Rockbridge Underwriting, An RLI Company
3700 Buffalo Speedway, Suite 300
Houston, TX 77098
(713) 874-8800
(713) 874-8899 fax

Corporate Emergency Room/Ambulatory Care Underwriting Questionnaire and Application for Professional Liability Insurance

INTRODUCTION

Please answer all questions. If the information is not known or is to follow, please indicate.
If the information requested is not applicable to your organization, indicate “N/A”.

GENERAL INFORMATION

Name of Organization: ____________________

Address: ____________________
Street

____
City County State Zip Code

Web Site: ____________________

Type of Ownership: ☐ Corporation ☐ Partnership ☐ Solo Practitioner

Number of years under present ownership: __________

Contact Person for Billings:

____________________ ( ) __________
Name Title Phone #

Contact Person for Claims:

____________________ ( ) __________
Name Title Phone #

Corporate Medical Director: ____________________
Name

Proposed Inception Date: __/__/__

Is Prior Acts coverage needed? ☐ YES ☐ NO **Retro Date:** __/__/__

IF “YES”, PLEASE COMPLETE THE PRIOR ACTS SUPPLEMENT.

	PER OCCURRENCE	AGGREGATE
Requested Limits of Liability:	$	$
Requested Deductible:	$	$
Requested Self-Insured Retention:	$	$

ORGANIZATIONAL LOCATIONS

Names and addresses of **ALL** locations for which insurance coverage is sought.

Location Name of Hospital Street, City, State	Annual Number of ED Visits Annual Number of Fast Track Visits	Number ED Hours/Year	✔ if Free Standing or Clinic	Number Clinic Visits/Year	Number Clinic Hours/Year	Other Types of Operations/ Services	Location to be Covered/ Retro Date
1.			☐				
2.			☐				
3.			☐				
4.			☐				
5.			☐				
6.			☐				
7.			☐				
8.			☐				
9.			☐				
10.			☐				
11.			☐				

What is the Trauma level(s) of the Emergency Department location(s) being covered? ________________________

What is your average door to doctor time? ________________________

What is your average length of stay in the ED for non-admitted patients? ________________________

What is your average length of stay in the ED for admitted patients? ________________________

ORGANIZATIONAL LOCATIONS (cont.)

Are any of the group's physicians medical directors of any EMS or other organization?
☐ YES ☐ NO If "YES," please attach list.

Is the adding of additional sites contemplated during the coming year: ☐ YES ☐ NO
If "YES," please describe ______________________________
Provide the following information for the past five years:

Fiscal Year	Total # of ER Visits	Total # of Clinic Visits
20		
20		
19		
19		
19		

PROFESSIONAL LIABILITY INSURANCE COVERAGE

Current Professional Liability Insurance:

Present Insurance Carrier: ______________________________

Coverage Type: ☐ Occurrence ☐ Claims Made

IF CLAIMS MADE, ATTACH COPY OF CURRENT POLICY.

Present Premium: ______________________________

Present Limits of Liability $______________/ $______________________________

Policy expiration date: __/__/__

Previous Professional Liability Insurance - past five years:

Policy Year	Insurance Carrier	Policy Limits	Policy Type	SIR/Deductible Amount
20			☐ Occurrence ☐ Claims Made	
20			☐ Occurrence ☐ Claims Made	
19			☐ Occurrence ☐ Claims Made	
19			☐ Occurrence ☐ Claims Made	
19			☐ Occurrence ☐ Claims Made	

Has any company refused coverage, canceled, or refused to renew any insurance?

☐ YES ☐ NO If Yes, please explain:______________________________

____

____

In the last five years, have claims or suits for any alleged malpractice ever been brought against the group, any of its employed or contracted physicians or paraprofessionals (whether or not affiliated with the group at the time of claim/suit)? ☐ YES ☐ NO

In the last five years, have any incidents occurred involving the group, any of its employed or contracted physicians or paraprofessionals (whether or not affiliated with the group at the time of incident), that could lead to a suit or claim? ☐ YES ☐ NO
If Yes, to either of the two preceding questions, complete the following page - include all items reported to other carriers.

