



Hospitals & Hospital Systems APPLICATION

For Claims Made Professional Liability
Insurance and Prior Acts Coverage

 **NORCAL**
Mutual Insurance Company

COVERAGE HIGHLIGHTS

Feature	Benefit
Physicians Administrative Defense Reimbursement Coverage	Provides defense cost reimbursement and practice interruption expense reimbursement for administrative proceedings and employment-related civil actions
Optional Health Care General Liability Insurance (additional charge applies)	Provides coverage for bodily injury, property damage, fire damage, personal injury, advertising injury and medical payments
Administration of Your Employee Benefits Program Insurance	Provides coverage for benefits errors in the administration of your employee benefits program
Prior Acts/Nose Coverage (Over Current Retroactive Date)	Conveniently provides coverage from one insurer
Right to Consent to Settle	Places the Insured in control of whether to settle a claim

The following benefits are provided in addition to the Limits of Liability of the policy:

- Defense Costs
- Attendance at Trial: *\$500 maximum per half day per Insured*
- Pre-judgment and Post-judgment Interest on that part of any judgement we pay
- Damage to Patient's Property: \$2,500 per patient/\$25,000 per policy period

Additional Highlights

Aggressive Claims Handling	Represents the Insured's interests and helps protect the Insured's reputation
On-Site Clinical and Administrative Assessment	Helps the hospital to identify risks and evaluate and improve its practice systems
Award-winning CME Material	Assists the hospital in enhancing patient safety and improving communication
Monthly <i>Claims Rx</i> Newsletter	Helps the hospital stay on top of current administrative and clinical issues
Risk Management 24/7 Phone Consultations	Offers peace of mind and allows an Insured to call NORCAL 24/7 for Risk Management advice

The above information is intended only to highlight the NORCAL policy features and benefits. The conditions of coverage are specifically explained in the NORCAL policy. Please read the policy for complete coverage information.

If you have questions regarding this application or would like a copy of the NORCAL policy, please contact your broker or NORCAL's Policyholder Services Unit at (877) 443-7232.

IMPORTANT INFORMATION

The coverage of any policy, if issued, is limited to the liability of the Named Insured and any Insured. Coverage for an Insured is provided only while he or she is acting within the course and scope of his or her duties for the Named Insured.

The coverage of any policy, if issued, is limited generally to liability only for those claims that are first made against an Insured and reported to NORCAL while the policy is in force. The coverage provided under the optional Health Care General Liability Insurance, if purchased, is limited to bodily injury, property damage, fire damage, personal injury or advertising injury that occurred during the policy period.

Please review the policy carefully and discuss the coverage with your lawyer, risk management consultant, insurance advisor, agent or broker. Please note that no coverage exists until written verification of coverage by NORCAL Mutual Insurance Company is issued in the hospital's name.

The application asks that you provide information regarding affiliations, practice associations, etc. This information is requested to provide us with an understanding of the hospital's exposure but does not mean that a policy, if issued, would cover such entities and persons.

APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- If you wish to explain any of your answers, please use the Remarks section on page 19. If you need more space, please attach additional pages.
- Please ensure that you sign and date the application on page 20 for California and Rhode Island applicants or page 21 for Alaska applicants.
- In addition to a completed application, please provide the following items:
 - A current audited financial statement.
 - Copies of the medical staff bylaws, medical staff rules and regulations, credentialing policy and appointment and reappointment forms.
 - Most recent JCAHO or AOA report and state licensure report with recommendations and the response to any contingencies.
 - Loss runs for the previous ten years. The loss runs must include paid and reserved amounts and be less than 90 days old.
 - A copy of the Declarations Page and any endorsements from the hospital's most recent insurance policy, if applicable.
 - The following items if the hospital has a self-insured trust fund:
 - A copy of the trust agreement.
 - Current balance of the trust fund.
 - A copy of the recent actuarial study supporting the funding of the trust fund.
- If the hospital engages in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, the hospital is considered a *Covered Entity* under HIPAA and thus required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at www.norcalmutual.com.
- Please make a copy of the completed application and supporting documentation for your records.

