



# 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
<b>Automobile Liability</b>		<input type="checkbox"/> \$1M CSL <input type="checkbox"/> Other Please specify “Other”:		
<b>Employers Liability</b>		<input type="checkbox"/> \$500/\$500/\$500 <input type="checkbox"/> 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?

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

**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:** \_\_\_\_\_

<b>Hospital Inpatient</b>	<b>List the Number of Licensed Beds in Each Category in this Column</b>	<b>List your Projected Patient Days for the Next 12 Months in this Column</b>
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):		

<b>Outpatient Visits</b>	<b>Outpatient Visits Projected for the Next Year</b>
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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
<b>Outpatient Surgical Procedures (not noted below)</b>	_____	
<b>Urgent Care Visits</b>	_____	
<b>Clinic/Physician Visits (not noted below)</b>	_____	
<b>Rehabilitation and Therapy</b>	_____	
<b>Chronic Pain Visits/Procedures</b>	_____	
<b>Cosmetic – facial</b>	_____	
<b>Outpatient Visits not named in a category below</b>	_____	
<b>Robotic Surgery (please specify)</b>	_____	
Breast Procedures	_____	
Liposuction	_____	
<b>Dermatology –</b>	_____	
Liposuction	_____	
Laser	_____	
Other Dermatology Procedures (please specify):	_____	
<b>Pain Management –</b>	_____	
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):	_____	
<b>Orthopedic –</b>	_____	
Total joint replacement (please specify)	_____	
Discectomy/Laminectomy	_____	
Spinal Fusion	_____	
Other Orthopedic Procedures (please specify):	_____	
<b>General Surgery –</b>	_____	
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	
<b>Radiology –</b>			
Myelogram	<input type="text"/>		
Vascular interventional	<input type="text"/>		
Mammography-stereotactic	<input type="text"/>		
Percutaneous Abdominal Aortic Aneurysm Repair	<input type="text"/>		
Kyphoplasty	<input type="text"/>		
Vertebroplasty	<input type="text"/>		
Other Radiology Procedures (please specify):	<input type="text"/>		
<b>GI – Procedures</b>			
Colonoscopies	<input type="text"/>		
Dilation	<input type="text"/>		
ERCP	<input type="text"/>		
Other GI Procedures (please specify):	<input type="text"/>		
<b>Gynecology –</b>			
Total abdominal hysterectomy (TAH)	<input type="text"/>		
Total vaginal hysterectomy (TVH)	<input type="text"/>		
Lap assisted TAH or TVH	<input type="text"/>		
Other Gynecology Procedures (please specify):	<input type="text"/>		
<b>Cardiovascular –</b>			
Catheterizations	<input type="text"/>		
Stints	<input type="text"/>		
Ablations	<input type="text"/>		
Pacemaker	<input type="text"/>		
Defibrulators	<input type="text"/>		
Other Cardiology Procedures (please specify):	<input type="text"/>		
<b>Ophthalmology –</b>			
Lasik	<input type="text"/>		
Cataract	<input type="text"/>		
Clear lens replacement	<input type="text"/>		
Corneal Transplants	<input type="text"/>		
Other Ophthalmology Procedures (please specify):	<input type="text"/>		
<b>ENT –</b>			
Endoscopic Sinus	<input type="text"/>		
Other ENT Procedures (please specify):	<input type="text"/>		
<b>Urology –</b>			
Laparoscopic/robotic approaches	<input type="text"/>		
Other Urology Procedures (please specify):	<input type="text"/>		
<b>Podiatry –</b>			

**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
- Formal link to quality management?       Yes     No
- Safety program and safety committee?       Yes     No

- Contract review and evaluation?       Yes     No
- Review and participation in medical staff committees?       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 information 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 be 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.