LEXINGTON INSURANCE COMPANY

100 Summer Street
Boston, MA. 02110-2103

Hospital Professional Liability - Claims-Made
And
Commercial General Liability - Occurrence
Application

This is an application for Professional Liability coverage written on a claims made basis and Commercial General Liability coverage written on an occurrence basis. The claims made coverage is limited generally to liability for claims first made against an Insured while the coverage is in force. Please review the policy carefully and discuss the policy with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

Please include the following:

1. Loss History: (supply the following)

   a. Ten years recently evaluated, including current year and ten years evaluated within past two years.
   b. Breakdown of total incurred losses (paid and outstanding for indemnity and expenses).
   c. Full details of allegation on all losses paid or outstanding in excess of $25,000.

2. Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies.

3. Current audited financial statement.

4. Indicate specialty of each employed physician, surgeon, intern and resident.

5. Copy of medical staff by-laws.

6. AHA survey of hospitals.

7. Risk management and quality improvement plan.

8. Copies of contracts with independent physician's groups.

9. All hold harmless agreements.

10. For self-insured programs:

    1. Copy of trust financial agreement.
    2. Copy of trust coverage wording.
    3. Financial statement of trust fund.
    4. Recent actuarial review supporting the funding of the self-insured retention.
    5. Name of Claims Adjusting Company.

The requested information is mandated before a quotation can be promulgated.

Instructions:

1. Please type or print clearly.
2. Answer **ALL** questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.
3. If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.
4. This form must be completed, dated and signed by a principal of your facility.

I. GENERAL INFORMATION

Producer Name: _____

Address: _____
Street City County State ZIP

Telephone #: (_____)_____

Applicant Name: _____

Business Address: _____
Street City County State ZIP

Mailing Address: _____

Years in Business: _____ Employer Federal Tax ID #: _____ Telephone #: _____

Applicant is (check all that apply):

A.__ Children's Hospital
__ Geriatric Hospital
__ General Hospital
__ Psychiatric Hospital
__ Rehabilitation Hospital
__ Teaching Hospital
__ Women's Hospital
__ Other: (please specify) _____

B. __ Individual
__ Partnership
__ Corporation
__ Joint Venture
__ Government

C. __ Profit
__ Non-profit
__ Charitable

D. __ Accredited by JCAHO
__ Licensed by State
__ Accredited by AOA
__ Medicare Approved
__ Member of AHA
__ Accredited by CARF

E. Hospital Professional Liability

Requested effective date: _____ Retroactive date: _____

F. General Liability

Requested effective date: _____

G. Current Form of Insurance:

Professional Liability __ Occurrence __ Claims-made
General Liability __ Occurrence __ Claims-made

H. Hospital Professional and General Liability

HPL Limit: _____ per claim _____ aggregate
GL Limit: _____ per claim _____ aggregate

I. General Liability Deductible

__ None __ $5,000 __ $25,000
__ $2,500 __ $10,000 __ Other _____

J. Professional Liability Deductible

__ None __ $5,000 __ $25,000
__ $2,500 __ $10,000 __ Other _____

Self-Insured Retention (if applicable):

1. To what line of coverage will a self-insured retention apply? _____
2. What limit of liability for the self-insured retention?
   _____ per claim _____ aggregate
3. Are loss adjustment expenses part of or outside the SIR limit?
4. Is there a dedicated trust? _____Yes _____No
   What financial institution manages the trust? _____
   _____
5. What organization handles claims for the SIR? _____
   _____
6. Has an independent actuarial review been completed? _____Yes _____ No

K. Prior Insurance History

Most recent five (5) Years: (separate Primary General Liability, Professional and Excess/Umbrella, if applicable).

Policy Period	Carrier	Limits	Coverage	Premium

II. FACILITIES AND SERVICES (check all that apply)

_____ Abortion Clinic
_____ Ambulance
_____ Blood bank
_____ Burn Unit
_____ CCU
_____ Coronary Rescue
_____ Day Care
_____ Dialysis
_____ Dietary
_____ Emergency
_____ Gift Shop
_____ ICU
_____ Inhalation Therapy
_____ Long-Term Care
_____ Morgue
_____ Nursery
_____ Obstetrical
_____ Open Heart
_____ Operating Rooms
_____ Pathology
_____ Pharmacy
_____ Physical Therapy
_____ Radiation Therapy
_____ Radiology
_____ Restaurant
_____ Self-Care
_____ Shock Trauma
_____ X-Ray

Does the institution engage in any of the following:

_____ Formal clinical research under the auspices of an institutional review board.
_____ Administration of non-FDA approved pharmaceuticals (experimental drugs).
_____ Biomedical device research and development.
_____ Animal research.
_____ Medical and/or surgical experimentation that is not approved by an institutional review board.

