Rockbridge Underwriting, An RLI Company
3700 Buffalo Speedway, Suite 300
Houston, TX 77098
(713) 874-8800

ABORTION CLINIC PROFESSIONAL LIABILITY INSURANCE APPLICATION

Instructions: Please complete and sign. Attach additional sheets as needed.

I. GENERAL INFORMATION

Corporate Entity Name: _____

Corporate Entity Address: _____

_____

Mailing Address: _____

_____

Contact person: _____
Title: _____
Telephone Number: _____
Web Site: _____

Administration:
Name of Chief Executive Officer: _____
Name of Medical Director: _____
Name of Risk Manager: _____

Applicant is a:
☐ Corporation ☐ Partnership Association
☐ Joint Venture ☐ Sole Proprietorship
☐ Partnership ☐ Other:

Applicant Operates: ☐ For Profit ☐ Not For Profit

Date Business Established: _____

II. COVERAGE REQUESTED

Requested Effective Date: _____ Retroactive Date: _____

Deductible/SIR Amount: _____

Limits of Liability:
☐ $100,000/$300,000
☐ $200,000/$600,000
☐ $250,000/$750,000
☐ $500,000/$1,500,000
☐ $1,000,000/$3,000,0000
☐ Other

III. REVENUE DATA: Please provide historical, current, and projected revenues:

Year	*$ Revenues*	
2006		
2007		
2008		
2009		
2010		
2011		
2012		
Projected 2013		

IV. LOCATION & OPERATIONAL INFORMATION: Please list each location of operations:

Name of Location	*Address*	*Description of Operations*	*% Ownership*

V. PROFESSIONAL EMPLOYEES/INDEPENDENT CONTRACTORS: Please list each physician providing services at your facility:

What is the total number of physicians working at your facility? _____

What are the professional liability insurance requirements for physicians? _____

Are your requesting physician coverage? ☐ Yes ☐ No
(If yes, then complete separate physician application for each physician).

Do you require that the physician working at your facility be Board Certified by the American Board of Obstetrics and Gynecology? ☐ Yes ☐ No

Are you requesting coverage for any contracted healthcare professional? ☐ Yes ☐ No

(If yes, list number, type, and how many hours each works). _____

Give the names of each person working at your facility:

Medical Director	***Specialty***	***Insurance Carrier***	***Employee/Contractor***	***Hours/Month***
Physician Names	***Specialty***	***Insurance Carrier***	***Employee/Contractor***	***Hours/Month***

Specify each type and number of allied health professional working at the clinic:

Type of Professional	***Employees***		***Contractors/Volunteers***	
	Number	***Hours/Month***	***Number***	***Hours/Month***
Nurse Midwives				
CRNA				
Physician Assistants				
Nurse Practitioners				
List other types:				

VI. PROFESSIONAL LIABILITY EXPOSURE INFORMATION: Indicate the services offered. If locations are in multiple states, please copy this page and provide grid by state.

Annual # of Services Provided (Use different lines for each location)	***Year***	***Year***	***Current***	***Projected***
Surgical Abortions – 1st Trimester (# of Procedures)				
Surgical Abortions – 2nd Trimester (# of Procedures)				
Surgical Abortions – 3rd Trimester (# of Procedures)				
Medical Abortions – 1st Trimester (# of Procedures)				
Medical Abortions – 2nd Trimester (# of Procedures)				
Medical Abortions – 3rd Trimester (# of Procedures)				
GYN/Family Planning (Visits):				
Other Services Provided:				
Laboratory Testing (in-house):				

Product Sales (List Type & Revenues):				

VII. ACCREDITATION:

Please check the box your facility is affiliated with or accredited by:

			Affiliated With or Accredited By?
Planned Parenthood	☐ Yes	☐ No	
NAF	☐ Yes	☐ No	
NCAP	☐ Yes	☐ No	
NFPRHA	☐ Yes	☐ No	
JCAHO	☐ Yes	☐ No	
Other (please specify):			
	☐ Yes	☐ No	
	☐ Yes	☐ No	

Is this facility licensed by the state: ☐ Yes ☐ No

If yes, please list the state(s): _____

VIII. RISK MANAGEMENT:

Does your facility have a formalized Risk Management Program? ☐ Yes ☐ No

Who coordinates your Risk Management Program?

