COPIC
Better Medicine • Better Lives

FACILITY APPLICATION

CLAIMS-MADE POLICY

Please review your policy provisions carefully to understand all of your rights and duties.

GENERAL INFORMATION

1. Legal Name of Facility: _____

   Primary Address: _____

   _____

   County: _____ City: _____ State: _____ Zip Code: _____

2. **Contacts** **Phone** **Email**

   a. Chief Executive Officer: _____

   b. Chief Financial Officer: _____

   c. Risk Manager: _____

   d. Website _____

3. Choose all that are applicable:

Hospital
- ☐ Children's Hospital
- ☐ Critical Access
- ☐ Psychiatric Hospital
- ☐ Rehabilitation Hospital

Non-Acute Care
- ☐ Ambulatory Surgery Center
- ☐ Imaging Facility
- ☐ Endoscopy Center

Designated by:
- ☐ TJC-The Joint Commission
- ☐ Licensed by State
- ☐ Medicare Approved
- ☐ AOA Accredited
- ☐ CARF Accredited
- ☐ Member of AHA
- ☐ AAAHC Accredited
- ☐ ASCA Accredited

(Please attach a copy when applicable)

☐ Other: _____

4. Does the Applicant have any operations beyond your domicile state? ☐ Yes ☐ No

   If "yes," please explain: _____

5. Does your facility conduct peer review activities? ☐ Yes ☐ No

   If "yes," are those activities conducted in compliance with the guidelines established by the appropriate statute or regulatory authority in your domicile state? ☐ Yes ☐ No

6. Is your facility governmentally immune? ☐ Yes ☐ No ☐ N/A

   If "no," please skip to question #7.

   a. Are you requesting physician/CRNA coverage under your new facility policy with COPIC? ☐ Yes ☐ No

      If "yes," are your physicians/CRNAs:

      a. Employees of the facility? ☐ Yes ☐ No
      b. Contracted with the facility? ☐ Yes ☐ No
      c. A combination of both? ☐ Yes ☐ No

      If "both," please list each employed/contracted physician/CRNA by name:

Employed Physicians/CRNAs	Contracted Physicians/CRNAs

SERVICES SECTION

7. Please indicate if the Applicant presently provides, plans to provide, or presently operates any of the following:

☐ Abortion Clinic	☐ Emergency Room	☐ Intensive Care Unit	☐ Off-Premises Labs
☐ Ambulance Service	☐ Experimental Surgery	☐ Laboratory	☐ Outpatient Surgical-Centers
☐ Assisted Living	☐ Home Health Care	☐ Nursery	☐ Pharmacy
☐ Bariatric Surgery	☐ Hospice	☐ Off-Premises Clinics	

☐ Other: _____

INSURANCE COVERAGE REQUEST

8. Requested Effective Date_____

9. Requested Limits

Professional Liability $ _____ / $_____ Retroactive Date _____
per claim aggregate

General Liability $ _____ / $_____ ☐ Claims Made Retroactive Date _____
per claim aggregate ☐ Occurrence Coverage

10. Deductible ☐ None

Professional Liability $ _____ / $_____ General Liability $_____ / $ _____
per claim aggregate per claim aggregate

If "yes," deductible is to apply to: ☐ Indemnity Only ☐ Indemnity and Expense

11. Excess/Umbrella Liability desired? ☐ Yes ☐ No

Limit $_____ Retroactive Date _____

SCHEDULE OF UNDERLYING COVERAGE

Coverage	Carrier	Limits of Liability	Policy Number	Policy Period
Automobile Liability		☐ $1M CSL ☐ Other		
		Please specify "Other":		
Employers Liability		☐ $500/$500/$500 ☐ Other		
		Please specify "Other":		

INSURANCE HISTORY

12. Complete the following professional liability insurance history:

Current Carrier _____ ☐ Claims Made ☐ Occurrence

Policy Term: _____ Retroactive Date _____

Limits $ _____ / $_____ Expiring Premium $ _____

Has any insurer ever canceled, declined to issue, refused to renew, or issued coverage to the Applicant with any restrictions or exclusions? ..... ☐ Yes ☐ No

Have all circumstances that might reasonably lead to a claim or suit (even if the Applicant believes the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ..... ☐ Yes ☐ No ☐ N/A*

**For purposes of this question, "N/A" means that the Applicant is aware of no circumstances that might reasonably lead to a claim or suit.*