SECTION I IDENTIFYING INFORMATION

Applicant's Legal Name					Tax ID Number	
Primary Address	City	County	State	Zip Code	Telephone # () -	Fax # () -
Mailing Address (Location where all mailings except invoices will be sent)		City	State	Zip Code	Telephone # () -	Fax # () -
Billing Address (Location where invoices will be sent)		City	State	Zip Code	Telephone # () -	Fax # () -

Authorized Representative

The Authorized Representative is the person responsible for providing consent decisions on behalf of the Named Insured and the person who will act on behalf of the Named Insured or other Insureds for all other purposes relating to the policy. One person may be designated for both purposes or a separate person may be designated for each purpose.

Please provide the name and title of the person authorized for providing consent decisions on behalf of the Named Insured:

Name: _____ Title: _____

E-Mail Address: _____ Telephone Number: _____

Please provide the name and title of the person authorized to act on behalf of the Named Insured and all other Insureds for all other (non-consent) purposes relating to the policy.

Name: _____ Title: _____

E-Mail Address: _____ Telephone Number: _____

SECTION II COVERAGE/INSURANCE INFORMATION

Requested Effective Date (the date you wish coverage to begin)

_____ 12:01 a.m. Local Time
Month Day Year

NOTE: NORCAL should receive the application at least thirty days before the Requested Effective Date.

Prior Acts Coverage (check one)

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and 2) arose out of acts or omissions occurring on or after the Retroactive Date and before the termination or Expiration Date of that policy. The Retroactive Date is the earliest date on which a medical incident or occurrence may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current carrier, if applicable. This coverage does not apply to the optional Health Care General Liability Insurance. **NORCAL does not automatically provide Prior Acts Coverage.**

- The hospital wishes to apply for Prior Acts Coverage. Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Tail Coverage from your current carrier. (Please identify the Requested Retroactive Date below):
- The hospital does not wish to apply for Prior Acts Coverage. It is understood that if the hospital does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the Effective Date of the NORCAL policy, if issued.

Requested Retroactive Date

_____ 12:01 a.m. Local Time
Month Day Year

NOTE: The Retroactive Date, if specified, must be the same as the Retroactive Date of your current policy.

Health Care General Liability Insurance – Occurrence

Health Care General Liability Insurance is an optional, occurrence-based coverage. Additional premium will be charged if this coverage is approved. NORCAL does not automatically provide Health Care General Liability Insurance coverage.

Does the hospital wish to apply for Health Care General Liability Insurance coverage? Yes No

If yes, please contact NORCAL or your broker for an application in order to apply for such coverage.

Requested Limits of Liability

Please indicate the desired limits of liability:

\$ _____ each claim/\$ _____ annual aggregate

Deductible

Does the hospital wish to have a deductible on the policy? Yes No

If yes, please complete the following:

NOTE: Deductibles apply to both Professional Liability Insurance and Health Care General Liability Insurance, if applicable.

Type: Indemnity only Indemnity and Expense

Per Claim Amount:

\$10,000 \$50,000 \$100,000 \$150,000 \$200,000
 \$25,000 \$75,000 \$125,000 \$175,000 \$250,000

Annual Aggregate: Yes No If yes, Annual Aggregate Amount: \$ _____

Insurance History

1. Has any professional liability insurance company ever canceled, nonrenewed, modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) the hospital's insurance, declined to offer the hospital coverage or notified the hospital of its intent to pursue such action? Yes No

If yes, please provide a detailed, written narrative in the Remarks section on page 19 and copies of all pertinent documentation (e.g., a copy of the nonrenewal or declination notice). At a minimum, the narrative must include the name of the insurance company, the date(s) of the action(s) and a detailed description of the reason(s) for the action(s).

2. Please complete the following regarding all Professional Liability Insurance maintained by the hospital during the past ten years, beginning with the most current. Please photocopy this page if additional space is needed.

Name of Insurer	Coverage Dates (Month/Day/Year)	Deductible or Self-insured Retention	Policy Type	If Claims Made, Check One
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____

3. If any one of the insurance coverages identified above was Claims Made Coverage, and the hospital did not purchase Tail Coverage or Prior Acts Coverage, please explain in the Remarks section on page 19.

