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 – Website: http://www.pajua.com

APPLICATION FOR HOSPITAL PROFESSIONAL LIABILITY INSURANCE

Limits of Liability: $500,000 Per Occurrence / $2,500,000 Per Annual Aggregate

POLICIES ARE ISSUED ON AN ANNUAL BASIS UNLESS OTHERWISE SPECIFIED AND APPROVED BY THE JUA

COVERAGE CANNOT BEGIN PRIOR TO APPLICATION AND PREMIUM RECEIPT BY THE JUA

JUA Coverage, if issued, will be on a CLAIMS-MADE Basis	**Requested Effective Date:**	
	Requested Retroactive Date:	

PART I – GENERAL INFORMATION

Applicant Name:

State License Number: Mcare License Number:

Address:

City: State: Zip: County:

Telephone: ( ) Fax: ( ) E-Mail Address:

PART II – BROKER INFORMATION (if this is being submitted by an insurance broker)

Broker: Contact Person:

Telephone: ( ) Fax: ( ) E-Mail Address:

Address:

Number and Street City State Zip

EIN or SSN (if broker is "new" to JUA): _____

PART III – COVERAGE INFORMATION

List ALL Prior Insurers for the last 8 years: (attach separate list if necessary)

Carrier or Self-Insurer	**Policy Number**	**Coverage Dates (Month, Day & Year) Eff. Exp.**	**Coverage Type (Occurrence or Claims-Made)**	**Retroactive Date (if Claims-Made)**	**Tail Coverage Purchased?**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**
			☐ **Occ** ☐ **CM**		☐ **Yes** ☐ **No**

If any of the above policies are still in force, explain why coverage is requested from the JUA:

Explain any gaps in coverage in the past 8 years including any period directly preceding JUA coverage:

Explain why tail coverage was not purchased for any claims-made policy listed above:

Attach a copy of the hospital's current Declarations and Policy History / Claim History Reports from each of the above carriers or self-insurers plus Mcare.

You need to contact each of your current or prior carriers and request they send you these reports. They are required to provide these reports to you if you request them. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if the hospital has had no claims.

Claims or Suits:

Have any claims been made or suits brought against the hospital during the past 8 years as a result of professional services rendered? (Regardless of whether the claim was dismissed or a judgment rendered)
☐ Yes ☐ No If yes, attach a description of all claims made or suits brought including the date and status.

Has the hospital ever operated for any period of time without insurance? ☐ Yes ☐ No
If yes, provide the dates the hospital was uninsured: _____. Also provide a letter signed by an authorized representative of the hospital on the hospital's letterhead listing all incidents, claims made and suits filed against the hospital during the uninsured period. Include claimants' names, dates of alleged incidents, dates the claims were made, brief descriptions, current status and indemnity payment amounts, if any. If there were no claims or incidents, provide a signed letter stating such.

Medical Incidents:

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.

Never Events:

Have any claims been made or suits brought against the hospital for an incident where the patient's medical insurance or Medicare refused to pay because it was on their preventable serious adverse event or "never event" list? ☐ Yes ☐ No If yes, attach a description of the incident including the date and status.

PART IV – EXPOSURE INFORMATION

1. Type of Hospital:
   ☐ General ☐ Long-Term Acute Care ☐ Psychiatric
   ☐ Children's ☐ Surgical Specialty ☐ Rehabilitation
   ☐ Critical Access ☐ Other (describe): _____

2. Services Provided (check all that apply):

☐ Ambulance Service	☐ Medical Intensive Care Unit	☐ Physical / Occupational Rehabilitation
☐ Bariatric Surgery	☐ Neonatal Intensive Care Unit	
☐ Blood Bank	☐ Neurosciences	☐ Psychiatric
☐ Burn Unit	☐ Nuclear Medicine	☐ Radiology
☐ Cardiac Catheterization Lab	☐ Obstetrics	☐ Substance Abuse Treatment
☐ Cardiac Intensive Care Unit	☐ Oncology	
☐ Dialysis	☐ Open Heart Surgery	☐ Transplants (type): _____
☐ Emergency Department	☐ Organ / Eye / Tissue Bank	
☐ Home Health Care	☐ Orthopedics	☐ Trauma Center
☐ Inpatient Surgical Services	☐ Outpatient Surgery	☐ Urgent Care / Fast Track
☐ Integrative Medicine	☐ Pediatrics	☐ Wound Care Center