COVERAGE OPTIONS

13. Choose your desired limit for the coverage below.

a. Employee Benefits Administration Liability:

☐ $250,000/$250,000 ☐ $500,000/$500,000* ☐ $1,000,000/$1,000,000* ☐ $1,000,000/$3,000,000*

b. Limited Pollution and Contamination Liability:

☐ $100,000/$100,000 ☐ $250,000/$250,000* ☐ $500,000/$500,000* ☐ $1,000,000/$1,000,000*

c. Medical Expense: ☐ $1,000 ☐ $5,000* ☐ $10,000*

d. Products-Completed Operations:

Do you desire this coverage? ☐ Yes ☐ No ☐ $1,000,000/$1,000,000* ☐ $1,000,000/$3,000,000*

*An additional premium will be charged if this limit is chosen.

14. Do you desire Sexual Misconduct Liability coverage? ..... ☐ Yes ☐ No

15. Are criminal background checks, including sexual offenses, performed on all employees, volunteers and contractors? ..... ☐ Yes ☐ No

If "no," please explain: _____

16. Which of the following abuse prevention methods are used?

a. Written sexual abuse and molestation prevention policy that is read and signed off by staff annually;..... ☐ Yes ☐ No
b. Training on sexual abuse and molestation prevention provided to staff annually; ..... ☐ Yes ☐ No
c. Zero tolerance policy regarding abuse; ..... ☐ Yes ☐ No
d. Written policy addressing abuse prevention. ..... ☐ Yes ☐ No

17. Do you have a formal process for documenting and investigating reports of suspicious or inappropriate behaviors including allegations of abuse? ..... ☐ Yes ☐ No

If "no," please explain.

_____

_____

18. Have there been any physical abuse, sexual abuse or molestation judgments, settlements, payments, claims, suits or demands made against any person or entity proposed for this insurance? ..... ☐ Yes ☐ No

19. Is any person or entity proposed for this insurance aware of any facts, circumstances, or situations which might afford grounds for any physical abuse, sexual abuse or molestation claim(s)? ..... ☐ Yes ☐ No

20. Do you follow any state and national guidelines regarding prescribing practices? ..... ☐ Yes ☐ No

21. Has the Applicant or any other associated entity ever lost a license, been denied a license or been disciplined (probations, sanctions, fines, etc.) by any governmental licensing agency, by any accrediting review body, or by any state or federal agency? ..... ☐ Yes ☐ No

If "yes," please explain: _____

22. What is your total number of employees? _____

23. Do you desire any of the following providers be covered under this facility policy?

	Employed	Contracted	Limits	Retro Date
Physician/Surgeon				
Certified Registered Nurse Anesthetist				

ACUTE BEDS/VISITS/PROCEDURES SECTION

If you have more than one **separately licensed facility**, please photocopy this page and complete the section below for each additional **separately licensed facility**.

24. **Facility Name:** _____

Hospital Inpatient	List the Number of Licensed Beds in Each Category in this Column	List your Projected Patient Days for the Next 12 Months in this Column
Acute Care Beds		
Cribs/Bassinets		
Sub-Acute/Transitional		
Skilled Nursing Beds		
Long Term Care Beds		
Psychiatric		
Physical Rehabilitation		
Chemical Dependency		
Hospice		
Neonatal Intensive Care		
ICU/CCU Beds		
Other (please specify):		

Outpatient Visits	Outpatient Visits Projected for the Next Year

Please list all of your projected patient visits for each category listed below. If there isn't a specific category that you need, list those patient visits under "Other" and please specify the type of visit.

Outpatient Visits (not listed below)	
Emergency Room Visits	
Urgent Care Visits	
Clinic/Physician Visits	
Outpatient Surgery	
Chemical Dependency Visits	
Rehabilitation and Therapy	
Psychiatric Visits	
Home Health Care Visits	
Reference Lab Visits	
Inpatient Surgery	
Number of Births	
Other (please specify):	

NON-ACUTE VISITS/PROCEDURES SECTION

Complete this section only if the applicant is a facility OTHER than a hospital.

If you have more than one **separately licensed facility**, please photocopy pages 5 and 6 and complete them for each additional **separately licensed facility**.

