

COASTAL INSURANCE RISK RETENTION GROUP, INC.

P.O. Box 211359
Montgomery, Alabama 36121-1359
334-271-5515

HOSPITAL MEDICAL PROFESSIONAL LIABILITY APPLICATION

Renewal Application – Claims Made

Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for risk retention groups.

Name of Applicant (*First Named Insured*) _____

Additional Named Insured(s) _____
(Attach list if necessary – Including Retroactive Date(s).)

Street Address _____

City State Zip

Billing Address _____

City State Zip

Effective Date: _____ Retro Date: _____

Contact Person _____ Phone Number _____

Email Address _____ Fax Number _____

Type of Facility: (*Please check those that apply*)

For Profit NFP Gov't Critical Access Center

Brief Description of Operations: _____

Are any management services provided for others? Yes No If yes, please describe. _____

Are management services provided for your facility? Yes No If yes, please give name, address and attach a copy of the contract.

Is the Management Company to be added to your policy as an Additional Insured? Yes No

Limits Requested: _____ Each Claim _____ Aggregate

Deductible: _____ Per Claim – Indemnity & Defense

Class	Inpatient Days
Hospital Beds	
Hospital Bassinets	
Deliveries excluding C Section(Actual Number)	
Deliveries C Sections (Actual Number)	
Psychiatric/Substance Abuse Beds	
Rehabilitation Beds	
Nursing Home Beds	
Assisted Living Beds	

Class	# Visits/Surg. Renewal
Inpatient Surgeries	
Outpatient Surgeries	
Emergency Visits	
Clinics, Dispensaries, Infirmaries Visits	
Outpatient Visits (Not listed elsewhere)	
Psychiatric/Substance Abuse Visits	
Rehabilitation Visits	
Home Health Visits	

Class	Units	Exposure Units Current Year
Wellness Center	*Receipts	
Medical/X-ray Laboratory	*Receipts	
Pharmacy	*Receipts	
Total # Employees	#	
.* Receipts for services performed for outside firms not hospital patients.		

Employed Position Classes	# Hrs. Wrk/Wk Current Year
Certified Midwives	
CRNAs – No On-Site Supervision	
CRNAs – On-Site Supervision	
Medical Students/Externs	
Nurse Practitioner	
Optometrists	
Physicians or Surgeons Assistants	
Podiatrists – Major Surgery	
Podiatrists – No Surgery	
Student (CRNAs)	
Student Nurses	

- a. Percent of RN care hours as a total of all nursing care hours: _____%
- b. Percent of contract (agency) RN hours as a total of all nursing care hours: _____%
- c. Licensed Nurse/patient ratio (e.g. 1: X); Surgery _____ Critical Care: _____
- d. Total number of physicians with hospital privileges: _____
- e. Are all medical staff required to provide a Certificate of Insurance: Yes No
- f. Any plans to purchase other healthcare facilities? Yes No
- g. Do you provide telemedicine services? Yes No
If yes, please describe. _____
- h. How many Bariatric Surgeries were performed in your facility in the past 12 months? _____

Nursing Home / Assisted Living:

- a. Do you conduct a background check (for criminal history and abuse/neglect at minimum) on all Nursing Home/Assisted Living care staff? Yes No
- b. Number of RN _____
- c. Number of LPN _____
- d. How many patients have dementia? _____

Emergency Department:

- a. What percent of Emergency physicians are board certified? _____%
- b. Are all Emergency physicians PAL certified? Yes No
- c. Do all discharge instructions contain specific contact information and time frame for follow-up visits? Yes No
If NO, Please explain: _____
- d. Are protocols in place for rapid treatment of high risk presentations? (e.g. chest pain, abdominal pain, children with fever, headache and trauma)? Yes No
- e. Provide the following annualized data for the past 12 months:
Average wait time in minutes (arrival to treatment time): _____
Average length of time in ED in hours (arrival to physical discharge): _____

Residents:

- a. Do you have residents/fellows at your hospital? Yes No
- b. Does your residency/fellowship program include defined scope of care and supervision requirements for different levels of training? Yes No
- c. Is the hospital part of an accredited medical school? Yes No

Obstetrics:

- a. Do you provide Obstetrics? Yes No
- b. Are PALS/NALS trained staff present at every delivery? Yes No
- c. How many VBAC deliveries have been done in the past 12 months? _____

Credentialing/Staff Privileges:

- a. Does the recredentialing process include a confirmation of competence regarding procedure specific staff privileges? Yes No
- b. Do you credential/appoint your physicians every 2 years?
If not, how often? _____ Yes No
- c. Do you credential/appoint non-physician providers (CRNA, PA, NP etc.) every 2 years?
If not, how often? _____ Yes No
- d. Are current Certificates of Insurance kept on file for all medical staff? Yes No
- e. J.A.C.H.O. Accredited: Yes No Date of Last Accreditation: _____
- f. State Certified: Yes No Date of Last Certification: _____

Do you know of any claims or incidences that reasonably may result in a claim that have not been reported to your Insurance Carrier? Yes No If yes, please explain.

Please provide your prior five year plus the current year loss history. This should be provided by your insurance carrier(s).

Insured's Representations:

I understand the submission of this application does not bind the Company to issue or me to purchase this insurance. By signing below, I grant permission (1) to the Company to contact third parties and (2) to third parties to release to the Company information which relates to the issuance and continuation of this insurance.

I represent that the information provided in this application (and attachments) and any previous applications is true. I understand (1) that the applications are the basis of and will become a part of the insurance contract with the Company; by reference (2) that the application information I provided is material to the Company; (3) that the Company is relying on this information in determining whether to rescind the insurance contract if any application contains any misrepresentation or omission with intent to deceive. Further, I agree to notify the Company of any change in the information provided.

Signature and Title of Applicant	Date	Phone Number
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Printed Signature	Date
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