

IMPORTANT!!!!!!!

PHYSICIANS LIABILITY INSURANCE COMPANY APPLICATION GUIDELINES

In order to expedite the review of applications, we must receive complete information. Please follow these guidelines to assure that your application is complete, and to assure prompt processing:

- All questions must be answered. If a question does not apply, enter “N/A” for that question. **DO NOT LEAVE ANY QUESTION BLANK!**
- Section 2 – Coverage Information (page 1): Previous Insurance Company information for the preceding 5 years must be provided. Proof of insurance from each carrier should accompany the application. If there are previous denials, non-renewals, cancellations, exclusion of specific procedures, or restrictions on the professional liability insurance, please explain on the Additional Information Section, or on a separate sheet of paper.
- *Entity coverage* - for associations, partnerships, corporations, or companies, on shared or separate limits basis, please provide the following documents or information:
 1. Names of all current principals/shareholders of the entity,
 2. Function or operations of the entity, if other than practice management,
 3. Advise if the entity offers ancillary services such as MRI's, x-rays, medical testing, etc. If so, please provide the number of procedures associated with each type of service.
 4. Copy of the W-9 and 1099(IRS) forms for the entity,
 5. Copy of the OES-3 form with a notation of employee's position for the entity,
 6. Provide a current Certificate of Insurance for each employed or contracted physicians not insured by PLICO.
- *License restrictions or investigations*– explain any restrictions or investigation in the Additional Information Section, or on a separate sheet of paper.
- *Physicians' Application Section 9 and Ancillaries' Application Section 5* – Explain any “Yes” answers in the Additional Information Section, or on a separate sheet of paper.
- *Medical and Surgical Procedures* (Physicians' Application Section 8) - indicate the procedures that you will perform under this policy/coverage.
- **CLAIMS HISTORY – issued by all previous insurance carriers must be submitted with every application, even if you are not aware of any claims. It is imperative that we receive complete claims history from every previous carrier for the past 10 year period.**



Accounting [405] 815-4824 • Claims [405] 815-4802 • Marketing [405] 815-4814 • Risk Mgt. [405] 815-4803
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**MISCELLANEOUS FACILITIES
 PROFESSIONAL LIABILITY INSURANCE APPLICATION**

THIS FORM PROVIDES CLAIMS MADE COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY.

SECTION 1 - GENERAL INFORMATION		
1. Name of Applicant:	2. Tax ID:	
3. Indicate other names (DBA):		
4. Office Address:		
5. Contact Person:		
6. Billing address (<i>if different than Office Address</i>) :		
7. Phone:	8. Fax:	9. E-mail:
10. Web Site:		
11. I hereby name as my insurance agent: _____		

SECTION 2 - COVERAGE INFORMATION				
1. Requested Effective Date: _____		2. Requested Retroactive Date: _____		
3. Requested Limits of Liability:				
<input type="checkbox"/> \$100,000 / \$300,000	<input type="checkbox"/> \$500,000 / \$1 million	<input type="checkbox"/> \$1 million / \$1 million		
<input type="checkbox"/> \$1 million / \$3 million	<input type="checkbox"/> \$2 million / \$2 million	<input type="checkbox"/> \$2 million / \$4 million		
4. Retention: <input type="checkbox"/> Deductible <input type="checkbox"/> SIR (self insured retention plan):				
Per Medical Incident: _____		Annual Aggregate: _____		
Defense: <input type="checkbox"/> Inside the Limits of Liability <input type="checkbox"/> Outside the Limits of Liability				
5. Insurance History				
Year	Insurance Company	Policy Type	Policy Period	Retroactive Date
Current Year:				
1 st year prior:				
2 nd year prior:				
3 rd year prior:				
4 th year prior:				
5 th year prior:				

6. Has the facility ever been denied professional liability insurance or has its coverage ever been non-renewed or cancelled? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Has the present professional liability insurance carrier excluded any specific procedures or imposed other restrictions on the facility's coverage? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Has the facility ever practiced without professional liability insurance or without any other type of risk transfer instrument? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

SECTION 2 - COVERAGE INFORMATION (continued)		
9. Will the physicians share limits with the facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Are all physicians insured, or will all physicians be insured by PLICO? Provide a certificate of insurance for each physician not insured by PLICO	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Has the medical license of any physician practicing at your facility ever been suspended, revoked, denied, or limited in any State? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Has the applicant or any of its employees had during the past five (5) years:		
a. A complaint filed with a regulatory authority?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Any professional/narcotic license or permit investigated, suspended, revoked, restricted, or placed under probation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. List the licenses and certifications held by the facility:		
a. Agency: _____ Issue Date: _____ Expiration Date: _____		b. Agency: _____ Issue Date: _____ Expiration Date: _____
14. Is the facility accredited by any non-governmental body or other organization? [JCAHO (Joint Commission on Accreditation of Healthcare Organizations), CARF (Commission for Accreditation of Rehabilitation Facilities), AAAHC (Accreditation Association For Ambulatory Healthcare), etc.]	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. Does the facility carry General Liability insurance? If "Yes" provide a certificate of insurance.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. Does the facility participate in any teaching programs? If "Yes", provide details on Section 8, including brief description of the program, who are the sponsors, number of students and faculty, etc..	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Do you anticipate any expansion of services/locations within the next year? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Has the facility discontinued offering any services/procedures in the past 5 years? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19. Has the facility entered into any joint ventures or limited partnerships agreements? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20. Is the facility or any part of it operated or leased by a management company? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

