Please complete this Application, provide the supporting document and return by overnight, registered mail or email to:

Yellowstone Insurance Exchange, RRG
4301 Hillsboro Pike, Suite 310
Nashville, Tennessee 37215
Telephone 866-216-7433

Yellowstone Insurance Exchange, RRG
HOSPITAL PROFESSIONAL / GENERAL LIABILITY APPLICATION

Name of Hospital **(or System):**_____

(Attach a complete list of subsidiaries and affiliates to be covered, including a description of operations and relationship.)

Mailing Address:_____

Phone:_____ Fax:_____

Contact Person & Title:_____

(Name) (Title)

Email:_____

Location Address:_____

_____

County:_____ Web Site Address:_____

1. Applicant is: (Please check all applicable boxes.)

☐ Individual ☐ Medicare Approved ☐ AHA Member ☐ Partnership

☐ Corporation ☐ State Licensed ☐ Joint Venture ☐ Multi-Hospital System

☐ Governmental ☐ Charitable ☐ Not for Profit ☐ Profit ☐ Other

If other, give brief description:_____

_____

2. Requested effective date:_____

3. Facility has/is:

A. ☐ Acute Care Hospital ☐ Nursing/Convalescent Home ☐ Clinic, Dispensary, Infirmary

☐ Abortion Clinic ☐ Off-site Surgical Center ☐ Children's Hospital

☐ Mental/Psychiatric ☐ Day Care ☐ Alcohol/Drug Rehab ☐ Off-site Urgent Care Ctr

B. Accredited by J.C.A.H.O. Date of Last Accreditation:_____
(If checked please attach a copy of last J.C.A.H.O. Report)

C. Number of years this facility has been: Operating:_____
Owned or Managed by Present Owners:_____

4. Please check those services that your facility provides.

- ☐ Abortions
- ☐ AIDS Unit
- ☐ Ambulance
- ☐ Blood Bank
- ☐ Burn Unit
- ☐ CCU
- ☐ Day Care
- ☐ Dept. of Corrections
- ☐ Outpatient Surgery Ctr.
- ☐ Radiation Therapy
- ☐ Pulmonary Rehabilitative Services
- ☐ Maternity Unit/Postpartum Unit
- ☐ Women's Center
- ☐ Endoscopy Unit
- ☐ Assisted Reproductive Tech. Lab
- ☐ Pastoral Care Services
- ☐ Diagnostic Center
- ☐ LDRP
- ☐ Sleep Disorder Lab
- ☐ Home Health Care
- ☐ Computerized Tomography
- ☐ Telemetry
- ☐ Intensive Care Unit
- ☐ Neonatal Intensive Care
- ☐ Obstetrical
- ☐ Surgery, Off-site
- ☐ Trauma Center
- ☐ X-ray
- ☐ Surgical Services
- ☐ Child Development Center
- ☐ Rehabilitative Services
- ☐ Cardiac Rehabilitative Services
- ☐ Nursery
- ☐ EEG
- ☐ Echocardiogram
- ☐ MRI
- ☐ Radiation Oncology Unit
- ☐ Emergency Department
- ☐ Pre-Post Interventional Unit
- ☐ Progressive Care Unit
- ☐ Hyperbaric Treatment
- ☐ Cardiac Catheterization Lab
- ☐ Addiction Treatment Program
- ☐ EKG/Stress Testing Unit
- ☐ Nuclear Medicine
- ☐ Cardiovascular Lab
- ☐ Ultrasound
- ☐ Social Work Services
- ☐ Intervention Radiology
- ☐ Perianesthesia Unit
- ☐ Surgical Intensive Care Unit
- ☐ Transitional Care Facility
- ☐ Diabetes Care Program
- ☐ Blood Flow Lab
- ☐ Pharmaceutical Services
- ☐ Dialysis
- ☐ Other _____
- ☐ Other _____

☐ Oncology Unit

a. Will any new services be provided in the next 12 months? ☐ Yes ☐ No
b. Will any new services be discontinued in the next 12 months? ☐ Yes ☐ No
c. Have any services been discontinued in the last 24 months? ☐ Yes ☐ No
d. If you answered yes to any of the above please provide details:

