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 PRIMARY HEALTH CARE CENTER 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

Number of Visits:	Estimated last 12 months	Projected for next 12 months
Emergency		
Other		
Mental Health/Mental Rehabilitation		
Outpatient Surgical		
Home Health Care		

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.

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. Attach a copy of the declarations for the applicant's most recent coverage if it was claims made.
3. Attach a current loss run from all prior carriers for the past eight (8) years plus Mcare.
4. Attach a copy of the current Certificate of Compliance (license).
5. Attach a copy of the financial statements including a balance sheet and income statement.

SIGNATURE: DATE:

(all pages must be signed)

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 with 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):

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 Indeminity 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 coverage was claims made.

Attach a copy of the current license and financial statements including a balance sheet and income statement.

SIGNATURE: DATE:

(all pages must be signed)

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 and residents to be covered** except residents that are subject to the facility's limit (1st year residents).
- We require a separate application each 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

1. Hospitals are facilities treating all general or special medical and surgical cases, including sanitariums with surgical operating room facilities.
2. Mental Health and Mental Rehabilitation are facilities that provide non-surgical medical intervention for:
   a. short term crisis stabilization for mental health and substance abuse; and
   b. 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).
3. 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.
4. 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.
5. Health Institutions are facilities that provide non-surgical medical treatment other than as described above under Mental Health / Mental Rehabilitation.
6. Home Health Care Services are organizations which provide nursing, physical therapy, housekeeping and related services to patients at their residences.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.