

Missouri Medical Malpractice Joint Underwriting Association

Post Office Box 219680
Kansas City, Missouri 64121-9680
Phone: 1-866-586-1693
Fax: 1-866-258-4892

Facility Professional Liability Application

Section I - Facility Information

Name of Applicant and Mailing Address:		
D.B.A.	Name of Parent Company	
Name of Administrator	Name of CFO	
Federal Tax Identification Number	Annual Receipts \$	Annual Payroll \$

Applicant is: (check all boxes applicable)

- | | | | |
|---|--|---|--|
| <p>A. <input type="checkbox"/> Children's hospital</p> <p><input type="checkbox"/> Geriatric hospital</p> <p><input type="checkbox"/> General hospital</p> <p><input type="checkbox"/> Psychiatric hospital</p> <p><input type="checkbox"/> Rehabilitation hospital</p> <p><input type="checkbox"/> Teaching hospital</p> <p><input type="checkbox"/> Skilled nursing home</p> <p><input type="checkbox"/> Assisted living home</p> <p><input type="checkbox"/> Independent Living</p> <p><input type="checkbox"/> Residential Care</p> | <p>B. <input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Corporation</p> <p><input type="checkbox"/> Joint venture</p> <p><input type="checkbox"/> Government</p> <p><input type="checkbox"/> Limited Liability Company</p> | <p>C. <input type="checkbox"/> Profit</p> <p><input type="checkbox"/> Non-profit</p> <p><input type="checkbox"/> Charitable</p> | <p>D. <input type="checkbox"/> Accredited by J.C.A.H.O.</p> <p><input type="checkbox"/> Licensed by state</p> <p><input type="checkbox"/> Accredited by A.O.A.</p> <p><input type="checkbox"/> Medicare approved</p> <p><input type="checkbox"/> Member of A.H.A.</p> <p><input type="checkbox"/> Accredited by C.A.R.F.</p> |
|---|--|---|--|

Section II - Facility Locations

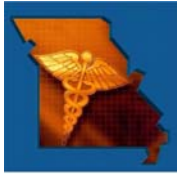
Primary Facility Address (Street, City, State, Zip Code)		
County	Primary Practice Phone Number	Primary Practice Fax Number

Secondary Location Address (Street, City, State, Zip Code) Attach Schedule if additional space needed.		
County	Secondary Practice Phone Number	Secondary Practice Fax Number

1. May we communicate with you by fax? Yes No
2. May we communicate with you by e-mail? Yes No E-Mail Address _____

For Agent's Use Only (If applicable)

Name of Agency: _____	Name of Agent: _____
Address: _____	Phone Number: _____
e-mail Address: _____	Fax Number: _____
Signature: _____	Date: _____
Are you authorized to place casualty insurance under subdivision 1(4) of Section 375.018, RSMo? <input type="checkbox"/> Yes <input type="checkbox"/> No	



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Section III - Coverage Selection

Requested Effective Date of Coverage:

Month Day Year

Important: Coverage will become effective only after the completion of all underwriting functions, acceptance by the Association, and receipt of payment.

Coverage Type and Limits of Liability (check all that apply)

- Facility Occurrence Professional Liability Coverage
\$500,000 each medical incident/\$1,500,000 annual aggregate
 - Facility Occurrence Professional Liability Coverage
\$1,000,000 each medical incident/\$3,000,000 annual aggregate
 - Commercial General Liability Occurrence Coverage
\$500,000 each incident/\$1,500,000 general aggregate
 - Commercial General Liability Occurrence Coverage
\$1,000,000 each incident/\$3,000,000 general aggregate
- (General Liability limits may not exceed Facility Occurrence Professional Liability Coverage limits)

Prior Acts Coverage (For Claims-Made Exposure with Current Carrier) (check all that apply)

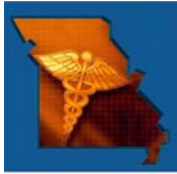
- Facility Prior Acts Coverage
\$500,000 each medical incident/\$1,500,000 annual aggregate
- Facility Prior Acts Coverage
\$1,000,000 each medical incident/\$3,000,000 annual aggregate
- Prior Acts Coverage Not Requested (please indicate reason below)
 - Reporting Coverage will be obtained from current claims-made carrier
 - Current coverage is on occurrence form
 - Prior Acts Coverage will not be obtained from the Association or from my current claims-made carrier. I understand that failure to obtain Prior Acts will leave me without complete coverage.

Important: A separate Prior Acts Policy for your claims-made exposure with your current carrier is available from the Association upon verification of active coverage and retroactive date, and if no gaps in coverage exist.