9. Within the past ten years has there been a change in the above information (i.e., entities dissolved, legal associations ended, etc.)?
 Yes No

If yes, please explain and identify the appropriate dates of the affiliation, etc.:

SECTION IV LOCATIONS

1. Please identify all locations owned or operated by the hospital, even if NORCAL insurance is not desired for the location. Please photocopy this page if additional space is needed.

Location (Name and Address)	Type of Location (e.g., Hospital or Surgery Center)	Accreditation	Is NORCAL Coverage Desired for the Services Rendered at This Location?*
		<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> JCAHO <input type="checkbox"/> AAAHC/AAAASF <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

* If NORCAL coverage is not desired for the services rendered at any location, please explain in the Remarks section on page 19.

2. Within the past ten years, has the hospital owned or operated any location other than a location identified in question 1?
 Yes No

If yes, please complete the following:

Name of Location	Address (City and State)	Type of Location (e.g., outpatient office)	From (Month/Year)	To (Month/Year)

SECTION V EMPLOYEES AND INDEPENDENT CONTRACTORS

1. Please indicate the number of individuals in the following categories who are employed by or working under the control of the hospital or its employees:

Designation	Number	Designation	Number
Certified Nurse Midwife	_____	Physician and Surgeon	_____
Certified Registered Nurse Anesthetist	_____	(other than hospitalist, intern and resident)	_____
Chiropractor	_____	Physician and Surgeon – Hospitalist	_____
Dentist	_____	Physician and Surgeon – Intern	_____
Dietician	_____	Physician and Surgeon – Resident	_____
Emergency Medical Technician	_____	Podiatrist	_____
Laboratory or X-ray Technician	_____	Psychologist	_____
Licensed Practical/Vocational Nurse	_____	Registered Nurse	_____
Nurse Practitioner	_____	Registered Nurse First Assistant	_____
Optometrist	_____	Respiratory Therapist	_____
Paramedic	_____	Social Worker	_____
Pharmacist	_____	Speech Therapist	_____
Physical Therapist	_____	Other (specify): _____	_____
Physician Assistant	_____	Other (specify): _____	_____

2. Does the hospital lease personnel from others (e.g., temporary employment agencies) to provide professional health care services?
 Yes No

If **yes**, please provide a copy of the contract(s).

3. Are all independent contractors (including physician and health care extender (e.g., PAs, NPs) staff members) required to:
- Maintain Professional Liability Insurance with limits of liability of at least \$1 million per claim/\$3 million annual aggregate?
 Yes No
 - Provide the hospital with proof of Professional Liability Insurance at least annually? Yes No

If you answered no to question 3a or 3b, please explain:

4. Are the items identified in questions 3a and 3b stated in the hospital's bylaws? Yes No

Staff Privileges

1. Please identify the number of staff physicians in each of the following categories:

Active: _____ Consulting: _____ Emeritus: _____ Associate: _____ Courtesy: _____ Provisional: _____

Other (specify): _____

2. Do any staff members have restricted licenses or privileges? Yes No

If yes, please explain:

Work Outside of Hospital Employment

1. Does the hospital permit its employees to render services unrelated to the hospital's practice? Yes No

NOTE: The NORCAL policy provides coverage to an Insured only while he or she is acting within the course and scope of his or her duties for the Named Insured.

If yes:

a. Is the employee required to obtain separate insurance to cover the outside exposure? Yes No

b. Is the employee required to notify the hospital of any such outside exposures? Yes No

If you answered no to 1a and/or 1b, please explain:

SECTION VI SERVICES, PROCEDURES AND OCCUPANCY

1. Please check all that apply regarding the available services. If there are multiple locations, please photocopy the page, complete one for each location and identify the location at the top.