SECTION 3 – UNDERWRITING		
1. Check the boxes that best describe your practice:		
<input type="checkbox"/> Surgery Center	<input type="checkbox"/> Dialysis Center	<input type="checkbox"/> Cancer Center
<input type="checkbox"/> Blood Bank	<input type="checkbox"/> Laboratory (diagnostic)	<input type="checkbox"/> Radiology (diagnostic)
<input type="checkbox"/> Urgi/Emergency Center	<input type="checkbox"/> Other _____	

2. Indicate the types of procedures performed at the facility:

SECTION 3- UNDERWRITING (continued)

3. Does the facility employ any of the following? If so, indicate number of providers:

Physician: _____ Surgeon: _____ Physician Assistant: _____
 CRNA: _____ Midwife: _____ Nurse Practitioner: _____
 RN: _____ LPN: _____ Podiatrist: _____
 Chiropractors: _____ Other: _____

Technicians:

EEG/EKG: _____ Medical/Lab.: _____ Operating Room: _____
 Perfusionist: _____ Physical therapist: _____ Respiratory: _____
 Phlebotomist: _____ Radiology: _____ Radiation: _____
 X-ray: _____ Physical Therapist: _____ Orthotist/Prosthetist: _____
 Respiratory therapist: _____ Other: _____

4. Complete a separate PLICO application (Physicians or Ancillary Medical Personnel) for each of the above professionals for whom individual limits of liability are requested.

5. Are credentials for new staff members checked/approved prior to granting privileges? Yes No

6. Are privileges probationary for at least six (6) months for all staff members? Yes No

7. Do department heads evaluate the work of their staff? Yes No

8. How often are staff's privileges reviewed? 6 months 1 Year Other

9. Do you require that all medical staff maintain professional liability?
If "Yes", what limits are required? _____

10. Has any member of the medical staff brought any complaints or suits against the facility? Yes No
If "Yes", provide details on Section 8.

11. Does the facility have a formalized Risk Management Program? Yes No
If "Yes", how often is the risk management plan reviewed and necessary changes implemented? Annually Every 2 Years Rarely Never
Who is in charge of implementing this program and any changes? _____

12. Does the facility have a formalized Quality Assurance Program? Yes No

13. Does the facility have a Medical Director? Yes No
If "Yes", please indicate their names and departments.

14. Do you contract with any PPO, HMO or other organization involved in contract medicine? If "Yes", please provide the names of the healthcare plans in Section 8.	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does the contract include an indemnity (hold harmless) agreement?	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Estimated percentage of practice that involves PPO or HMO patients: _____	
16. Does the facility have written job descriptions for all medical personnel?	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION 4 – RISK MANAGEMENT

1. Do you provide informed consent prior to any surgical procedure?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Does the informed consent disclose possible risks associated with such procedure?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are sponges, needles, and instruments counted before and after surgeries?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Are nursing charts maintained, including patients condition at discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Are patients charted by nursing staff a minimum of once a shift?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. How long are orders, consent forms, Doctor's orders, Doctor's notes, ancillary reviews and charts retained after discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Are credentials for new staff members checked and approved prior to granting staff privileges? If "Yes", by whom? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Are privileges probationary for at least six (6) months for all staff members?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Do department heads evaluate the work of their staff members? If "Yes", are these evaluations done in writing?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Is an ongoing medical audit maintained on all staff members' clinical work?	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Are all staff privileges reviewed at a minimum of every other year?	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you received any complaints or suits brought by a member of the medical staff? If "Yes", provide details on Section 8.	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Do you have a written, formalized Risk Management program? If "Yes": a. How often is the program reviewed for effectiveness? _____ b. Who is in charge of implementing this program? _____ c. Are necessary changes implemented?	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Do you contract with outside entities or vendors for the removal and/or disposal of the following wastes? a. Low level radioactive b. Other radioactive materials c. Hazardous or toxic d. Medical or infectious If "Yes" to any of the above, indicate what limits of liability and if proof of insurance is required.	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 <input type="checkbox"/>
15. Have you been identified as a potentially responsible party (PRP) in Federal or State Administrative Environmental Enforcement Actions(s)? If "Yes", provide details and the status of such action(s) in detail on Section 8.	Yes <input type="checkbox"/> No <input type="checkbox"/>

21. Do you provide preventative maintenance or repairs on medical equipment leased to others? Yes No
 If "Yes", provide details on Section 8.

SECTION 5 – CLAIMS HISTORY/ REPORT

1. Has the facility or any non-physician employee been involved in a professional liability claim/suit in the past ten (10) years? Yes No

2. Have all claims/suits/incidents been reported to your current/prior professional liability carrier? Yes No
 If "No", please explain on Section 8.

3. **Complete the following questions for all claims or incidents in which you have been directly or indirectly involved. We require ten (10) year claim or incident history/report from your current insurer with a recent valuation date, even if you have not had any claims/suits.**

Claim #	Patient's Initials	Insurance Company	Date of Loss	Date Reported	Date Closed	*Award's Amount

*Attributed to the facility's involvement: \$ _____ *Paid by All Parties \$ _____

What is/was the facility or employee's status in the case?

Primary Defendant Co-defendant Other (explain) _____

If the claim or suit is pending, when was the last contact with the Plaintiff's attorney? _____

What is/was the alleged harm to the patient? _____

What were the allegations made against the facility/employee? _____

Describe the patient's illness and related effects of the alleged harm _____

Describe any other details you believe are pertinent to the case _____

Name of other parties named in the suit: _____