Section IV - Insurance History

Professional Liability:

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date and Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No



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General Liability:

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-Made
Effective Date and Expiration Date					
Limits of Liability					

1. Has your facility ever operated without professional liability coverage? Yes No
2. Has your facility ever operated without commercial general liability coverage? Yes No
3. Was your professional liability coverage ever placed with a non-admitted carrier? Yes No
4. If previously insured on a claims-made form, has your facility ever failed to obtain Extended Reporting Coverage? Yes No
5. Do you owe any outstanding premium to any carrier? Yes No

If any answer to questions 1 - 5 above is "Yes", please provide dates and explanations below:

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Section V - Professional Employees or Contractors

Following is list of professional allied health care providers for which coverage does not extend and a separate policy is required. If coverage is desired, please complete a separate application of each.

Professional Employees or Contracted Individuals: (Indicate the total number of individuals in each category)

	Employed physicians
	Contracted physicians
	Employed surgeons
	Contracted surgeons
	Podiatrists
	Oral surgeons/Dentists
	Physician assistant/Surgeon assistant
	Nurse midwives
	Nurse anesthetists
	Nurse practitioner
	Psychologist
	Profusionists
	Chiropractor
	Certified Nurse Anesthetists
	Cytotechnologist
	Emergency Medical Technicians
	Residents/Interns
	Optometrist
	Total Number of Professionals



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Other Covered Employees or Contractors: (Indicate the total number of individuals in each category.)

	Registered nurses
	LPN's
	Student nurses
	X-Ray technicians
	Pharmacists
	Physical Therapists
	Paramedics
	Volunteers
	Other employees
	Total Other Covered Individuals

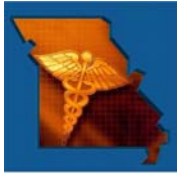
Section VI - Exposure Data Information

Facilities and Services Available: (Please check all that apply)

	Abortion Clinic		Ambulance		Blood Bank
	Burn Unit		CCU		Coronary Rescue
	Day Care		Dialysis		Dietary
	Emergency		Gift Shop		ICU
	Inhalation Therapy		Long-Term Care		Morgue
	Neonatal ICU		Nursery		Obstetrical
	Open Heart		Operating Rooms		Pathology
	Pharmacy		Physical Therapy		Radiation Therapy
	Radiology		Restaurant		Self-Care
	Shock Trauma		X-Ray		

Indicate if department is staffed by employees, contractors, or staff and limits of liability required? (Please provide verification of coverage for contract services)

Department	Staffing	Insurance Limits
Anesthesiology	<input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contract Physicians <input type="checkbox"/> Staff Physicians	
Radiology	<input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contract Physicians <input type="checkbox"/> Staff Physicians	
Emergency Department	<input type="checkbox"/> Employed Physicians <input type="checkbox"/> Contract Physicians <input type="checkbox"/> Staff Physicians	
Pharmacy	<input type="checkbox"/> Employed Pharmacists <input type="checkbox"/> Contract Pharmacists <input type="checkbox"/> Staff Pharmacists	



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Professional Liability Exposures: (Please indicate zero where not applicable. Provide number of licensed beds and average occupied for past 12 months)

Acute Care:

Subacute Care:

Skilled Care:

Assisted Living:

Independent Living:

Residential Care:

Psychiatric/Mental Health Beds:

Chemical Dependency / Rehabilitation

Beds:

ICU/CCU/NICU:

Bassinets:

# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	
# of Licensed Beds		Average # of Occupied Beds	

Inpatient Surgeries and Outpatient Visits: (Please indicate zero where not applicable. Provide number of procedures for previous 12 months and number of outpatient visits projected for the next 12 months)

Inpatient Surgeries:

Outpatient Surgeries:

Births Total:

Vaginal Births

Cesarean Sections

Health Institutional (clinical) Visits:

Chemical Dependency:

Emergency Room Services:

Counseling/Therapy Visits:

Home Health/Hospice Visits:

Mental Health (psychiatric) Visits:

All other Outpatient Visits:

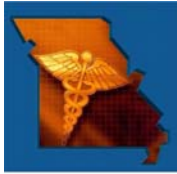
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	
# of Procedures		#of Outpatient Visits	

How many surgical procedures were performed in the last year by:

Employed Physicians _____ Staff Surgeons _____ Interns _____ Residents _____

Do you operate an Emergency Room? Yes No

Level of care given in Emergency Room? Level I Level II Level III Level IV



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Section VII - Rating Information