Name: _____

Phone Number: _____

List the types of healthcare products & approximate annual quantity distributed (including samples) at the clinic:

Annual # of Products Distributed	***Year***	***Year***	***Current***	***Projected***
Sponges				
IUD's				
Birth Control Implantables				
Pills				
RU-486 (Mifepristone)				
Patches				
Condoms				
Other: (list each)				

Does your facility document counseling & informed consent regarding the specific risks, benefits, and alternatives of each type of contraception recommended to patients in the medical record? ☐ Yes ☐ No

Have any of your patients had adverse reactions after taking the following products:

RU-486 (Mifepristone) ☐ Yes ☐ No

Patches ☐ Yes ☐ No

If yes, give the number and details below:

Have any of the products that you distribute ever been recalled? ☐ Yes ☐ No

If yes, please give details:

Is there a credentialing process in place for your physicians? ☐ Yes ☐ No

What types of anesthesia are provided by your facility?

General Anesthesia ☐ Yes ☐ No

Local Anesthesia ☐ Yes ☐ No

Spinal Anesthesia ☐ Yes ☐ No

Conscious Sedation Anesthesia ☐ Yes ☐ No

Who is providing the anesthesia?

Anesthesiologists ☐ Yes ☐ No

CRNA's ☐ Yes ☐ No

Staff Nurses ☐ Yes ☐ No

Physician Performing the Procedure ☐ Yes ☐ No

What type of patient follow-up is done?

Who does the patient selection and screening?

How many patients were de-selected last year? _____

Do you consistently test all pregnant women for Rh factor and administer Rhogam as indicated? ☐ Yes ☐ No

Are there any patients that have more than one abortion? ☐ Yes ☐ No
If yes, please provide number and details:

How many abortions are preformed on minors? _____

Was parental consent obtained if required by the state where abortion was performed? ☐ Yes ☐ No

How many high risk procedures do you annually perform in an acute care setting? _____
What is the nature of these high risk procedures?

How many of these procedures over the past five years have involved any complications and what is the nature of the complications?

Do you have a transfer agreement with a hospital in the event there is an emergency? ☐ Yes ☐ No
If yes, give the name of the healthcare facility:

Is there a formalized training program during new hire orientation and annually for all staff to be familiar with policies & procedures pertaining to emergency clinical situations? ☐ Yes ☐ No

Do you have a formalized infection control program? ☐ Yes ☐ No
If yes, please describe:

VIII. RISK MANAGEMENT: Please provide past policy information requested:

Year	*Insurer*	*Policy Period*	*Premium*	*Limits*	*Ded/SIR*	*CM (w/ Retro) or Occurrence*
Current						
Year 2						
Year 3						
Year 4						
Year 5						

IX. LOSS HISTORY:

Please provide currently valued carrier produced loss runs for each of the past 5 years.
If provided check the box: ☐ Yes ☐ No

If no claims have been reported to you, then initial here: _____

Are you aware of any circumstance, accident, or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? ☐ Yes ☐ No

If yes, please give dates, allegations, and disposition and include with listing of all reported claims:

Date of Incident	*Date Claim Reported*	*Allegation*	*Status**	*Amount Reserved*	*Amount Paid*

*Status should be shown as (O) Open; (C) Closed; (I) Incident

X. TO COMPLETE THIS APPLICATION, PLEASE ATTACH:

- ☐ LOSS HISTORY – Submit company produced 5 year loss history for professional liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status, and a detailed explanation for each loss.
- ☐ Copies of all marketing materials.
- ☐ Most current year-end financial statements.
- ☐ Copies of most recent inspection reports within the past 3 years.

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection Regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my background, competence and qualifications may be conducted by the Company.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains by my background, competence and qualifications, and I incurred in connection therewith.

ACKNOWLEDGED AND AGREED:

APPLICANT (Signature Required) DATE:

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.