last twelve (12) months, any plant, facility, branch or office closing, consolidations or layoffs affecting 20% or more of the total employees or affecting an entire division, location or business unit?**  Yes  No  
If yes, please provide details: \_\_\_\_\_
- E. Describe the internal controls maintained for Employment Practices:**
  - 1. Have all supervisors and officers attended training on sexual harassment and discrimination within the last eighteen (18) months?  Yes  No
  - 2. Does labor relations counsel review the employment policies/procedures at least annually?  Yes  No
  - 3. Is there a separate Human Resources Department?  Yes  No
  - 4. Does the applicant publish and distribute an employee handbook?  Yes  No  
If yes, does it include policies for:
    - a. anti-harrassment?  Yes  No
    - b. equal employment opportunity?  Yes  No
    - c. at-will employment provision?  Yes  No
    - d. Americans with Disabilities Act?  Yes  No
    - e. Family and Medical Leave Act?  Yes  No
    - f. all employees to receive a copy and sign for receipt?  Yes  No
  - 5. Are all mandatory federal and state posting requirements met?  Yes  No
  - 6. Are there written procedures for handling employee grievances or complaints?  Yes  No
  - 7. Does the applicant use an application for employment?  Yes  No  
If yes, does it include:
    - a. an "at will" statement?  Yes  No
    - b. an equal employment opportunity statement?  Yes  No

8. Are terminations reviewed by either Human Resources, Senior Management or outside labor relations counsel?  Yes  No

**F. What is the applicant's annual percentage turnover rate for employees?**

(voluntary=retired or resigned; and involuntary=terminated)

Previous Year                      Current Year

Voluntary:                      \_\_\_\_\_                      \_\_\_\_\_

Involuntary:                      \_\_\_\_\_                      \_\_\_\_\_

**G. Are stock options offered to employees, officers or directors as part of their compensation?**  Yes  No

If yes, please explain: \_\_\_\_\_

**H. Third Party Claims Exposure**

- 1. Does the applicant have direct contact with customers, clients or other third parties?  Yes  No
- 2. Does the applicant have written procedures for the handling of customer/client/third party relations?  Yes  No
  - a. Are these procedures included in the employee handbook?  Yes  No
  - b. Do they include anti-discrimination and anti-sexual harassment policies?  Yes  No
  - c. Do they include procedures for handling complaints of discrimination and sexual harassment by a customer/client/other third party?  Yes  No

**I. Prior Activities Information**

- 1. Within the last five (5) years, has any person or entity proposed for this insurance been the subject of or involved in any litigation, administrative proceeding, demand letter or formal or informal governmental investigation or inquiry, including any investigation by the Department of Labor or the Equal Employment Opportunity Commission?  Yes  No  
If yes, please complete the Claim/Wrongful Act/Incident Supplemental Application for each such matter.
- 2. Is any person or entity proposed for this insurance aware of any wrongful act, facts, incidents, or any circumstance which may result in claims being made against you?  Yes  No

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### Supplemental Claim/Wrongful Act/Incident Form

Please complete a separate form for each claim or incident and answer all questions fully. Prior to attaching to the application, a principal, partner or officer of the applicant must sign and date this form and attach it to the signed application along with any explanations. No full indication can be provided without this complete information.

**1. Name of individual(s) employed by the applicant charged in the claim/incident:**

{Defendant(s)}: \_\_\_\_\_ Title: \_\_\_\_\_  
 {Defendant(s)}: \_\_\_\_\_ Title: \_\_\_\_\_  
 {Defendant(s)}: \_\_\_\_\_ Title: \_\_\_\_\_

**2. Name of person(s) or entities making complaint/allegations in incident (Plaintiff):** \_\_\_\_\_

**3. Date of alleged Wrongful Act.**

\_\_\_\_ MM \_\_\_\_ YYYY

**4. Date the applicant became aware of alleged Wrongful Act:**

\_\_\_\_ MM \_\_\_\_ YYYY

**5. How did the applicant become aware of the Wrongful Act? (Please check all that apply)**

- a. \_\_\_\_\_ **Personally observed incident**
- b. \_\_\_\_\_ **Verbal complain from employee**
- c. \_\_\_\_\_ **Written notice from employee or employee's attorney**
- d. \_\_\_\_\_ **Verbal/written notice from someone else other than complaining employee**
- e. \_\_\_\_\_ **Filing with state agency**
- f. \_\_\_\_\_ **Filing with EEOC**
- g. \_\_\_\_\_ **Receipt of lawsuit**
- h. \_\_\_\_\_ **Filing with HUD**
- i. \_\_\_\_\_ **Other (please describe):** \_\_\_\_\_