1. Does your institution engage in formal clinical research under the auspices of an institutional review board? Yes No
If yes, please explain below.
2. Does your institution engage in administration of non-FDA approved pharmaceuticals? Yes No
If yes, please explain below.
3. Does your institution engage in bio-medical device research and development? Yes No
If yes, please explain below.
4. Does your institution engage in animal research? Yes No
If yes, please explain below.
5. Does your institution engage in medical and/or surgical experimentation that is not approved by institutional review board? Yes No
If yes, please explain below.
6. Have your licenses, certifications or ability to participate with Medicare or Medicaid ever been suspended, revoked, placed on probation or voluntarily surrendered? If yes, please explain below. Yes No
7. Do you own or operate a blood bank? Yes No
If no, from where is the blood product obtained?
8. Does your facility meet current life safety code requirements as published in Fire/Code Uniform Fire Code? Yes No
If no, please explain below.
9. Does your facility maintain a written patient transfer plan for all contingencies which includes providing appropriate continuity of care information to the receiving facility, notification of family or guardian of transfer, appropriate and safe transportation and an audit process that is monitored through committee? Yes No
10. Is your facility accredited by J.C.A.H.O. or A.H.C.A., or equivalent? Yes No
If yes, does your accreditation have outstanding contingencies? Yes No

NOTE: If your facility is a nursing home, a state license issued by the Missouri Department of Health and Senior Services, and a copy the state report meets this requirement.
11. Does your facility perform background checks on all staff who have patient or resident contact (employees, leased workers and volunteers) including criminal history (5 years), felonies, misdemeanors, sexual offenses, abuse, theft, assault, credit history, verification of all education, verification of references, US citizenship status/Visa, and substance test? Yes No
If no, please explain below.
12. Does your facility operate solely in the State of Missouri? Yes No
13. Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff? Yes No
If yes, please explain below.
14. Do facility by-laws require staff doctors, employed doctors, and contract doctors to carry medical malpractice insurance of at least \$1,000,000 each medical incident/\$3,000,000 annual aggregate? Yes No
NOTE: If the facility is a Nursing Home, and no physicians are employed or contracted, questions 14, 16, 17, 18, 19, and 20 do not apply.
15. Does your facility require certificates of insurance for all contract services? Yes No
16. Do you require all employed, contract, and staff doctors to be Board Certified or Board Eligible? Yes No
17. Are privileges probationary for at least six months for all staff doctors? Yes No
18. Are all new physicians required to be proctored by a member of the active medical staff? Yes No
19. Are staff physicians' privileges and overall performances evaluated periodically? Yes No
20. Are all privileges granted to staff physicians detailed in writing? Yes No
21. Does the facility utilize the unit-dose system of dispensing medicine? Yes No
22. Is the pharmacy for patient-use only? Yes No
23. Does any nursing service or nursing facility rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination? Yes No



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2. Other than those claims/suits indicated in question 1 above, do you have knowledge of any incident, potential claim, suit, or circumstances that might reasonably lead to a claim or suit being brought against you arising out of the rendering or failing to render professional services ? Yes No

If "Yes" How many? _____

If "Yes" Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? Yes No

Important: For each loss indicated in questions 1 and 2 above 1) you are required to complete the attached Supplementary Loss Information Form and 2) A 5-Year Carrier Loss Run is needed from your current and/or previous professional liability carrier(s). The Loss Run should include date of occurrence, date of report, description,, indemnity amount paid, indemnity amount reserved, defense amount paid, defense amount reserved and current status.

Section X - Nursing Care Facilities Only

1. Years under current management: _____

2. Does a management company manage the facility? Yes No

If yes, Name of Management Company: _____

If yes, Number of years with current company: _____

3. Total number of units: _____

4. Total number of residents at full occupancy: _____

5. There is documentation that Residents are attended to on a daily basis? Yes No

6. Are residents allowed to have home health care aids? Yes No

7. Is the Director of Nursing a Registered Nurse? Yes No

8. Do you require nurses to carry malpractice coverage? Yes No

9. Total number of nurse employees? _____

10. Is a nursing assessment conducted and documented for every new resident immediately upon admission? Yes No

If "Yes" does this assessment include evaluation of:

- Full body skin breakdown/decubiti Yes No
- Mobility limitations Yes No
- Urinary incontinence Yes No
- History of prior injuries Yes No
- Required assistance Yes No
- Orientation/cognition Yes No
- Current medications Yes No
- Fall risk Yes No
- Wandering tendencies Yes No
- Nutritional needs Yes No
- Risk of provoking or initiating abusive behavior? Yes No

11. How often are your residents reassessed? _____

12. Does the facility have a policy clearly identifying the types of dementia residents for whom staff is capable of providing care? Yes No

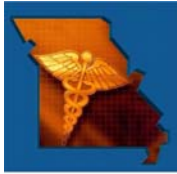
If "Yes", please attach policy.



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13. Does your facility have a secured unit(s) for residents prone to wandering? Yes No
If "Yes":
- Are all exit doors alarmed and/or physically monitored? Yes No
 - Are alarm bracelets used in the facility? Yes No
 - Is a care plan developed and implemented for each identified wandering resident? Yes No
14. Does staff receive training and education regarding wandering residents and associated management strategies? Yes No
15. Are fall assessments performed:
- Following any acute change of condition? Yes No
 - When there is a change in medication regimen? Yes No
 - When there is a change in treatment plan? Yes No
 - At least quarterly? Yes No
16. Does the facility have and enforce a policy regarding smoking in and around the facility? Yes No
17. Are residents and visitors who are smoking properly monitored? Yes No
18. Are regular rounds performed and documented of the physical plant and grounds, to ensure they are in a safe and well maintained condition? Yes No
19. Are equipment checks and preventive maintenance routinely performed and documented? Yes No
20. Is staff education on wound prevention and treatment provided and documented? Yes No
21. Are policies and procedures on assisting residents with self-medication and administering medication in place?
If "Yes" please provide a copy. Yes No
22. Are protocols in place for notification of resident's health care provider in cases of Acute Change of Condition?
If "Yes" please provide a copy. Yes No
23. Is there a written Emergency Evacuation Plan for the facility?
If "Yes" please provide a copy Yes No
24. Does staff orientation include a review and drill of any disaster plan? Yes No



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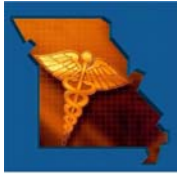
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Section XI - General Liability

<u>Location and Occupancy Including Patient Care Buildings, Other Buildings and Parking Lots</u>	<u>Square Footage</u>	<u>Age</u>	<u>Type of Construction</u>	<u>Number of Floors</u>	<u>Type of Fire Protection</u>

1. Does your facility include a swimming pool? Yes No
2. Hot tub/sauna? Yes No
3. Exercise/weight room? Yes No
4. Gymnasium? Yes No
 Please provide details below. A separate charge will be made for each of these facilities.
 If yes to questions 1-4, do you allow use of these facilities by sports teams, clubs or other outside entities? Yes No
 If yes, do you make a charge for this usage? Yes No
 Do you require signed hold harmless agreements from each person/organization entering your premises for these activities? Yes No
5. Do you have a heliport? (if yes, please provide verification of coverage) Yes No
6. Are there elevators or escalators on any premises? Yes No
7. Do you have planned any new construction and/or abatement for this year? Yes No
8. Has your facility agreed to hold harmless or indemnify others under contract? Yes No
9. Does your facility rent or lease any equipment from others? Yes No
10. Are there dwellings or other buildings rented or leased to others located on your premises? (Please provide details below. A separate charge will be made) Yes No
11. Does your facility include a cafeteria where meals are served to visitors or the general public for a charge? Yes No
 If yes, please provide annual receipts _____
12. Does your facility include rooms that are offered to non-affiliated entities for meetings or events? Yes No
 If yes, please provide square footage of these rooms _____

If any answer to questions 1-12 above is "Yes", please provide details and explanation below:



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Please Read and Sign

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the company. I agreed to notify the company if there is any future material change in any answers to this application, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other physician, firm or professional association.

I UNDERSTAND THAT ANY MATERIAL MISPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT AFFECT, PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT, AND/OR REQUIRE RETROACTIVE UPWARD PREMIUM ADJUSTMENT.

Applicant's Signature

Date

Applicant's Name

Applicant's Title

Application Checklist:

- Copy of most current declaration page
- Five-year Company Loss History
- Copy of Business Letterhead
- Supplemental Loss Information for each loss
- Allied Health Care Provider Application for each Allied Health Care Provider
- Signature and Date on Application
- Verification of Extended Reporting or Prior Acts Coverage
- Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies
- Copy of medical staff by-laws
- A.H.A. Survey of hospitals
- Risk Management and quality improvement plan
- Verification of professional liability coverage for all contracted services
- All hold harmless agreements
- Completed, Signed Authorization to Release Information
- Copy of Missouri License



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Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section VIII - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked Not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only
- Summary judgment in your favor
- Suit settled out of court
- Suit threatened, no action taken
- Jury verdict in your favor
- Suit filed awaiting mediation
- Suit filed but dropped by claimant
- Jury verdict in favor of the plaintiff
- Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section VIII - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked Not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? Yes No

What is the status of this matter? Open Closed (Check applicable description below)

- Incident report only
- Summary judgment in your favor
- Suit settled out of court
- Suit threatened, no action taken
- Jury verdict in your favor
- Suit filed awaiting mediation
- Suit filed but dropped by claimant
- Jury verdict in favor of the plaintiff
- Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____



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AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by Missouri Medical Malpractice Joint Underwriting Association (the "Association") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Association upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Association may have a bearing upon his acceptability to the Association as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for the State of Missouri and any other State in which he has practiced, or resided, and any and all physicians having information regarding the undersigned, to release to the Association upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Association may have a bearing upon his acceptability to the Association as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Association, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Association and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

Date: _____