



## Medical Group Practice Professional Liability Application

Attach a copy of the applicable group practice letterhead and brochure(s) for advertising/public relations.

1. Group Practice Name \_\_\_\_\_ Telephone Number \_\_\_\_\_  
Main Location Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Mailing Address/P.O. Box Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
Tax Identification Number \_\_\_\_\_ Requested Effective Date \_\_\_\_\_

2. Name and describe all legal entities (subsidiaries, joint ventures and partnerships) and indicate below if entity is to be insured:

Name and Address      Percent Owned      Operations Description      Relationship to Clinic      To Be Insured?      Retroactive Date

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3. Coverage Requested:

Medical Group Practice Professional Liability

- a. Limits of Liability: \$ \_\_\_\_\_ Each Medical Incident      \$ Annual Aggregate  
b. Deductible Amount \$ \_\_\_\_\_ SIR Amount \_\_\_\_\_  
c. Is Prior Acts Coverage being requested?     Yes     No  
d. Is coverage to apply separately for each physician or will it be shared with the corporate entity? Individual Limits  Shared   
e. Will physicians carry the same limits of liability as the corporate entity or will they maintain different limits?  
If the physicians maintain different limits of liability, indicate below.

4. Medical Professional Liability Insurance Coverage (For previous five year period):

Current Year      First Prior Year      Second Prior Year      Third Prior Year      Fourth Prior year

Insurance Company

Policy Number:

Limits of Liability

Deductible/SIR Amount

Coverage Form

Retroactive Date

Policy Period

**5. Main Location:**

Street	City	State	Zip Code
<b>Additional Locations:</b>			
Location #2:			
Street	City	State	Zip Code
Location#3:			
Street	City	State	Zip Code
Location#4:			
Street	City	State	Zip Code

**If more space is required, use additional sheet(s) of clinic letterhead.**

6. a. Does group practice own property that is leased to other entities \_\_\_\_ Yes \_\_\_\_ No
- b. Date group practice entity was established \_\_\_\_\_
- c. Length of time at main location? \_\_\_\_\_
- d. Within the next 12 - month period , does the group practice plan to:
  - ~~///~~ Obtain another group practice or entity? \_\_\_ Yes \_\_\_ No
  - ~~///~~ Add to the number of locations? \_\_\_ Yes \_\_\_ No
  - ~~///~~ Expand the number of locations? \_\_\_ Yes \_\_\_ No
  - ~~///~~ Form any joint ventures? \_\_\_ Yes \_\_\_ No
  - ~~///~~ Start any new services or activities? \_\_\_ Yes \_\_\_ No
  - ~~///~~ Add additional physicians? \_\_\_ Yes \_\_\_ No
- e. Were any services or operations discontinued? \_\_\_ Yes \_\_\_ No
- f. Have any locations been sold? \_\_\_ Yes \_\_\_ No

**If answer to any of the above questions is yes, please elaborate on additional sheet(s) of clinic letterhead.**

**7. Administration:**

- a. Name of Chief Executive Officer: \_\_\_\_\_ How long with the group practice? \_\_\_\_\_
- b. Name of Medical Director : \_\_\_\_\_ How long with the group practice? \_\_\_\_\_
- c. Name of Administrator/Risk Manager: \_\_\_\_\_ How long with the group practice? \_\_\_\_\_

**8. Physicians (Individual applications are required): Please indicate number of:**

	Current Year	First Prior Year	Second Prior Year
Full Time Physicians	_____	_____	_____
Part - Time Physicians	_____	_____	_____
Dentists	_____	_____	_____
Podiatrists	_____	_____	_____
Total*	_____	_____	_____



B. Please list all managed care organizations that the group practice is currently contracting with? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

13. Does group practice attract patients because of reputation in any particular field of medicine? \_\_\_ Yes \_\_\_ No  
If yes, please specify: \_\_\_\_\_