25. Do you maintain any beds for overnight recovery?..... ☐ Yes ☐ No
If "yes," please explain: _____

26. **Facility Name:** _____

Please indicate your total number of beds here: _____	**List the Number of Licensed Beds in Each Category in this Column**	**List your Projected Patient Days for the Next 12 Months in this Column**
Convalescent Beds		
Other (please specify):		

Please list all of your projected patient visits/procedures for each bolded category listed below. If there isn't a specific category listed, use the "Notes" section to add this information.

Visits/Procedures	**Visits/Procedures projected for next 12 months**	**Notes**
Outpatient Surgical Procedures (not noted below)		
Urgent Care Visits		
Clinic/Physician Visits (not noted below)		
Rehabilitation and Therapy		
Chronic Pain Visits/Procedures		
Cosmetic – facial		
Outpatient Visits not named in a category below		
Robotic Surgery (please specify)		
Breast Procedures		
Liposuction		
Dermatology –		
Liposuction		
Laser		
Other Dermatology Procedures (please specify):		
Pain Management –		
Epidural steroid injections		
Cervical		
Lumbar		
Thoracic		
Other steroid injections (please specify		
Rhizotomies, with fluoroscopy		
Percutaneous stimulators		
Intrathecal pain pumps		
Other Pain Management Procedures (please specify):		
Orthopedic –		
Total joint replacement (please specify)		
Discectomy/Laminectomy		
Spinal Fusion		
Other Orthopedic Procedures (please specify):		
General Surgery –		
Laparoscopic (gallbladder, other)		
Bariatric (please specify):		
Other General Surg. Procedures (please specify):		

26. (continued) **Facility Name:** _____

Visits/Procedures (continued)	**Visits/Procedures projected for next 12 months**	**Notes**
Radiology –		
Myelogram		
Vascular interventional		
Mammography-stereotactic		
Percutaneous Abdominal Aortic Aneurysm Repair		
Kyphoplasty		
Vertebroplasty		
Other Radiology Procedures (please specify):		
GI – Procedures		
Colonoscopies		
Dilation		
ERCP		
Other GI Procedures (please specify):		
Gynecology –		
Total abdominal hysterectomy (TAH)		
Total vaginal hysterectomy (TVH)		
Lap assisted TAH or TVH		
Other Gynecology Procedures (please specify):		
Cardiovascular –		
Catheterizations		
Stints		
Ablations		
Pacemaker		
Defibulators		
Other Cardiology Procedures (please specify):		
Ophthalmology –		
Lasik		
Cataract		
Clear lens replacement		
Corneal Transplants		
Other Ophthalmology Procedures (please specify):		
ENT –		
Endoscopic Sinus		
Other ENT Procedures (please specify):		
Urology –		
Laparoscopic/robotic approaches		
Other Urology Procedures (please specify):		
Podiatry –		

OBSTETRICAL SECTION

27. Do you offer obstetrical services? ..... ☐ Yes ☐ No

If "no," please skip to the next section.

28. Is the Applicant a regional referral center for newborns requiring intensive care or for high-risk pregnancies?... ☐ Yes ☐ No

    a. If "no," does a written procedure exist for transferring all high-risk mothers or babies which the hospital is not qualified to treat? ..... ☐ Yes ☐ No

29. How many vaginal births after C-section (VBACs) were performed in the past 12 months? _____

30. Can C-sections be performed at all times within 30 minutes from "decision to incision"? ..... ☐ Yes ☐ No

    If "no," please explain.

    _____

    _____

31. Is an obstetrician available in-house 24 hours per day for the obstetrical suite? ..... ☐ Yes ☐ No

    If "no," what is the maximum time for arrival at the hospital? _____

32. Is continuous electronic fetal monitoring performed on all patients in active labor? ..... ☐ Yes ☐ No

33. Is an anesthesiologist or CRNA available in-house 24 hours per day for the obstetrical suite? ..... ☐ Yes ☐ No

    If "no," what is the maximum time for arrival at the hospital? _____

EMERGENCY ROOM SECTION

34. Do you provide emergency room (ER) services? ..... ☐ Yes ☐ No

    If "yes," what is your trauma level?_____

DAY CARE SECTION

35. Does the Applicant own or have an adult or child day care facility? ..... ☐ Yes ☐ No

If "no," please skip to the next section.

    a. Does the Applicant check references or conduct background checks on the day care staff? ..... ☐ Yes ☐ No
    b. Is the day care facility on the hospital premises? ..... ☐ Yes ☐ No
    c. If "no," what is the address of the day care facility?