☐ Telemedicine / Remote Services (describe – attach separate sheet if necessary):

_____

_____

☐ Other (describe – attach separate sheet if necessary): _____

_____

3. Have any services been discontinued in the *last* 12 months? ☐ Yes ☐ No
   If yes, explain: _____
4. Will any services be discontinued in the *next* 12 months? ☐ Yes ☐ No
   If yes, explain: _____
5. Will any new services be provided in the *next* 12 months? ☐ Yes ☐ No
   If yes, explain: _____

SIGNATURE (all pages must be signed) TITLE DATE

6. Exposure Data:

Beds means the daily average number of occupied beds, cribs and bassinets used for patients during the policy period. The unit of exposure is each bed, computed by dividing the sum of the daily numbers of beds, cribs and bassinets used for patients for each day of the policy period, by the number of days in such period.

Visits means the total number of visits to the institution (regardless of the number of visits to particular departments within such institution) by outpatients (patients not receiving bed and board services), during the policy period. The unit of exposure is each 100 visits.

Number of Beds:	Estimated last 12 months	Projected for next 12 months
Acute Care, Cribs and Bassinets		
Mental Health/Mental Rehabilitation		
Extended Care		
Outpatient Surgical		
Health Institution		
Number of Visits:		
Emergency		
Mental Health/Mental Rehabilitation		
Extended Care		
Outpatient Surgical		
Health Institution		
Home Health Care		
Other (describe):		

7. Provide the Historical Exposure Information for the current policy year and each of the five prior policy years for experience rating purposes:

	Current Year	**1st Year Prior**	**2nd Year Prior**	**3rd Year Prior**	**4th Year Prior**	**5th Year Prior**
Number of Beds:						
Acute Care, Cribs and Bassinets						
Mental Health/Mental Rehabilitation						
Extended Care						
Outpatient Surgical						
Health Institution						
Number of Visits:						
Emergency						
Mental Health/Mental Rehabilitation						
Extended Care						
Outpatient Surgical						
Health Institution						
Home Health Care						
Other						

PART V – OWNERSHIP AND MANAGEMENT

1. Type of Entity: (Check all that apply)
   - ☐ Individual
   - ☐ Partnership
   - ☐ Corporation
   - ☐ Joint Venture
   - ☐ Limited Liability Company
   - ☐ Profit
   - ☐ Non-Profit
   - ☐ Governmental
   - ☐ Charitable
   - ☐ Other (describe): _____
2. Years hospital has been in operation _____
3. Years owned by current owners _____
4. Years experience owners have in hospitals _____
5. Years managed by current management _____
6. Years experience management has in hospitals _____

PART VI – MEDICAL STAFF

1. Provide the number of employed and contracted health care providers for each category below:

	Physicians	Surgeons	Residents	Podiatrists	Nurse Midwives
Employed					
Contracted					

2. Do the specialists listed below provide services at the hospital? ☐ Yes ☐ No If yes, check all that apply:
   ☐ Hospitalists: ☐ Employed or ☐ Contracted ☐ Intensivists: ☐ Employed or ☐ Contracted
   ☐ Laborists: ☐ Employed or ☐ Contracted ☐ Nocturnists: ☐ Employed or ☐ Contracted
3. What is the total number of all medical staff physicians (active, associate, courtesy, provisional, consulting, temporary and honorary)? _____
4. Credentialing – Are the following items checked or verified? Please answer Yes or No for each.
   Employment History ☐ Yes ☐ No Claims History ☐ Yes ☐ No References ☐ Yes ☐ No
   Criminal Record ☐ Yes ☐ No Education ☐ Yes ☐ No License ☐ Yes ☐ No
5. How often are: Credentials reviewed? _____ Privileges reviewed? _____
6. Does the hospital obtain evidence of medical professional liability insurance in force at the state-mandated limits for all health care providers listed in 1., 2. and 3. above? ☐ Yes ☐ No
7. How often is the evidence of insurance verified? ☐ Annually ☐ Other (describe) _____
8. Are the insurance requirements stated in the bylaws? ☐ Yes ☐ No