**6. Name of insurer that the claim was report to (if any):** \_\_\_\_\_

**7. Is the applicant represented by an attorney?**  Yes  No

**8. Present status of claim/incident:**  Pending  Closed  In Suit

**9. If closed, total damages paid:** \$ \_\_\_\_\_

total expenses paid: \$ \_\_\_\_\_

**10. If EEOC or state agency filing:**

**a. Has a right to sue letter been issued?**  Yes  No

If yes, date: \_\_\_\_\_  
 MM DD YYYY

Date right to sue expires (or did expire)? \_\_\_\_\_  
 MM DD YYYY

**b. Has determination of fault been decided?**  Yes  No

If yes, what was the determination? \_\_\_\_\_

If claimant/plaintiff has a right to sue, what date does (did) this expire?  
 MM DD YYYY

**11. If pending, is plaintiff demanding a settlement amount?**  Yes  No

If yes, how much? \$ \_\_\_\_\_

**Has plaintiff offered a settlement amount?**  Yes  No

Is yes, how much? \$ \_\_\_\_\_

Legal expenses to date: \$ \_\_\_\_\_

**12. Please provide a detailed description of the complaint and the applicant's response (please attach a separate piece of paper if additional space is needed):**

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

**13. Explain what actions have been taken to prevent an incident like this from happening again:**

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

**14. If a complaint was for sexual harassment, has the alleged perpetrator been disciplined or terminated? Please explain:**

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

I understand that the information submitted herein becomes a part of my application and in the event that coverage is bound, is subject to the same warranty and conditions.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### MANAGED CARE SUPPLEMENTAL APPLICATION

**A. Please indicate the coverages, limits and deductibles desired on the chart below.**

#### COVERAGES, LIMITS AND DEDUCTIBLES

Coverage	Requested Per Claim / Medical Incident or Per Occurrence Limits	Requested Aggregate Limits	Occurrence or Claims-Made	Shared or Separate Limits	Deductible (if Self-Insured Retention (SIR), please complete the SIR Supplemental Application)	Is ALAE included in the deductible (if allowed by state law)?
<input type="checkbox"/> <b>Managed Care Liability</b>	\$ _____	\$ _____	<input type="checkbox"/> Claims-Made ONLY Retro-Date: _____	<input type="checkbox"/> Shared Limits <input type="checkbox"/> Separate Limits	<input type="checkbox"/> Deductible Amount: \$ _____ <input type="checkbox"/> SIR <input type="checkbox"/> None	<input type="checkbox"/> Yes <input type="checkbox"/> No

**B. Is Managed Care Coverage desired?**  Yes  No

**C. Applicant is organized as:** (Check all that apply.)

- HMO     
  PPO     
  IPA     
  TPA     
  Utilization Review Contractor     
  Other: \_\_\_\_\_

Please describe operations: \_\_\_\_\_

**D. Does the applicant own, operate or manage another entity (hospital, clinic, pharmacy, dispensary or other medical facility)?**  Yes  No

If Yes, please provide details: \_\_\_\_\_

**E. Do you offer peer review or post care review services for others?**  Yes  No

If Yes, please provide details: \_\_\_\_\_

**F. Is the applicant administering or providing managed care services on behalf of a health care plan that includes:**

1. the creation, sale and marketing of a health care plan?  Yes  No
2. the selection, credentialing and contracting of health care providers?  Yes  No
3. the evaluation of the cost, quality and proper utilization of treatment options available or being provided to participants?  Yes  No
4. the adjustment, investigation and processing of claims for benefits?  Yes  No
5. case management?  Yes  No

If Yes for any of the above, please provide details: \_\_\_\_\_

With/for whom: \_\_\_\_\_

Type of services being provided: \_\_\_\_\_

Annual revenue for services: \_\_\_\_\_

If other services (not listed above) are being provided, please provide details: \_\_\_\_\_

**G. Does the applicant employ physicians, surgeons, dentists or other healthcare professionals to perform any medical duties other than administrative functions or as member of peer review or utilization review boards or committees?**  Yes  No

If Yes, please describe their duties and attach a schedule showing the number in each specialty and/or the number of each type of allied professional: \_\_\_\_\_

**H. Are medical services provided under a written contract between the applicant and a health care provider?**  Yes  No

If Yes, please attach a copy of the contract. If No, please explain: \_\_\_\_\_

**I. Credentialing:**

**1. Who is responsible for the applicant's credentialing activities relating to managed care for healthcare professionals:**

- Applicant  
 Other, please explain: \_\_\_\_\_

**a. If the applicant contracts with an outside source for credentialing, does the applicant review the process and results?**  Yes  No