Please provide details if any of the above apply:_____
_____
_____

A. **Professional Employees**: (indicate total number of employees in each category)

Position	**Full-Time**	**Total Full-Time Equivalents**
Employed physicians	_____	_____
Employed surgeons	_____	_____
Interns	_____	_____
Residents	_____	_____
Dentists	_____	_____
Podiatrists	_____	_____
Physician assistants	_____	_____
Registered nurses	_____	_____
LPNs	_____	_____
Student nurses	_____	_____
X-Ray technicians	_____	_____
Lab technicians	_____	_____
Pharmacies	_____	_____
Profusionists	_____	_____
Paramedics	_____	_____
CRNAs	_____	_____
Other employees	_____	_____
Volunteers	_____	_____

On a separate sheet, please indicate the specialty of each employed Physician, Surgeon, Intern and Resident.

B. Professional Liability Exposures

1. Hospital beds:	# of Licensed Beds	Average # of Occupied Beds
a. Acute care	_____	_____
b. Cribs and bassinets	_____	_____
c. Mental health (psychiatric)	_____	_____
d. Chemical dependency	_____	_____
e. Other rehabilitation	_____	_____
f. Ailing home beds	_____	_____
g. Hospice	_____	_____
h. Other (please specify)_____	_____	_____
TOTAL:	_____	_____

2. Inpatient Surgeries	# of Procedures (previous 12 months)	# of Outpatient Visits (projected next 12 months)
	_____	_____

3. Outpatient Visits

a.	Births	_____	_____
b.	Emergency room	_____	_____
c.	Health Institutional (clinical) visits	_____	_____
d.	Outpatient surgery	_____	_____
e.	Chemical dependency	_____	_____
f.	Rehabilitation/Therapy	_____	_____
g.	Mental health (psychiatric)	_____	_____
h.	Home health	_____	_____
i.	Other (please specify) _____	_____	_____
	TOTAL:	_____	_____

j. If hospital owns or operates a blood bank:

i. Number of volunteer donations _____
ii. Number of paid donations _____
iii. Number of pheresis procedures _____
iv. Number of outpatient transfusions _____
v. Number of therapeutic plasma exchanges _____

Is coverage desired for blood bank operations? Yes No
If "yes", please attach testing procedures.

If hospital does not own or operate a blood bank, from where is the blood or blood product obtained?

_____
_____
_____

4. Criteria for qualifications of employed physicians and surgeons:

a. Is history of previous employment verified? Yes No

b. Are references checked? Yes No

c. Has the license of any employed physician or surgeon ever been restricted or suspended? Yes No

If yes, please provide details: _____
_____

d. Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff? Yes No

If yes, please explain: _____
_____

e. How many employed physicians are board certified or board eligible? _____

f. Do employed physicians, employed surgeons, interns and residents carry own insurance? Yes No

g. Are employees to be included as additional insureds? Yes No

5. Staff Privileges of Private Practitioners:

a. Are credentials of doctors approved by the medical staff and/or hospital review board before privileges are granted? Yes No

b. Is there a probationary period of at least six months for all staff doctors? Yes No

c. Are staff doctors' performances periodically reviewed by medical staff and/or hospital review board? Yes No

d. Do hospital by-laws require staff doctors to carry medical malpractice insurance? Yes No

If yes, what are limits required? _____ per claim _____ aggregate

e. Are all privileges granted to staff doctors detailed in writing? Yes No

f. Has the license of any staff physician ever been restricted or suspended? Yes No

If yes, please provide details: _____

_____

6. Anesthesiology

a. Is anesthesiology department staffed by:

__ Employed Physicians __ Contract Group __ Employed CRNAs __ Staff Physicians

b. If under contract, name of group: _____

If contract group, are certificates of insurance required? Yes No

If yes, what are limits required? _____ per claim _____ aggregate

c. Are all anesthesiologists required to be board certified or eligible in Anesthesiology? Yes No

d. Is the anesthesia care performed by CRNAs supervised and reviewed by the anesthesiologists? Yes No

If no, please explain: _____

_____

e. Do any of the anesthesia services staff routinely work more than a 12-hour duty shift? Yes No

If yes, please explain: _____

_____

7. Radiology

a. Is radiology department staffed by:

__ Employed Physicians __ Contract Group __ Staff Physicians

b. If under contract, name of group: _____

If contract group, are certificates of insurance required? Yes No

If yes, what are limits required? _____ per claim _____ aggregate

c. Are all radiologists to be Board Certified or eligible in Radiology and/or Nuclear Medicine? Yes No

8. Emergency Department

a. How is emergency department classified according to JCAHO standards:

__ N/A __ Level I (tertiary) __ Level II (comprehensive) __ Level III (basic)
__ Other _____

b. Is emergency department staffed by:

__ Employed Physicians __ Contract Group __ Rotating Staff

c. If under contract, name of group: _____

If contract group, are certificates of insurance required? Yes No

If yes, what are limits required? _____ per claim _____ aggregate

d. Are all physicians board certified or eligible in emergency medicine? Yes No

Are the emergency physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution? Yes No

e. Is the emergency room equipped with the following:

Emergency resuscitation care equipped with defibrillator?	Yes	No
Electrocardiograph machine	Yes	No
Staffed radiology room(s)	Yes	No
Dedicated triage area and staff	Yes	No
Dedicated trauma room(s)	Yes	No
Dedicated laboratory personnel	Yes	No

f. Do any of the emergency department staff routinely work more than a 12-hour duty shift? Yes No
If yes, please explain: _____

_____

9. Obstetrics

a. Is the facility a regional referral center for high risk pregnancies or newborns requiring intensive care? Yes No

If no, does a written procedure exist for transferring all high-risk mothers and/or babies which the hospital is not qualified to treat? Yes No

b. Do you have the following nurseries:

__ Level I: Well baby Number of bassinets _____
__ Level II: Intermediate care Number of bassinets _____
__ Level III: Neonatal intensive care Number of bassinets _____

c. Is "Rooming -In" offered? Yes No

d. How many births at your facility (previous 12 months)? _____

e. How many cesarean sections (previous 12 months)? _____

f. How many vaginal births after C-section (VBACs) (previous 12 months)? _____

g. Is continuous electronic fetal monitoring performed on all patients in active labor? Yes No

If no, please explain: _____

_____

h. Do nurse midwives practice at your hospital? Yes No

10. Surgery

a. How many surgical procedures were performed in the last year by:

Employed physicians _____ Outside Surgeons _____ Interns _____ Residents _____

b. Are sponge, needle and instrument counts performed in the course of a surgical procedure? Yes No

If yes, at what intervals of the operation? _____

c. Are any of the following performed at your facility?

Neurosurgery Yes No
Experimental surgery Yes No
Sex change operations Yes No
Weight reduction surgery Yes No
Laser assisted surgery Yes No

d. Are "scope" surgical procedures routinely videotaped? Yes No

11. Pharmacy

a. Does the facility utilize the unit dose system of dispensing medicine? Yes No

b. Is the pharmacy for patient use only? Yes No

If no, annual receipts for non-patients medications are $_____.

c. Is the pharmacy staffed by a contract group? Yes No

If yes, please explain: _____

_____

C. Commercial General Liability Exposure

1. Location	Area	Age	Type of Constr.	# of Floors	Type of Fire Protection
Patient Care Buildings					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Other Buildings					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Parking Lots					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Vacant Lots					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Fire Protection Key AS = Approved sprinkler H = Heat detector
S = Smoke detector A = Automatic alarm

2. Incidental exposures

a. Has the hospital planned any new construction and/or abatement for this year? Yes No

If yes, please provide details: _____

_____

b. Are there elevators or escalators on any premises owned, leased or occupied by the insured? Yes No

If so, how many? _____

c. Does the hospital have a heliport? Yes No

d. Does the hospital have an ambulance or other emergency use vehicles? Yes No

e. List the number and type of owned or leased vehicles: _____

_____

f. List all owned, leased and non-owned watercraft: _____

_____

g. List all owned, leased or chartered aircraft: _____

_____

6. Hold Harmless and Indemnification Agreements

a. Has the hospital agreed to hold harmless or indemnify others under contract? Yes No

b. Does the hospital rent or lease any equipment from others? Yes No

If a. or b. is yes, please explain: _____

_____

7. Risk Management

a. Who coordinates your risk management program?

Name: _____ Title: _____

Telephone: ( ) _____

b. Is there a written, risk management program that has been approved by a governing body? Yes No

c. Does the governing body review the effectiveness of the program and approve necessary changes? Yes No

d. Is the risk manager accountable and solely responsible for risk management? Yes No

If no, explain other responsibilities: _____

_____

e. Does the risk management program include the following:

Occurrence reporting	Yes	No
Claim management	Yes	No
Formal link to quality management	Yes	No
Safety program and safety committee	Yes	No
Review and participation in medical staff committees	Yes	No
Contract review and evaluation	Yes	No

The information requested is mandatory before a quotation can be promulgated.

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED. COMPLETION OF THIS FORM DOES

NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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."

NOTICE TO LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE

INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "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, CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY" (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: "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."

NOTICE TO VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

Signature of Applicant: _____

Time: _____

Date: _____

Signature of Producer: _____

License #: _____

Date: _____