

JUA Coverage, if issued will be on a Claims Made Basis	Requested Effective Date:	
Requested retroactive date:		
(Coverage cannot begin prior to application and premium receipt by the JUA)		

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Hickory Pointe, Suite 125, 2250 Hickory Road, Plymouth Meeting, PA 19462
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com

APPLICATION FOR NURSING HOME PROFESSIONAL LIABILITY INSURANCE

LIMITS OF LIABILITY: \$ 500,000 PER OCCURRENCE / \$ 1,500,000 PER ANNUAL AGGREGATE

PART I – GENERAL INFORMATION

Applicant Name: _____

State License No. _____

Mcare License Number: _____

Address: _____

City: _____

State: _____

Zip: _____

County: _____

Telephone: _____

Fax: _____

E-Mail Address: _____

PART II

1. a. Type of Home (see definitions): Skilled Nursing Convalescent
- b. Average Number of Occupied Beds Last 12 Months

- c. Projected Average Number of Occupied Beds Next 12 Months

2. Medical Incidents (Applicable if a claims-made retroactive date is being requested before the effective date):
Are you aware of any medical incidents which occurred during one of the claims-made policies for which a claim has not yet been made? Yes No
If yes, attach a complete description of the incidents including the date and status of the incident.
3. Does the applicant have **unrestricted** General Liability Insurance (e.g., no patient injury, products liability or other significant exclusions)?
 Yes **If yes, please provide evidence of insurance so indicating**
 No **If no, what are the annual gross receipts for nursing services?**
Last 12 Months _____ Projected Next 12 Months _____

PART III

Attachments (A separate page is provided for your convenience):

1. Current and Prior Insurance Coverage and Loss Information:
Attach a list of:
 - a. All carriers for the past eight (8) years. Explain any gaps in coverage.
 - b. All claims made claims or suits been filed against you during the last eight (8) years as a result of professional services rendered. Include the date of the alleged incident, date the claim was made, current status and amount of payment, if any.
2. A copy of the declarations for the applicant's most recent coverage if coverage was claims made.
3. Attach a current loss run from all prior carriers for the past eight (8) years plus Mcare.
4. For Each Facility - Attach a copy of a) the current license; b) HCFA 672 - Resident Census; c) HCFA 2567 L – Statement of Deficiencies; and d) financial statements including a balance sheet and income statement.

SIGNATURE: _____

DATE: _____

(all pages must be signed)
JUAAPP-NH 7/2007

PART IV

I certify that I am authorized to act on behalf of the Insured.

I certify that I will not accept insurance from the JUA if I am able to obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information which is calculated to influence the judgment of the JUA in considering this application.

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 subjects such person to criminal and civil penalties.

IMPORTANT: This application and release **must** be signed by the Chief Executive Officer or Administrator

SIGNATURE: _____ DATE: _____

TITLE: _____

COMPLETE THIS PORTION IF APPLICATION IS BEING SUBMITTED THROUGH A BROKER

Signature of Producing Broker _____ Date _____

Name and address of Broker Company (print or type):

Definitions

Skilled Nursing Facilities

Skilled Nursing Facilities are free-standing facilities which provide the same service as a Convalescent Facility, except that 50% or more of their patients are over 65.

Convalescent Facilities

Convalescent Facilities are free-standing facilities which provide skilled nursing care and treatment for patients requiring continuous health care, but do not provide any hospital services (such as surgery); and 50% or more of their patients are under 65.

General Information

We write **only professional liability** (the *general liability is not covered*), nor do we write any excess coverage (coverage that is over the Mcare).

- **It is critical that the type of claim be indicated on loss history reports** (professional liability separated from general liability; institutional professional separated from physicians professional).
- We require a **separate application for all employed physicians to be covered.**
- We require a separate application for each licensed facility.
- We provide coverage only for the licensed health care provider (not any holding company or other parent company). No additional insureds will be added. The name of the insured will be as shown on the license.

ATTACHMENTS

List of Prior carriers for past 8 years (list most recent carrier first):

Carrier Name	Policy Number	Coverage Type (CM or Occ)	Effective Date	Termination or Expiration Date

Explain any gaps in coverage:

Attach policy/claim history for each carrier even if there were no claims.

List of Claims made or Suits brought against the applicant in the past 8 years (attach a separate list if needed):

Incident Date	Report Date	Status (open or closed)	Amount of Indemnity Payment	Amount of Expense Payments	Description of incident

Medical incidents which occurred during one of the claims-made policies for which a claim has not yet been made (attach a separate list if needed):

Incident Date	Description of incident (including injured patient)

Attach a copy of the declarations for the insured's most recent coverage if it was claims made.

Attach a copy of a) the current license; b) HCFA 672 - Resident Census; c) HCFA 2567 L – Statement of Deficiencies; and d) financial statements including a balance sheet and income statement.

SIGNATURE:

DATE:

(all pages must be signed)