PART VII – RISK MANAGEMENT

1. Is there an established risk management program? ☐ Yes ☐ No
2. Is there an assigned risk manager? ☐ Yes ☐ No
   If no, how is this role filled? _____
3. Does the risk manager have other responsibilities? ☐ Yes ☐ No
   If yes, describe: _____
4. Is there a risk management committee? ☐ Yes ☐ No
5. Is there an incident/event reporting and analysis system in place? ☐ Yes ☐ No
6. Is there a patient satisfaction survey system? ☐ Yes ☐ No
7. Is there a patient complaint resolution program? ☐ Yes ☐ No
8. Has the facility developed and implemented an approved patient safety plan? ☐ Yes ☐ No
9. Is there a patient safety committee? ☐ Yes ☐ No
10. Is there an assigned patient safety officer? ☐ Yes ☐ No
11. Is there an internal infection control plan? ☐ Yes ☐ No

PART VIII – ADDITIONAL PROFESSIONAL INFORMATION

1. Is the hospital that is applying for JUA coverage a stand-alone facility or it is located in or on the premises of another hospital? □ Stand-Alone Facility □ Located in or on the premises of another hospital
   Name of host facility (if applicable): _____
2. Are there any departments whose services are provided by a contract group? □ Yes □ No
   If yes, check all that apply: □ Anesthesiology □ Pathology
   □ Emergency □ Pharmacy
   □ Obstetrics □ Radiology
   □ Other (list): _____
   Does the hospital obtain evidence of medical professional liability insurance in force for the contract group(s)? □ Yes □ No What liability limits are required? _____
3. Does the hospital participate in any Clinical Trials? □ Yes □ No If yes, describe involvement:
   _____
   _____
   _____
4. Is the hospital currently accredited by: □ The Joint Commission □ CARF
   □ Other (describe): _____ □ None / No accreditation
   Is the accreditation: □ Full/Unconditional □ Preliminary □ Provisional □ Conditional
5. a. Does the hospital use Electronic Health Records (EHR) / Electronic Medical Records (EMR)?
      □ Yes □ No
   b. If yes, what is the name of the EHR/EMR system? _____
   c. Is the EHR/EMR system certified? □ Yes □ No
   d. Name of certifying body: _____
   e. How long has the system been in use? _____
   f. Is all or part of the system in use? □ All □ Part
   g. What type of training has been provided? _____
   h. How is data protected? _____
   i. Is there a process in place to receive regular or available system updates? □ Yes □ No
6. Does the hospital have unrestricted General Liability insurance (e.g. no patient injury, products liability or other significant exclusions)? □ Yes □ No
   If yes, provide evidence of insurance so indicating.
   If no, explain: _____
   _____
   _____
7. Has any enforcement action ever been taken against the hospital (limitation/ban on admissions/services, license revoked or suspended, refusal to renew license, provisional license, civil money penalty, etc.)? □ Yes □ No If yes, provide date, description of action taken and name of governmental agency assessing the enforcement action. Attach a separate page if necessary.
   _____
   _____
   _____
8. Has adverse action ever been taken against the hospital's Medicare or Medicaid certification? □ Yes □ No If yes, provide date, description of action taken and name of governmental agency assessing the action. Attach a separate page if necessary.
   _____
   _____
   _____

ADDITIONAL ITEMS TO BE SUBMITTED WITH THE APPLICATION:

1. A copy of the current policy's Professional Liability Declarations page.
2. A copy of the current Certificate of Licensure.
3. A copy of the most recent Pennsylvania Department of Health full State Licensure survey.
4. Evidence of unrestricted General Liability insurance (e.g. no patient injury, products liability or other significant exclusions).
5. A copy of the Mcare hospital experience modification factor letter for the coverage year for which the hospital is applying for coverage.
6. Current audited financial information including a profit & loss statement and balance sheet.
7. An organizational chart displaying the various ownership interests.
8. Company prepared loss runs or claims history reports from all carriers for the last 8 years, even if there were no claims.
9. Mcare loss run (see General Information Supplement for ordering instructions).
10. JUA Supplemental Claims Information forms for any claims not listed on the carriers' or Mcare's loss runs.

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 **must** be signed by the Chief Executive Officer or Administrator.

SIGNATURE (all pages must be signed) TITLE DATE

GENERAL INFORMATION

We write **only** *professional liability* coverage (*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 each physician, podiatrist and certified nurse midwife 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.

DEFINITIONS

Hospitals are facilities treating all general or special medical and surgical cases, including sanitariums with surgical operating room facilities.

Mental Health and Mental Rehabilitation are facilities that provide non-surgical medical intervention for:

- short term crisis stabilization for mental health and substance abuse; and
- long-term mental health rehabilitation.

This includes facilities that assist individuals to develop or improve task and role-related skills, and social and environmental supports needed to perform as successfully and independently as possible at home, family, school, work, socialization, recreations and other community living roles and environments).

Extended Care: All beds located within a hospital, licensed by the state and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous and extended basis.

Outpatient Surgical Facilities are facilities that provide surgical procedures on an outpatient (same day) basis. Beds are used primarily for recovery purposes, and overnight stays, if any, are the exception.

Health Institutions are facilities that provide non-surgical medical treatment other than as described above under Mental Health / Mental Rehabilitation.

Home Health Care Services are organizations which provide nursing, physical therapy, housekeeping and related services to patients at their residences.

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.

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

Personal Care Facilities are free-standing facilities which provide health-related personal care, residential and social care with some routine health care, but not continuous skilled nursing care. Residents are primarily or exclusively over 65. Personal care facilities are not eligible for coverage.

Sanitariums or Health Institutions – not hospitals or mental psychopathic institutions are facilities with regular bed and board accommodations, and with laboratory or medical departments, but not risks with surgical operating room facilities even though designated as sanitariums or health institutions.

Primary Health Center means a community-based non-profit corporation meeting standards prescribed by the Department of Health, which provides preventive, diagnostic, therapeutic, and basic emergency health care by licensed practitioners who are employees of the corporation or under contract to the corporation.

ORDERING MCARE LOSS HISTORIES

Request must be in writing and signed by the health care provider.

Must include health care provider's name and PA license number.

Include address of where loss runs are to be sent.

Requests are to be sent to:

Natalie McLaughlin
Mcare Fund
1062 Lancaster Avenue, Suite 15F
Rosemont, PA 19010

Natalie's telephone number: (610) 801-2200 x 3016

Natalie's fax number: (610) 801-2211

Natalie's email address: nmclaughli@state.pa.us

There is no fee involved for requesting the loss runs.

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Supplemental Claims Information Form

Complete one form for each claim. Make additional copies of this form as needed.

Hospital Name: _____

License Number: _____

Claimant's Name: _____
(First) (Middle) (Last)

Incident Date: _____
(Month, Day and Year)

Date Reported: _____
(Month, Day and Year)

Location Where Incident or Alleged Injury Occurred: _____

Carrier Name: _____

Policy Number: _____ Effective Date: _____

Status (check all that apply):

☐ Open ☐ Closed Date Closed: _____

☐ Settlement ☐ Judgment ☐ Dismissed

Amount of Indemnity Payment (if any): $_____

Description of Claim:

_____

_____

_____

_____

_____

_____

_____

_____