_____
_____
_____
_____

5. Type(s) of Patient Care:

☐ Alcoholic
☐ Custody/ High Security
☐ Dietary
☐ General
☐ Hyperbaric Treatment
☐ Intensive Care Unit
☐ Medical
☐ Occupational Therapy
☐ Pediatrics
☐ Progressive Care Unit
☐ Recreational Therapy
☐ Respiratory Therapy
☐ Speech Pathology
☐ Surgical ICU
☐ Trauma
☐ Anesthesiology
☐ Dental
☐ Drug Addiction
☐ Geriatrics
☐ Immunology
☐ Maternal / Child
☐ Morgue
☐ Open Heart Surgery
☐ Physical Therapy
☐ Psychiatric
☐ Research / Experimental
☐ Self Care
☐ Surgery
☐ Transplants
☐ Tuberculosis

6. a. Does hospital have any teaching affiliations? ☐ Yes ☐ No
b. Is hospital a teaching and/or research center? ☐ Yes ☐ No
c. Does the hospital have any revenue affiliations? ☐ Yes ☐ No
(e.g. Joint ventures, PPO's, HMO's, etc.?)
d. If you answered yes to any of the above, provide details:

_____
_____
_____

7. Are products sold to others *for* use *off* applicant's premises? ☐ Yes ☐ No
If yes, indicate type of products and annual receipts:_____
_____

8. Do you lease of rent any equipment to others? ☐ Yes ☐ No
If yes, indicate type of equipment and annual receipts:_____
_____

9. Do you lease or rent any clinical equipment from others? ☐ Yes ☐ No
If yes, type of equipment:_____

10. Do you own or operate a child and/or adult Day Care Center? ☐ Yes ☐ No Child
☐ Yes ☐ No Adult

If yes:
Centers are open to: ☐ Employees' Children/Seniors Only ☐ General Public ☐Both
a. Location:_____
b. Hours of Operation:_____
c. Number of Children/Adults (licensed):_____
d. Are hospital and/or day care center vehicles used to transport children? ☐ Yes ☐ No

11. Will there be any sponsored fund raising events this year for which you will need coverage? ☐ Yes ☐ No

If yes, please describe:

_____

_____

PROFESSIONAL/GENERAL LIABILITY

Current HPL/CGL insurance carrier:_____

Policy Period From:_____ To:_____

Has any previous carrier ever declined, cancelled, or refused to renew your professional or general liability coverages? ☐ Yes ☐ No

If yes, please explain:_____
_____
_____

1. Do you request Prior Acts coverage? ☐ Yes ☐ No

2. Current Retroactive Date:_____

3. Limits of Liability: $_____ Each Medical Incident/Aggregate

4. Deductible or SIR: $_____ Each Medical Incident/Aggregate

5. Desired Deductible Options: $_____ $_____

6. Price Per Year $_____ $_____

Employees:

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

General Data: (From most recent fiscal year)

1. Total annual net patient service revenue: $_____
2. Total annual surgical procedures: _____
3. Total annual births: _____
4. Total annual admissions: _____
5. Number of employed physicians: _____
6. Number of employed CRNA's: _____
7. Number of employed Midwives: _____
8. Number of employed Nurse Practitioners: _____
9. Number of employed Physician Assistants: _____

Beds and Outpatient Utilization (give figures from most recent year):

	Licensed	**In Service**	**Number of Inpatient Days**
Total hospital beds (include cribs)			
Total Bassinets			
Nursing Home Beds			

Outpatient Utilization:

	Number of Visits
Emergency Room	
Organized Outpatient Clinic	
	Number of Procedures
One Day Surgery	

	Number of Beds	**Average Daily Occupancy %**
Acute Care		
Psychiatric Care		
Rehabilitation		

Outpatient Data:

Type Visit	12 – Months	24 - Months
Hospice		
Alcohol/Drug Abuse		
Emergency Room		
Off-site Emergency Room		
On-site Home Health		
Physical Rehabilitation		
Psychiatric		
Surgical Outpatient		
Other		
Total Number of Outpatient Visits		

Credentialing:

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

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

3. Do medical staff and/or hospital review boards periodically review staff doctors' performances? ☐ Yes ☐ No

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

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

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

6. Has license of any staff physician ever been restricted or suspended? ☐ Yes ☐ No

7. Does a committee review qualifications of non-physician professionals? ☐ Yes ☐ No

   Continuous coverage when they leave the hospitals medical staff? ☐ Yes ☐ No

Personnel:

1. Professional Employees:
Indicate total (full-time equivalents for part time) employees:

Type	Total	Specialty
RNs		
Nurse / Midwives		
CRNAs		
LPNs		
Nursing Students		
Radiology Techs		
Physicians Assistants		
Medical Students		
Midwives		
Pharmacists		
Nurse Practitioners		
Paramedics		
Perfusionists		
Respiratory Therapists		
Employed Physicians		
Employed Surgeons		
Interns		
Externs		
Residents		
Dentist		
Lab Technicians		
Volunteers		
DPM		
DC		
Others		
TOTAL EMPLOYEES		

Criteria for qualification of employed physicians and surgeons:

1. History of previous employment investigated? ☐Yes ☐ No

2. References checked? ☐Yes ☐ No

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

Anesthesia:

1. Is anesthesia provided by:

   ☐ Hospital Employees
   ☐ Contract Group (name):_____
   ☐ Staff (fee for services)

   If contract group, are Certificates of Insurance required? ☐ Yes ☐ No
   If yes, what limits of insurance are required? $_____ per Claim / $_____ Aggregate

2. Number of Anesthesiologists: Full-time: _____ Part-time: _____

3. Number of those who are Board Certified: _____

4. Are CRNAs supervised at all times by an Anesthesiologist? ☐ Yes ☐ No

5. Is anesthesia equipment equipped with oxygen analyzers? ☐ Yes ☐ No

6. Is anesthesia equipment equipped with disconnecting alarms? ☐ Yes ☐ No

7. If you answered no to any of the above, provide details:

_____

_____

_____

Pharmacy:

1. Does the pharmacy provide medicine to non-patients? ☐ Yes ☐ No

   If yes, annual receipts for non-patient medications are: $_____

2. Does the facility utilize the Unit-dose system of dispensing medicine? ☐ Yes ☐ No

3. Is a registered pharmacist directing the operations of the pharmacy? ☐ Yes ☐ No

Radiology:

1. Is the radiology department staffed by:
   ☐ Hospital Employees
   ☐ Contract Group (name):_____
   ☐ Staff

2. If contract group, are certificates of insurance required? ☐ Yes ☐ No
   If yes, what limits of insurance are required? $_____ per Claim / $_____ Aggregate

3. Are radiologists board-certified? ☐ Yes ☐ No

4. Are X-ray technicians licensed? ☐ Yes ☐ No

5. Are X-ray technicians certified? ☐ Yes ☐ No

Surgery:

1. Indicate the number of surgical procedures performed in the last year:

- Total: _____
- Inpatient: _____
- Outpatient: _____

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

If yes, at what intervals of the operations?_____

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

☐ Experimental Surgery
☐ Neurosurgery
☐ Sex Change Operations
☐ Weight Reduction Surgery
☐ Bariatric Surgery - Procedures

Obstetrics/Nursery:

1. How many caesarian sections?_____

Perform VBACS ☐ Yes ☐ No Annual Number_____

2. Is electronic fetal monitoring performed on all patients in active labor? ☐ Yes ☐ No

3. Does a written procedure exist for transferring all high-risk mothers and/or babies whom the hospital is not qualified to treat? ☐ Yes ☐ No

4. Are labor-inducing drugs always administered by an obstetrician? ☐ Yes ☐ No

5. How many annual abortions?_____

6. Indicate OB level (I - V):_____

Emergency Room:

1. Is emergency room staffed by?

   ☐ Hospital Employees
   ☐ Contract Group (name):_____
   ☐ Staff

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

   If yes, what are the minimum limits required? $_____ per Claim / $_____ Aggregate

3. Is the emergency room staffed by a physician on a 24-hour basis? ☐ Yes ☐ No

   If no, provide details:_____
   _____

4. What level is the Emergency Room?_____

5. Is the emergency room equipped with the following?

   ☐ Blood
   ☐ Cardiopulmonary Resuscitation Facilities
   ☐ Intravenous Fluids
   ☐ Life-Saving Drugs

6. Staffing Standards: What is the minimum qualification required *of* the senior medical professional at all times (i.e., Physicians, Staff Physician, Resident, RN)?

_____

_____

_____

7. Support facilities:

   ☐ 24-hour X-ray availability ☐ 24-hour surgery
   ☐ 24-hour laboratories ☐ 24-hour anesthesia

8. Does this facility regularly handle:
   Street Trauma ☐ Yes ☐ No
   Indigent Cases ☐ Yes ☐ No

9. Does the hospital have a heliport? ☐ Yes ☐ No

If yes, Landings per year?_____
If yes, do you obtain certificates of insurance from users of the heliport/helipad?
☐Yes ☐No

If yes, what limits of insurance are required by the hospital?_____

10. Does the hospital own ambulances or other emergency-use vehicles? ☐ Yes ☐ No

If yes, what is the number of EMT's utilized?_____

11. Indicate level of emergency services:_____

12. Does the hospital require all E.D. patients to see a physician before discharge?
☐Yes ☐No

Risk Management:

1. Is there a written, formalized Risk Management Program? ☐ Yes ☐ No

2. Is the program periodically reviewed for effectiveness and the necessary changes implemented? ☐ Yes ☐ No

3. Who coordinates your risk management program?

Name:_____

Title:_____

Phone:_____

E-mail:_____

Length of Employee / Experience:_____

_____

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

5. To whom does the risk manager report?

Name:_____ Title / Phone Number:_____

Is the risk manager responsible for reviewing incident reports? ☐ Yes ☐ No

How Often?_____

7. Are the following findings incorporated in the risk management program?

Area of Concern	Yes	No
Generic or Critical indicator Screening		
Incident Reporting		
Infection Control Committee		
Full-time Patient Representative		
Peer Review Organization		
Quality Assurance Coordinator		
Safety Committee		
Tissue Review Committee		
Other \		

8. Does the hospital utilize the following risk management systems?

Area of Concern	Yes	No
Generic or Critical Indicator Screening		
Incident Reporting		
Infection Control Committee		
Full-time Patient Representative		
Peer Review Organization		
Tissue Review Committee		
Other \		

SUPPLEMENTAL INFORMATION NEEDED:

1. Hospital organizational chart

2. A copy of the most recent JCAHO and or State Accreditation Report

3. Updated loss experience for the past 10 years to include all carriers involved

4. A copy of the latest actuarial funding report for self-insured programs

5. A copy of the latest annual CPA audited financial statements

6. Completed exposure data form provided by Yellowstone Insurance Exchange, RRG

Signature of CEO or Authorized Hospital Personnel:

Signature:_____

Title:_____

Date of Signature:_____

Signing this application does not bind Yellowstone Insurance Exchange, RRG to complete the insurance. All information requested in this application is considered material and important. If a company agrees to be bound under the terms of this application, your policy is void if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application. If accepted the application will form the basis for policy issuance and will be included as part of the policy.

Please attach your Emergency Management/Preparedness Plan including any separate plan that addresses chemical and bioterrorism.

The person completing this form should sign below:

Name & Title:_____

Date:_____

Please return completed application and any additional information to:

Eric J. Gardzina, CPHRM
Director of Underwriting
Yellowstone Insurance Exchange, RRG
4301 Hillsboro Pike, Suite 310
Nashville, TN 37215
Tel 866-216-7433
Fax 866-216-7434

Email: Ericg@yierrg.com

Thank You.