- | | | |
|--|---|---|
| <input type="checkbox"/> Addiction Medicine | <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Organ Transplants |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Outpatient Surgery Center |
| <input type="checkbox"/> Audiology | <input type="checkbox"/> Infusion Therapy | <input type="checkbox"/> Organ Bank (Marrow Donor) |
| <input type="checkbox"/> Cancer-Oncology | <input type="checkbox"/> Intensive Care | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Intensive Care – Neonatal | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Blood Bank | <input type="checkbox"/> Internal Medicine | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Burn Unit | <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Pulmonary Medicine |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Long-term Care | <input type="checkbox"/> Rehabilitation and Physical Medicine |
| <input type="checkbox"/> Dentistry | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Respiratory Care |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Mental Health – Adolescent/Child | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Short Stay-Recovery-Infirmar |
| <input type="checkbox"/> Diagnostic Imaging | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Sleep Medicine |
| <input type="checkbox"/> Diagnostic Tests | <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Surgery – Bariatric |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Surgery – Other than Bariatric |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Occupational Health | <input type="checkbox"/> Trauma Center |
| <input type="checkbox"/> Endocrinology | <input type="checkbox"/> Ophthalmology-Optometry | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Endoscopy | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Vascular Medicine |
| <input type="checkbox"/> Family/General Practice | <input type="checkbox"/> Pain Management | |
| <input type="checkbox"/> Mobile Unit (please specify): _____ | | |
| <input type="checkbox"/> Other (please specify): _____ | | |

Contracted Services

1. Does the hospital contract with health care providers/groups to provide medical services (e.g., ambulance services, anesthesia, emergency services and radiology services)? Yes No

If yes:

a. Please provide copies of the contracts and identify the medical services that are contracted:

b. Are the health care providers credentialed by the hospital in the same manner as staff physicians? Yes No

2. Does the hospital contract with entities/individuals to provide ancillary services (e.g., housekeeping)? Yes No

If yes, has the hospital signed any contract or agreement in which it has agreed to indemnify or hold harmless any one of these entities/individuals for liability? Yes No

If yes, please submit a copy of each such contract or agreement.

Occupancy and Procedures

1. Please complete the following table regarding the hospital's occupancy and visits for the indicated years:

	Current Year Estimated Average Annual	Next Year Projected	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year
Beds:						
Total Beds (regardless of occupancy)						
Occupied Beds:						
Total Beds						
Acute Care Beds						
Cribs						
Bassinets						
Extended Care Beds						
Skilled Nursing Beds						
Psychiatric Care Beds (including detoxification beds)						
Chemical Dependency Beds (excluding detoxification beds)						
Rehabilitation Beds						
Other: _____						
Other: _____						
Outpatient Visits:						
Emergency Room Visits						
Other Outpatient Visits (per patient per registration day)						
Counseling Visits						
Home Health Care Visits						
Procedures/Tests Performed:						
Inpatient Surgeries						
Outpatient Surgeries						
Deliveries (excluding cesarean sections)						
Cesarean Sections						
VBACs						
Reference Laboratory Tests						

Anesthesia Services

1. Is an in-house anesthesiologist available 24 hours a day? Yes No

If no, please explain:

2. Do CRNAs administer anesthesia in the hospital? Yes No

If yes, who supervises the CRNAs (please check all that apply)?

Anesthesiologist Other Physician/Surgeon

Neither/Other (please explain): _____

Emergency Department

1. Please identify the levels of care of the emergency department (as defined by the JCAHO). Please check all that apply:

Level I (Tertiary) Level II (Comprehensive) Level III (Basic) Level IV (Standby) Trauma Center

2. Does the emergency department have transfer agreements with other hospitals for those patients that the department is not able to treat in-house? Yes No

If yes, please identify the hospitals:

If no, please explain:

3. Do other hospitals transfer patients to your emergency department? Yes No

If yes, please identify the hospitals, the type(s) of patients transferred and how often this occurs:

4. Is the emergency department's medical director board certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine? Yes No

5. Is a qualified emergency medicine physician present in the emergency department 24 hours a day, seven days a week?
 Yes No

6. Are all physicians who staff the emergency department (including the medical director) subject to the hospital's customary credentialing process and members of the hospital medical staff with clinical privileges in emergency medicine? Yes No

If you answered no to question 4, 5 or 6, please explain:

7. Please identify the minimum qualifications for the following emergency department personnel:

a. Physicians: _____

b. Nurses: _____

8. Please identify if the following are available in the facility and immediately available for a patient at all times:

Adult and pediatric crash cart Yes No

Anesthetics Yes No

Basic airway equipment (i.e., laryngoscope, endotracheal tubes, etc.) Yes No

Blood (at least "O" negative) Yes No

Central vein catheters and cardiac drugs Yes No

Defibrillator Yes No

Electrocardiograph machine Yes No

Intravenous fluid Yes No

Pulse oximetry Yes No

Supplemental oxygen Yes No

X-ray machine capable of accommodating an unconscious person in any position Yes No

If you answered no to any of the above, please explain:

Obstetrical Services

1. Is there a separate birthing center? Yes No

If yes, is it physically separate from the hospital? Yes No

If it is physically separate from the hospital, how far is it from the hospital (in miles)? _____

2. Please identify the number of:

Labor rooms: _____ Delivery/Operating rooms: _____

3. Describe the hospital's procedures for tagging and pairing infants with their mothers:

4. Is the delivery/operating room separate from the surgical suite? Yes No

5. Is fetal monitoring performed on all patients in active labor? Yes No

6. Is the attending physician required to approve the use of oxytocic drugs during labor? Yes No

7. Is a physician required to be in-house when oxytocic drugs are used? Yes No

8. Can cesarean section be performed within 30 minutes at all times? Yes No

If you answered no to question 4, 5, 6, 7 or 8, please explain:

9. Is there a written procedure regarding the transfer of high risk mothers and/or babies whom the hospital is not qualified to treat?
 Yes No

If yes, please describe and identify the location(s) to where the mothers and/or babies are transferred or attach a copy of the policy:

If no, please explain:

10. Are the following available in-house for the obstetrical suite 24 hours a day?

Obstetrician Yes No Anesthesiologist or CRNA Yes No

If you answered no to either, what is the maximum time of arrival for the individual(s)?

11. Are VBACs performed in the facility? Yes No

If yes:

a. Is a physician who has hospital privileges to perform cesarean section in-house when a VBAC patient is in active labor?
 Yes No

b. Is an anesthesia provider in-house when a VBAC patient is in active labor? Yes No

If you answered no to question 11a or 11b, please explain:

12. Are family practitioners or nurse midwives permitted to perform the following?

a. Obstetrical services Yes No

b. VBACs or cesarean sections Yes No

If you answered yes to question 12a or 12b, please describe the protocol(s) or attach a copy of the applicable policy:

Radiology Services

1. Is the radiology department's medical director board certified by the American Board of Radiology or the American Osteopathic Board of Radiology? Yes No

2. Please identify the annual number of X-ray exposures for:

Diagnosis: _____ Treatment: _____

3. If X-ray treatment is provided, what are the minimum qualifications required of the staff?

4. Are radium or other isotopes used? Yes No

If **yes**, please describe the safety precautions taken when they are used, or attach a copy of the applicable policy:

Telemedicine

Telemedicine is defined as “the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine.”

1. Is the hospital involved in telemedicine services with a site not located within the hospital? Yes No

If **yes**:

- a. Please explain:

- b. Do the telemedicine services involve any state other than the state in which the hospital is located, or a country other than the United States? Yes No

If **yes**, please explain:

- c. Does the hospital fully credential and privilege the telemedicine providers in the same manner that it credentials physician and health care extender staff members? Yes No

If **no**, please explain:

2. Does the hospital utilize teleradiologists? Yes No

If **yes**, does a hospital radiologist overread the studies performed by the teleradiologist? Yes No

If a hospital radiologist overreads the studies:

- a. How long after the initial read does the overread take place? _____
- b. Please explain how the hospital handles discrepancies between the teleradiologist and the overreading radiologist and how the discrepancies are communicated to the emergency room physician, surgeon, etc.

Teaching/Residency/Training Programs

1. Is the hospital involved with any teaching programs? Yes No

If yes, please provide any applicable information regarding the program and describe the program in the Remarks section on page 19.