14. Does group practice own, control, or staff one or more of the following?

- a. Facilities for overnight patient monitoring or care? \_\_\_ Yes \_\_\_ No
- b. Hospital \_\_\_ Yes \_\_\_ No
- c. Surgicenter \_\_\_ Yes \_\_\_ No
- d. Emergency Room \_\_\_ Yes \_\_\_ No
- e. Birthing Center \_\_\_ Yes \_\_\_ No
- f. Substance Abuse Program \_\_\_ Yes \_\_\_ No
- g. Radiation and/or Shock Therapy \_\_\_ Yes \_\_\_ No
- h. Laboratory \_\_\_ Yes \_\_\_ No
- i. Emergency Vehicles \_\_\_ Yes \_\_\_ No
- j. Pharmacy (Annual Gross Sales \$ \_\_\_\_\_) \_\_\_ Yes \_\_\_ No
- k. Optical Goods Store (Annual Gross Sales \$ \_\_\_\_\_) \_\_\_ Yes \_\_\_ No
- l. Hearing Aid Store (Annual Gross Sales \$ \_\_\_\_\_) \_\_\_ Yes \_\_\_ No
- m. Weight Control Clinic Name: \_\_\_\_\_ \_\_\_ Yes \_\_\_ No

15. Specify hospitals at which physicians hold staff or courtesy privileges:

Hospital Name:	Staff	Courtesy	JCAHO Accredited
_____	_____	_____	___ Yes ___ No
_____	_____	_____	___ Yes ___ No
_____	_____	_____	___ Yes ___ No
_____	_____	_____	___ Yes ___ No
_____	_____	_____	___ Yes ___ No

16. Risk Management

- a. Does group practice have a written loss control/risk management program? \_\_\_ Yes \_\_\_ No  
If yes, please describe nature or program on your letterhead.
- b. Does the plan include the following risk management elements:
  - Generic or critical indicator screening of medical charts \_\_\_ Yes \_\_\_ No
  - ~~///~~ Incident Reporting \_\_\_ Yes \_\_\_ No
  - ~~///~~ Patient Complaints \_\_\_ Yes \_\_\_ No
  - ~~///~~ Claims Handling \_\_\_ Yes \_\_\_ No
  - ~~///~~ Contract Review \_\_\_ Yes \_\_\_ No
- c. Does the group practice have an arbitration plan? \_\_\_ Yes \_\_\_ No  
If yes, please give details on your letterhead.
- d. Does the group practice have a Peer Review or Claim review Committee? \_\_\_ Yes \_\_\_ No
- e. Who coordinates the risk management program? \_\_\_\_\_
- f. How often is the program reviewed and updated? \_\_\_\_\_
- g. Does the group practice occupy the entire building \_\_\_ Yes \_\_\_ No
- h. Please describe how fee - related complaints are handled: \_\_\_\_\_  
\_\_\_\_\_
- i. Does the group practice provide for continuing education programs? \_\_\_ Yes \_\_\_ No  
**If yes, please describe on your letterhead and indicate how physicians are reimbursed by the clinic.**
- j. Are any research or teaching programs conducted? \_\_\_ Yes \_\_\_ No
- k. Is there a Credentials Committee? \_\_\_ Yes \_\_\_ No

**If no, who does the credentialing of the clinic's physicians?**

1. Does the clinic have written policies and procedures in place for credentialing, recredentialing, and making decisions which adversely affect a physician's credentials?  Yes  No
2. Does the written credentialing procedures follow JCAHO or NCQA standards and comply with any applicable law?  Yes  No
3. Does the clinic query the National Practitioner Data Bank or the Federation of State Medical Boards as part of the the credentialing process?  Yes  No
4. How often does the clinic recredential? \_\_\_\_\_
5. Does the clinic restrict the practice of any physician who has a mental or physical disorder which may impair his/her ability to practice?  Yes  No
1. Are informed consent forms used?  Yes  No

