

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 Nursing Home Professional Liability Insurance
Limits of Liability: \$500,000 Per Occurrence / \$1,500,000 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 10 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?
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Occ <input type="checkbox"/> CM		<input type="checkbox"/> Yes <input type="checkbox"/> 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 facility'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 facility has had no claims.

SIGNATURE (all pages must be signed)

TITLE

DATE

Claims or Suits:

Have any claims been made or suits brought against the facility during the past 10 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 facility ever operated for any period of time without insurance? Yes No
If yes, provide the dates the facility was uninsured: _____. Also provide a letter signed by the owner or administrator on the nursing home’s letterhead listing all incidents, claims made and suits filed against the nursing home 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 facility for an incident where the patient’s medical insurance or Medicare refused to pay because it was on their “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 Home (see Definitions below) Convalescent Skilled Nursing

Definitions:

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.

Skilled Nursing Facilities

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.

2. The actual number of occupied beds for the last 12 months. _____
3. The projected number of occupied beds for the next 12 months. _____
4. Does the applicant 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, provide the annual gross receipts for nursing services for:
The last 12 months _____
Projected for the next 12 months _____

PART V – OWNERSHIP AND MANAGEMENT

1. Years facility has been in operation _____
2. Years owned by present owners _____
3. Years managed by present management _____
4. Years experience present owners have in nursing homes _____
5. Years experience present management has in nursing homes _____
6. Nursing Home Administrator:
a. Full name _____
b. License number _____
c. Years experience as an Administrator _____ Years at this facility _____
d. Employed or Contracted Number of hours per week at this facility _____
e. Serving this facility only or other facilities as well?

SIGNATURE (all pages must be signed)

TITLE

DATE

7. Director of Nursing (DON):
- Full name _____
 - License number _____
 - Years experience as a DON _____ Years at this facility _____
 - Employed or Contracted Number of hours per week at this facility _____
 - Serving this facility only or other facilities as well?
8. Medical Director:
- Full name _____
 - License number _____
 - Years experience as a Medical Director _____ Years at this facility _____
 - Employed or Contracted Number of hours per week at this facility _____
 - Serving this facility only or other facilities as well?
 - Serves as attending physician for any residents? Yes No
If yes, how many? _____

PART VI - STAFFING

1. Nurse staffing

	1 st shift	2 nd shift	3 rd shift
RN			
LPN			
Nurse Aides			

- Are nursing personnel provided on each floor of the facility? Yes No
- Total number of direct nursing care hours per resident per 24 hour period _____
- What is the staff turnover rate for the last 12 months? _____%
- Do you utilize contracted or temporary personnel? Yes No
If yes, what percentage of your nurse staffing is contracted or temporary? _____%
- Is there an employee orientation program? Yes No
- Is inservice training conducted? Yes No What is the frequency? _____
- Who is authorized to administer drugs and medications? _____

PART VII - RESIDENTS

1. Age range of residents

	Under 50	50 - 64	65 and over
Number			

- Is an initial nursing assessment performed for each new resident upon admission? Yes No
Are there regular updates? Yes No How often? _____
- Is there an individual discharge plan for each resident? Yes No
- Does each resident have a written physician's order for each medication received? Yes No
- Does each resident have his or her own attending physician? Yes No
If no, who fills that role? _____
- Do you obtain evidence of medical professional liability insurance in force at the state-mandated limits for all attending physicians? Yes No

PART VIII – RISK MANAGEMENT

- Is there an established risk management program? Yes No
- Is there an assigned risk manager? Yes No
If no, how is this role filled? _____
- Is there a risk management committee? Yes No
- Is there an incident reporting and analysis system in place? Yes No
- Is there a resident satisfaction survey system? Yes No
- Is there a resident complaint resolution program? Yes No

SIGNATURE (all pages must be signed)

TITLE

DATE

PART IX – ADDITIONAL PROFESSIONAL INFORMATION

1. Has any enforcement action ever been taken against the facility (ban on admissions, license revoked, 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.

2. Has adverse action ever been taken against the facility’s Medicare or Medicaid certification? Yes No If yes, provide date, description of action taken and name of governmental agency assessing the action.

ADDITIONAL ITEMS TO BE SUBMITTED WITH THE APPLICATION:

1. A copy of the current policy’s Declarations page.
2. A copy of the current Certificate of Licensure.
3. Financial information including a profit & loss statement and balance sheet.
4. A copy of the Resident Census form CMS 672.
5. A copy of the Statement of Deficiencies form CMS 2567L with Plan of Correction for the most recent survey. This should not be a draft copy.
6. An organizational chart displaying the various ownership interests.
7. Company prepared loss runs or claims history reports from all carriers for the last 10 years, even if there were no claims.
8. Mcare loss run.

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** (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.

ORDERING MCARE LOSS HISTORIES

Request must be in writing and signed by the insured 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.

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

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:
