

COASTAL INSURANCE RISK RETENTION GROUP, INC.

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

MEDICAL PROFESSIONAL LIABILITY APPLICATION

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

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. _____

Limits Requested: Each Claim Aggregate

Deductible: Per Claim – Indemnity & Defense

Effective Date: Retro Date:

Contact Person Phone Number

Email Address Fax Number

Class	Inpatient Days	Class	# Visits/Surg. Renewal
Hospital Beds		Hospital Inpatient	
Hospital Bassinets		Surgeries	
Deliveries excluding C Section (Actual Number)		Hospital Outpatient	
Deliveries C Sections (Actual Number)		Surgeries	
Psychiatric/Substance Abuse Beds		Hospital Emergency	
Rehabilitation Beds		Department Visits	
		Clinics, Dispensaries, Infirmaries Visits	
Nursing Home Beds		Other Hospital	
Assisted Living Beds		Outpatient Visits	
		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	
Dentists NOC (Contracted)	
Dentists NOC (Employed)	
Dentists/Oral Surgeons (Employed)	
Dentists/Oral Surgeons (Contracted)	
Medical Students/Externs	
Nurse Practitioner	
Optometrists	
Physicians or Surgeons Assistants	
Podiatrists – Major Surgery	
Podiatrists – No Surgery	
Student (CRNAs)	
Student Nurses	

GENERAL QUESTIONS

- a. Does your hospital have a management contract to provide management services to other facilities? Y N
- b. Does another facility provide management services to your hospital? Y N
(If yes please provide the name address of the entity and a copy of contract)
- c. Percent of RN care hours as a total of all nursing care hours: %
- d. Percent of contract (agency) RN hours as a total of all nursing care hours: %
- e. Licensed Nurse/patient ratio (e.g. 1: X); Surgery Critical Care:
- f. Total number of physicians **with** hospital privileges:
- g. Are all medical staff required to provide a Certificate of Insurance: Y N
- h. Any plans to purchase other healthcare facilities? Y N
- i. Do you provide telemedicine services? Yes No
- If yes, please describe.

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? Y N
- 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? Y N
- c. Do all discharge instructions contain specific contact information and time frame for follow-up visits? Y N
If **NO**, Please explain:
- d. Are protocols in place for rapid treatment of high risk presentations? Y N
(e.g. chest pain, abdominal pain, children with fever, headache and trauma)?
- 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? Y N
- b. Does your residency/fellowship program include defined scope of care and supervision requirements for different levels of training? Y N
- c. Is the hospital part of an accredited medical school? Y N

Obstetrics

- a. Do you provide Obstetrics? Y N
- b. Are PALS/NALS trained staff present at every delivery? Y N

Credentialing/Staff Privileges

- a. Does the recredentialing process include a confirmation of competence regarding procedure specific staff privileges? Y N
- b. Do you credential/appoint your physicians every 2 years?
If not, how often? Y N
- c. Do you credential/appoint non-physician providers (CRNA, PA, NP etc.) every 2 years?
If not, how often? Y N
- d. Are current Certificates of Insurance kept on file for all medical staff? Y N

- e. J.A.C.H.O. Accredited: Y N Date of Last Accreditation:
- f. State Certified: Y N 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? 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).

DECLARATION

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
Printed Signature		