2. Is the hospital involved with any residency program? Yes No

If yes:

- a. Please provide copies of any contract(s) or agreement(s), describe the program and identify any other parties involved in the program in the Remarks section on page 19.
- b. Please identify the number of residents in each medical specialty:

Medical Specialty	Number	Medical Specialty	Number
Anesthesiology	_____	Orthopedic Surgery	_____
Cardiology	_____	Otolaryngology	_____
Dermatology	_____	Pathology	_____
Family/General Practice	_____	Pediatrics	_____
General Surgery	_____	Plastic Surgery	_____
Internal Medicine	_____	Radiology	_____
Neurology	_____	Other (specify): _____	_____
Neurosurgery	_____	Other (specify): _____	_____
Obstetrics and Gynecology	_____	Other (specify): _____	_____
Ophthalmology	_____	Other (specify): _____	_____

3. Is the hospital involved in any other training programs? Yes No

If yes, please provide the following on a separate sheet of paper:

- The profession(s) for which the training program applies
- Maximum number of students in the program at one time
- Length of the program
- Number of sessions per year
- Number of faculty involved in the program
- Qualifications of the faculty (e.g., MD)

SECTION VII MISCELLANEOUS

1. Within the next 12 months are there any changes planned for the hospital (e.g., changes in its legal structure, locations, type of services provided)? Yes No

If yes, please explain and identify the anticipated date(s) of the change(s):

2. Does the hospital comply with all federal, state and local laws and regulations regarding the disposal of hazardous waste material? Yes No

If no, please explain:

3. Does the hospital participate in any clinical studies? Yes No

If yes, please explain and indicate whether the hospital has an institutional review board (IRB):

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

If yes:

- a. Please provide a description of the equipment:

- b. Has the hospital signed any contract or agreement in which it has agreed to indemnify or hold harmless the owner of the equipment for liability? Yes No

If yes, please submit a copy of each such contract or agreement.

5. Does the hospital have a website? Yes No

If yes, what is the website address (if more than one, please identify each): _____

SECTION VIII RISK MANAGEMENT

1. Does the hospital have a formal risk management program? Yes No

- a. **If yes,** who (name and title) is responsible for the risk management program and what other job responsibilities does this person have?

- b. If the hospital does not have a formal risk management program, please explain:

Credentialing

1. Does the hospital have a formal process to credential its health care providers? Yes No

a. **If yes**, please identify who performs the initial credentialing:

b. **If no**, please explain:

2. Does the hospital perform background investigations of health care providers regarding the following?

Claim History	<input type="checkbox"/> Yes <input type="checkbox"/> No	National Practitioner Data Bank History	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Privileges	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical and Narcotics Licenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employment History	<input type="checkbox"/> Yes <input type="checkbox"/> No	Felony/Misdemeanor History	<input type="checkbox"/> Yes <input type="checkbox"/> No
Education History	<input type="checkbox"/> Yes <input type="checkbox"/> No	American Medical Association Master File	<input type="checkbox"/> Yes <input type="checkbox"/> No
Board Certification	<input type="checkbox"/> Yes <input type="checkbox"/> No		

a. **If yes**, please identify who is responsible and what sources are used to verify this information:

b. If you answered no to any one of the above, please explain:

3. Are staff members required to maintain provisional privileges for at least six months before being granted active or courtesy privileges? Yes No

If no, please explain:

4. Are all foreign school graduates required to be certified by the Educational Council for Foreign Medical School Graduates? Yes No

5. How often are the health care providers recertified and what does the recertification process involve?

Quality Assurance

1. Does the hospital have a formal process to evaluate and address concerns of unexpected patient outcomes? Yes No

2. Does the hospital have a formal process to evaluate patient complaints? Yes No

3. Does the hospital conduct patient satisfaction surveys? Yes No

If yes, how often: _____

4. Does the hospital have any current quality improvement initiatives in place? Yes No

If yes, please list and describe:

Utilization Review

1. Does the hospital have its own utilization review committee? Yes No

If yes:

a. Does the hospital have written policies and procedures for appeals of denied procedures? Yes No

b. Who performs the utilization reviews? _____

c. Are claim denial procedures explained in writing to patients? Yes No

d. Does a physician review all proposed denials of benefits? Yes No

e. Is there a fast track appeal system for denied procedures that may severely impair the quality of life for a patient if not performed? Yes No

Medical Records

1. Who is responsible for medical records issues in the organization? _____

2. Does the hospital currently use electronic medical records? Yes No

If yes:

a. Who is the vendor? _____

b. How often are the electronic files backed up? _____

c. Who backs up the files? _____

d. Are the backed-up files stored at an off-site location? Yes No

If you answered no to question 2d, please explain:

e. Do all locations use electronic medical records? Yes No

f. Are all systems (e.g., inpatient, outpatient, billing and scheduling) electronic? Yes No

If you answered no to question 2f, how are the different systems coordinated?