If No, please explain: \_\_\_\_\_

**b. Does the applicant require the outside credentialing source to carry professional liability insurance?**  Yes  No

**c. How frequently does the applicant credential contract healthcare providers?** \_\_\_\_\_ # Times/  Wk.  Mo.  Yr.

**J. Operational Volume:**  
**1. Please provide the number of enrollees in the table below:**

	THIS POLICY YEAR (ESTIMATED)	PRIOR POLICY YEAR
Insured enrollees (if operations cover more than one state, provide listing by state)		
Enrollees in self-insured plans administered by the applicant (listing by state)		
Percentage of enrollees <u>NOT</u> covered by ERISA		
Number of admissions per 1000 enrollees per year		
Number of inpatient days per 1000 enrollees per year		
Quality, Cost or Utilization Review Service Contracts: <u>Case Numbers</u>		
Quality, Cost or Utilization Review Service Contracts: <u>Revenue</u>		

- 2. Does the applicant provide EAP or other counseling services?**  Yes  No
- 3. How many counselors are employed by the applicant?** \_\_\_\_\_  
 Are the counselors required to be licensed?  Yes  No
- 4. Do these employees provide assessment and referral?**  Yes  No  
 Short-term counseling?  Yes  No  
 If Yes, what is the maximum number of visits allowed? \_\_\_\_\_
- 5. Do any employees of the insured provide longer term counseling?**  Yes  No
- 6. Does the applicant have any physicians or psychiatrists providing clinical services or furnishing drug prescriptions?**  Yes  No
- 7. How many client contact hours were provided last year?** \_\_\_\_\_
- 8. How many client contact hours does the applicant estimate for this year?** \_\_\_\_\_
- 9. Healthcare providers under contract:**
- a. Number of hospitals:** \_\_\_\_\_
- b. Number of physicians:** \_\_\_\_\_
- c. Other (please specify):** \_\_\_\_\_
- d. Does the applicant anticipate any changes in these numbers over the next year?**  Yes  No  
 If Yes, please estimate the amount of the changes: \_\_\_\_\_
- 10. Does the applicant own all health plans being managed?**  Yes  No
- 11. Does the applicant manage health plans for others under contract?**  Yes  No  
 If Yes, how many? \_\_\_\_\_
- 12. Does the applicant have any investment or minority ownership in plans managed for others?**  Yes  No  
 If Yes, please describe: \_\_\_\_\_
- 13. Does the applicant have any investment or minority ownership in plans managed by others?**  Yes  No  
 If Yes, please describe: \_\_\_\_\_
- 14. Who is the stop-loss insurance carrier?** \_\_\_\_\_  
 Per Claim attachment point and limit: \_\_\_\_\_ Aggregate attachment point and limit: \_\_\_\_\_
- 15. Are any claims handled by outside adjusters?**  Yes  No  
 If Yes, what percentage and types of claims are handled outside? \_\_\_\_\_% Types of claims: \_\_\_\_\_
- Please attach a copy of any contract or agreement with outside adjuster services.*
- 16. If the applicant is compensated through capitation, how is the price set?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Who is the consulting actuary? \_\_\_\_\_

**K. Related Services:**

**1. Please complete the table below. If not applicable, print "N/A."**

	THIS POLICY YEAR (ESTIMATED)	PRIOR POLICY YEAR
<b>Claims Administration: Years of experience:</b> _____		
Revenue		
Number of Claims		
Number of Claims Handlers		
<b>Management Services: Years of experience:</b> _____		
Revenue		
Number of Contracts		

**1. (Continued) Please complete the table below. If not applicable, print "N/A."**

	THIS POLICY YEAR (ESTIMATED)	PRIOR POLICY YEAR
<b>Computer Services: Years of experience: _____</b>		
Revenue		
Number of Contracts		
<b>Actuarial Services: Years of experience: _____</b>		
Revenue		
Number of Contracts		
<b>Insurance Services: Years of experience: _____</b>		
Sales Revenue (including insurance, annuities and mutual funds)		
Consulting Revenue		
Number of Contracts		
<b>Other Service Revenue (please describe): _____</b>		

2. Does the applicant carry any other insurance which may apply to the above operations?  Yes  No
3. Does the applicant, or any partner, director, officer or employee of the applicant, act as a trustee for any client?  Yes  No

**L. Sales and Marketing:**

1. Describe how the applicant's products and services are marketed: \_\_\_\_\_
2. Are products and services sold exclusively by employees?  Yes  No  
If No, please specify: \_\_\_\_\_
3. How many sales personnel are employed? \_\_\_\_\_  
What are their duties? Please describe: \_\_\_\_\_
4. Are all sales representatives licensed (whether employed or not)?  Yes  No
5. Do all contracts, advertising, sales and marketing materials:
- a. clearly specify what is and is not covered?  Yes  No
  - b. clearly define any restrictions on experimental or investigational care or treatment?  Yes  No
  - c. clearly define organ transplants and the extent of the plan's coverage for such procedures?  Yes  No
  - d. clearly state that the applicant has the discretion to interpret the provisions of the plan?  Yes  No
  - e. always refer to healthcare providers under contract as independent contractors?  Yes  No
6. Do any contracts, advertising, sales and marketing materials make any broad or generalized warranties or statements regarding the comprehensiveness or breadth of coverage, or the quality of quantity of care?  Yes  No  
If Yes, please describe: \_\_\_\_\_
7. Are all contracts reviewed by the applicant's legal counsel before being used or distributed?  Yes  No