**17. Hazardous Materials:**

- a. Describe how you dispose of contaminated materials, human tissue, nuclear waste or any other hazardous materials:  
 \_\_\_\_\_  
 \_\_\_\_\_
- b. Do you have an EPA Registration Number?  Yes  No  
 If yes, attach the RCRA or Super Fund application forms.
- c. Are oxygen and other gas cylinders used?  Yes  No  
 If yes, where are they stored? \_\_\_\_\_
- d. Does the group practice use radium or other isotopes?  Yes  No  
 If yes, on your letterhead describe safety precautions taken and type and frequency of tests for stray x-ray radiation.
- e. Do floor and ceiling of room in which radium and x-ray are used have lead lining or equivalent protection?  Yes  No

**18. New Physicians**

- a. Are all perspective physicians required to be certified or Board Eligible?  Yes  No  
 If No, explain reasons on your letterhead.

**19. Medical Records Procedures (Check those applicable)**

- |   |   |
|---|---|
| <input type="checkbox"/> Terminal Digit                       | <input type="checkbox"/> Progress Notes Written (signed and dated by Physician) |
| <input type="checkbox"/> Color Coded                          | <input type="checkbox"/> Progress Notes Typed (signed by Dictating Physician)   |
| <input type="checkbox"/> Alphabetic                           | <input type="checkbox"/> Drug Allergies Noted In Patient File                   |
| <input type="checkbox"/> Numerical with Cross Referenced File | <input type="checkbox"/> Medical Records Librarian                              |
| <input type="checkbox"/> Centralized                          | <input type="checkbox"/> Medical Records Supervisor                             |
| <input type="checkbox"/> Fastened in Folder                   | <input type="checkbox"/> Medical Records Committee                              |
| <input type="checkbox"/> Loose Leaf Folder                    | (Indicate how often it convenes and to whom it reports)                         |

- b. Are records reviewed periodically?  Yes  No  
 If Yes, please explain who reviews records and how often.

\_\_\_\_\_

c. How are record keeping deficiencies handled?  
 \_\_\_\_\_

- d. Are all records kept at the Main Group Practice Location?  Yes  No

**20. Pharmacy**

a. If the clinic has a pharmacy, is it owned and operated by the clinic?  Yes  No

If no, please complete the following questions:

Please provide the name of the entity that owns/operates the pharmacy . \_\_\_\_\_

Is this entity required to carry professional liability insurance?  Yes  No

Does the clinic require a certificates of insurance from this entity?  Yes  No

What are the minimum limits of liability that the pharmacy is required to carry? \_\_\_\_\_

Is the clinic named as an additional insured on the pharmacy's policy? \_\_\_\_\_

b. Is the pharmacy supervisor a licensed pharmacist?  Yes  No

c. Does the pharmacy repackage or re-label any products under its own name?  Yes  No

If so, who is/are the manufacturer(s)? \_\_\_\_\_

Does this manufacturer have a history of Product Liability claims?  Yes  No

d. Does the pharmacy require that all manufacturers provide liability information for the products that the insured sells?  Yes  No

e. Is the Pharmacy is compliance with all local, state , and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs?

21. **Accreditation**

a. Are you a member of a national organization?

MGMA \_\_\_\_ AGPA \_\_\_\_ Other \_\_\_\_\_

b. Is the entity certified or accredited by any of the following?

AAAHC \_\_\_\_ ARC\_\_ CAP\_\_ JCAHO\_\_ Other\_\_

22. During the preceding five year period, has any claim or suit been brought against any medical practitioner or this group,  Yes  No

or are you aware of any incident which took place during that period which may lead to a claim or suit?