3. If the hospital does not use electronic medical records, or uses them but not at all locations, how are records made available to health care providers who are not at the location where the medical record is stored?

4. How are record-keeping deficiencies handled?

SECTION IX SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (e.g., medical board documents, letters from a hospital, diversion program and/or treating physician, etc.).

1. Has any governmental agency **ever** investigated the hospital, placed it on probation, suspended or taken any action against it? Yes No
2. Has the hospital **ever** been denied accreditation, certification and/or licensure or has its accreditation, certification and/or licensure **ever** been suspended or revoked? Yes No
3. Has any individual who works on the hospital's behalf **ever** been accused of sexual misconduct? Yes No
4. Do you know if any individual who works on the hospital's behalf has a prior history or propensity for sexual misconduct? Yes No

SECTION X CLAIMS HISTORY

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the hospital or any of its employees, or has the hospital or any of its employees been notified of its involvement in a malpractice claim or suit, either directly or indirectly? Yes No

If yes, please complete a Claim Information Form on page 22 for the following:

- Each claim or suit in which a \$100,000 or more indemnity payment was made on behalf of the hospital or any one of its members
- Each claim or suit that remains "open" with a \$100,000 or more indemnity reserve

2. Is the hospital or any of its employees aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against the hospital or employee, directly or indirectly, even if you believe the claim or suit would be without merit? Yes No

If yes, has each such incident, accident, conduct, circumstance or occurrence been reported to the hospital's current or to a previous professional liability insurance company? Yes No

If it has not been reported to the current or a previous insurer, please explain:

FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY

Warranties and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on the hospital's behalf is incorporated into and made a part of any policy of insurance that may be issued to the hospital by NORCAL ("the Company").

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between the hospital and NORCAL, the dispute will be submitted to binding arbitration.

I understand that the policy, if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that in the event the coverage is canceled, any unearned premiums will be refunded to the person or organization that paid NORCAL (i.e., the payer).

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on the hospital's behalf, including changes in its partners or associates, license, locations, operations, or services.

I understand that NORCAL generally does not cover any liability of another person or organization that is assumed under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by the hospital or others trading under the hospital's name.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and any past and present association(s), society(ies) and their insurance agents, brokers or consultants; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of the hospital's insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about the hospital that is done in good faith and without malice.

Signature of Authorized Representative

Date

Name (Print)

FOR ALASKA APPLICANTS ONLY

Representations and Authorization To Release Information

I understand that this application and any supplemental information supplied by me or on the hospital's behalf is incorporated into and made a part of any policy of insurance that may be issued to the hospital by NORCAL ("the Company").

I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between the hospital and NORCAL, the dispute will be submitted to binding arbitration.

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I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by the hospital or others trading under the hospital's name.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and any past and present association(s), society(ies) and their insurance agents, brokers or consultants; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of the hospital's insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about the hospital that is done in good faith and without malice.

Signature of Authorized Representative

Date

Name (Print)

CLAIM INFORMATION FORM

Name of Patient: _____ Gender: Male Female

Age of Patient (at time of treatment): _____

Name of Claimant (if different than patient): _____

Allegation: _____

Location of Incident: _____

Additional Defendants: _____

Date Incident or Claim Was Reported to the Insurance Company: _____

Name of Insurance Company: _____

Disposition or Current Status of the Incident, Claim or Suit:

Open

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

Closed

Date Closed (Month/Day/Year): _____

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in the hospital's/hospital employee's favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): _____

Amount paid on hospital's/hospital employee's behalf (if different): _____

Total verdict amount (if different than total loss payment amount): _____



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