       _____

    d. Is the day care facility open to the public? ..... ☐ Yes ☐ No
    e. If "yes," who runs the day care facility? _____
    f. If it's an independent operator/contractor, do they carry general liability coverage? ..... ☐ Yes ☐ No
    g. Does the day care center operate under a different name? ..... ☐ Yes ☐ No

       If "yes," please list the name here:_____

STAFF PRIVILEGES SECTION

36. Are credentials of all providers checked and approved prior to the granting of privileges? ..... ☐ Yes ☐ No

37. Are providers' privileges and overall performances evaluated periodically? ..... ☐ Yes ☐ No

38. Has the license or privileges of any provider ever been restricted or suspended, or has the facility had to notify the National Practitioners Data Bank of a suspension, peer review action, or liability payment of any provider? ☐ Yes ☐ No

    If "yes," please provide details on a separate sheet of paper.

RISK MANAGEMENT SECTION

39. Is there a written risk management program that has been approved by the governing body? ..... ☐ Yes ☐ No

40. Does the governing body review the effectiveness of the program and approve necessary changes? ..... ☐ Yes ☐ No

41. Does the risk management program include the following:

Occurrence reporting?	☐ Yes	☐ No	Contract review and evaluation?	☐ Yes	☐ No
Formal link to quality management?	☐ Yes	☐ No	Review and participation in medical staff committees?	☐ Yes	☐ No
Safety program and safety committee?	☐ Yes	☐ No	Claim management?	☐ Yes	☐ No

PHYSICAL PREMISES SECTION

42. Does the Applicant plan any new construction for the coming year?..... ☐ Yes ☐ No

If "yes," please explain:

_____

_____

YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THE FOLLOWING ATTACHMENTS:

- ☐ A copy of the most recent Joint Commission report and your response(s) to any contingencies and/or a copy of your most recent Department of Public Health and Environment Survey - Statement of Deficiencies and Plan of Correction and/or Critical Access survey results (if applicable).
- ☐ A copy of your state license.
- ☐ Loss history is required from your prior carriers for the last ten (10) years. Please call your prior carriers and request a currently valued loss run. A total of 10 years prior history is required.
- ☐ A copy of your current policy, including all endorsements.

STATE FUND APPLICANTS ONLY:

PARTICIPATION UNDER FACILITY MEDICAL LIABILITY LAWS IN YOUR DOMICILE STATE

43. If approved for COPIC coverage, will you file evidence of this coverage as proof of financial responsibility to become qualified as a health care provider under facility medical liability laws in your domicile state?..... ☐ Yes ☐ No

44. Have you at all times subsequent to the retroactive date indicated in this application and as shown on the insurance declarations page(s) attached to the application been a qualified health care provider under facility liability laws in your domicile state? ..... ☐ Yes ☐ No

If "no," please explain. _____

_____

Note: *For purposes of this question "qualified health care provider" means that you have filed proof of financial responsibility with the Department of Insurance in your principal state of practice.*

The Applicant represents that the application statements and facts are true and that no material facts have been suppressed or misstated. Completion of this form does not bind coverage. Applicant's acceptance of Company's proposal is required before Applicant may be bound and a policy issued.

The facility agrees 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 facility undertakes in managing its medical professional exposures.

Application must be signed by an officer of the company

Applicant Signature: _____ Date: _____

Applicant Name and Title (please print): _____

Agent (if any):_____

Telephone Number: _____ E-mail Address:_____

INSURANCE FRAUD WARNINGS

The following Insurance Fraud Warnings are required to be provided with all applications.

ALABAMA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include Imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or in formation to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from Insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false Information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

MARYLAND

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may subject to civil fines and criminal penalties.

NEW YORK

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON

Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

RHODE ISLAND

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company.

Penalties include imprisonment, fines and denial of insurance benefits.

VIRGINIA

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits and civil damages.

WASHINGTON

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

With respect to all other states, please be advised of the following:

GENERAL FRAUD WARNING

Insurance fraud is committed when a person knowingly and with intent to defraud or deceive supplies false, incomplete or misleading information concerning any fact or thing material to an insurance policy. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any person who knowingly attempts to commit insurance fraud is subject to civil action by the Company and shall be reported to the appropriate law enforcement authority.