**If Yes, complete the Claim/Incident Information Summary.**

23. Has any insurance company cancelled, refused to issue or renew your Professional Liability and/or General Liability insurance policy(s)?  Yes  No

If yes, explain

24. Is this group engaged in any medical research?  Yes  No

If yes, please explain in detail

25. Does the medical group practice currently purchase Directors and Officers Liability Insurance?  Yes  No

If yes, please provide the following:

Insurance Company Name \_\_\_\_\_ Policy Period \_\_\_\_\_  
Limits of Liability \_\_\_\_\_ Deductible \_\_\_\_\_  
Past Acts Exclusion Date \_\_\_\_\_ Policy Premium \_\_\_\_\_

26. Does the medical group currently purchase employment practice liability insurance?  Yes  No

If yes, please provide the following:

Insurance Company Name \_\_\_\_\_  
Limits of Liability : \_\_\_\_\_  
Retroactive Date : \_\_\_\_\_

Policy Period \_\_\_\_\_  
Deductible \_\_\_\_\_  
Policy Premium: \_\_\_\_\_

26. Does the group practice have its own website?  Yes  No

If yes, please provide the website address \_\_\_\_\_

26. What are the 10 most common ICD9 and 10 most common corresponding CPCT4 codes used by the group practice?

\_\_\_\_\_  
\_\_\_\_\_

27. Physical Premises

a. If co - tenanted, please provide a list of tenants.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Describe your premises:

<u>AREA (SQ FT.)</u>	<u>AGE</u>	<u>TYPE OF CONSTRUCTION</u>	<u># OF FLOORS</u>	<u>TYPE OF FIRE PROTECTION</u>
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We hereby certify that if Prior Acts Coverage is being requested, we have no knowledge of any professional liability claims which have been asserted against us, or any affiliated professional association, corporation or subsidiary or any occurrence, incident or circumstance likely to result in such a claim on or after the requested initial effective date of the Prior Acts Coverage, except the following (Provide a brief description of each such claim, occurrence, incident or circumstance):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

We declare that the above statements and particulars are true; that we have not suppressed or misstated any facts and do authorize Chubb Executive Risk to conduct any investigation to substantiate this information and/or any aspect of our professional competency.

**Please provide the following information along with other requested information**

- A. Last two audited financial statements and the last interim Financial Statement.  
If the applicant is newly formed, pro forma financial statements and a business plan.
- B. Specimen Copy of the contracts used when entering into agreements with physicians and Healthcare organizations.
- C. Copy of current Professional and General Liability policies.
- D. Copy of the latest Accreditation Report (AAAHC, JCAHO). (If applicable)
- E. Loss History (Supply the following):
  - 1. Seven years recently evaluated including current year. This must be in hard copy from the insurance carrier.
  - 2. Breakdown of total incurred losses (paid and outstanding for indemnity and expenses)
  - 3. Full details of allegations or losses in excess of \$50,000.
- F. Copy of the bylaws.
- G. For Self Insured Programs:
  - 1. Copy of latest Trust financial agreement.
  - 2. Copy of Trust coverage wording.
  - 3. Latest financial statement of trust fund.
  - 4. Latest actuarial review supporting the funding of the Self Insured Retention.
- H. Listing of physicians as well as their:
  - 1. Names
  - 2. Specialties
  - 3. Retroactive Dates
  - 4. Hours worked per week
  - 5. Appropriate categories regarding no surgery, minor surgery or major surgery. \*\*
  - 6. Start Date with the clinic

\*\* (Please reference all categories that apply)

- Category 1: No surgical procedures performed other than incision of boils and superficial abscess, or suturing of skin and superficial fascia, or circumcision.
- Category 2: Assist in surgery on your own patients. Please provide number of procedures.
- Category 3:
  - Closed Fractures - other than fingers and toes
  - D&C performed under local anesthesia
  - Vasectomies
- Category 4: Obstetrical procedures and/or prenatal care beyond the first trimester and not including Cesarean sections.
- Category 5: All other types of surgery and operations performed under general anesthesia.
- Category 6: Administration of anesthesia (other than local).

**Completion of this application DOES NOT obligate the company to bind coverage.**

\_\_\_\_\_  
**Chief Executive Officer Date**  
**Chief of Medical Staff**  
**(Signature Required)**

\_\_\_\_\_  
**Clinic Administrator Date**  
**(Signature Required)**