

# 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, Infirmarys 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.

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|   |             |                     |
|---|-------------|---------------------|
| <b>Signature and Title of Applicant</b> | <b>Date</b> | <b>Phone Number</b> |
|---|-------------|---------------------|

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|                          |             |
|--------------------------|-------------|
| <b>Printed Signature</b> | <b>Date</b> |
|--------------------------|-------------|