**M. General Information:**

1. Are appeal procedures for claims clearly explained to plan participants?  Yes  No
2. Is the person making the appeal decision identified to plan participants?  Yes  No
3. Is an expedited appeal process in place for claim situations where denial or delay of the requested health care may seriously affect the plan participant's quality of life (e.g. organ transplants)?  Yes  No
4. Does the applicant provide profit sharing arrangements or other financial inducements to the contracted healthcare providers, professionals or claims handling companies?  Yes  No  
If Yes, will current procedures allow them to appeal any negative input regarding their individual cost, utilization or quality performance?  Yes  No
5. Does the applicant make sure its plans and its client's plans comply with ERISA?  Yes  No
6. Does the applicant suggest or require providers to follow pre-determined practice parameters or critical pathways?  Yes  No  
If Yes, how were these parameters formulated? \_\_\_\_\_
7. To what extent does the applicant retain outside counsel to review contracts? \_\_\_\_\_
8. Is the applicant aware of any claims that have been made or incidents which may give rise to any claims that may be covered by this insurance?  Yes  No  
If Yes, please provide details: \_\_\_\_\_
9. Who is the applicant's current managed care professional liability carrier? \_\_\_\_\_
- Per Claim Limit: \$ \_\_\_\_\_ Aggregate Limit: \$ \_\_\_\_\_  
Deductible or Retention: \$ \_\_\_\_\_ Expiring Policy Premium: \$ \_\_\_\_\_

## ATTACHMENTS

*A copy of the following information must be submitted with this Managed Care Supplemental Application:*

- A. Financial information.** Last three (3) years of audited financial statements and annual reports including auditor's opinion.
- B. Loss information.** Current loss runs with updated values from insurance carriers covering the last ten (10) full years including indemnity payments or indemnity reserves of \$50,000 or more including expenses. All claims must be first dollar/ground up, and if possible, sent electronically.
- C. Copy of your current managed care liability insurance policy, with endorsements.**
- D. Organizational chart,** including the names of all entities and a brief description of operations.
- E. Agreements or contracts with healthcare providers or professions** (a sample is sufficient if they are all the same).
- F. Agreements or contracts with members enrolled in the applicant's health plan, or health plans being administered.**
- G. Contracts for management services, computer services, evaluation and payment of health care claims, actuarial services or insurance services to others.**

## NATIONAL FIRE & MARINE INSURANCE COMPANY

### SELF-INSURED RETENTION (SIR) SUPPLEMENTAL APPLICATION

**A. Please indicate any applicable retention by checking the box(es) below:**

- Self-Insured Retention                       Captive
- Trust     Risk Retention Group (RRG)

**B. What are the limits of liability for the SIR?**                      \$ \_\_\_\_\_ Per Medical Incident / \$ \_\_\_\_\_ Annual Aggregate

**C. Please indicate ALAE treatment within the SIR/Captive/RRG limit:**

- ALAE erodes the SIR limit
- ALAE is paid by the retention but does not erode the retention limit
- Other, please explain: \_\_\_\_\_

**D. Please indicate the ALAE treatment in excess of the SIR/Captive/RRG limit:**

- ALAE is included inside the excess limit
- ALAE is paid entirely by the SIR/Captive/RRG and the excess limit excludes ALAE payments
- Other, please explain: \_\_\_\_\_

**E. What coverages are contemplated? Specify the claims basis for each line of business:** \_\_\_\_\_

\_\_\_\_\_

**F. Is there a dedicated trust?**  Yes  No

**G. Has an independent actuarial funding study been completed?**  Yes  No

**H. Who handles the claims within the SIR/Captive/RRG?** \_\_\_\_\_

**I. Is the applicant interested in utilizing National Fire & Marine Insurance Company for handling claims within the retention?**  Yes  No

**J. What law firm is utilized for claims?** \_\_\_\_\_

**K. If a TPA is being utilized, please provide the contact information below:**

\_\_\_\_\_  
Third Party Administrator

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
Primary Contact Person Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Phone                                      Fax                                      E-mail

### ATTACHMENTS

*Please provide a copy of the following documents (if applicable):*

1. Most recent **actuarial funding study**.
2. **Trust agreement** for the Self-insured Retention or policy form(s) for Captive or RRG.
3. **Claims handling policy and procedure manual**.
4. **Trust fund or Captive/RRG financials**.