List all insurance claims for each physician for the last five years. Use a separate sheet if necessary, or attach a copy of the loss report.

Physician's Name	Institution City/State	Allegation	Type of Injury	Date of Treatment / Date of Claim	Status (Event, Claims, Suit)	Amounts Paid to Date	Amounts Reserved to Date	Name of Insurance Carrier
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								

MEDICAL INDEPENDENT CONTRACTORS/EMPLOYEES	MEDICAL SPECIALTY	Number Full Time	Number Part Time
	Anesthesiology		
	Family Practice		
	Emergency Medicine		
	Internal Medicine		
	Pathology		
	Pediatrics		
	Psychiatry		
	Radiology		
	Other		

	SURGICAL SPECIALTY	Number Full Time	Number Part Time
	General		
	Neurosurgery		
	OB/GYN		
	Oral Surgery		
	Ophthalmology		
	Orthopedics		
	Plastic		
	Urology		
	Vascular/Thoracic		

Are the physicians employed or contracted by the Named Insured? ____________________

What is your turnover rate for physicians that work for you? __________________________%

Are references listed by new applicants checked in writing? ☐ YES ☐ NO

Are diplomas, licenses and other credentials for applicants verified prior to employment? ☐ YES ☐ NO

What percentage of physicians American Board Certified in Emergency Medicine? ______%

What percentage board certified in another specialty? ____________________________%

How many physicians are not American Board Certified in any medical specialty? ________

What percentage of physicians ATLS and ACLS certified? ___________________________%

Is the initial employment for a specified probationary period? ☐ YES ☐ NO If "Yes," what is the probationary period? ____

Does the organization have a formal physician peer-review process? ☐ YES ☐ NO

Is there a Risk Manager? ☐ YES ☐ NO If yes, please provide a copy of his/her resume.

Do you have a formal, written risk management protocol? ☐ YES ☐ NO

Is credentialing done for all physicians? ☐ YES ☐ NO

Is credentialing done _____ internally or _____ by a third party?

How often does the Insured re-credential its physicians? ____________________________

Provide credentialing policies and procedures (including copy of application new physicians are required to complete).

Are any non-physician professionals (employees/independent contractors) associated with your organization? ☐ YES ☐ NO If "Yes," please describe: _______________________

Have any of your physicians been involved in an impaired physician program for substance abuse or mental or nervous disorder? ☐ YES ☐ NO If "Yes," please attach details.

Have any of your physicians had a license suspended or revoked, or hospital privileges suspended or revoked? ☐ YES ☐ NO If "Yes," please attach details.

Group Practice Policies

Please indicate if the policies and procedures listed below exist in written form and require mandatory compliance. If none exists, state the alternative or reason or plans to rectify on a separate sheet. Please explain all "no" answers on a separate sheet.

		Yes	No
1.	Triage Policy	○	○
2.	Medical Screening Exam	○	○
3.	Transfer (COBRA) Policy	○	○
4.	Clinical Protocols	○	○
5.	Patient Satisfaction Survey	○	○
	Average Score _____		
6.	Claims Management	○	○
	Incident Reporting	○	○
	Report & Track Claims	○	○
	Credentialing Protocols	○	○
7.	Medical Records	○	○
	Dictated	○	○
	Dictated	○	○
	Handwritten	○	○
8.	If handwritten, are preformatted charts used?	○	○
9.	Mechanism to handle Test Discrepancies:	○	○
	Radiology	○	○
	Lab	○	○
	EKG	○	○

CURRENT PHYSICIAN ROSTER

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
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26. ______________________________
27. ______________________________
28. ______________________________
29. ______________________________
30. ______________________________

PRIOR ACTS SUPPLEMENTARY INFORMATION

Name of Group (Insured): ____

Requested Policy Term: ____

PRIOR ACTS COVERAGE IS PROVIDED FOR ALL PHYSICIANS ONLY FOR WORK PERFORMED ON BEHALF OF THE ABOVE NAMED GROUP AT SCHEDULED LOCATIONS SUBSEQUENT TO THE RETROACTIVE DATE SHOWN FOR EACH LOCATION, AND DOES NOT INCLUDE ANY MOONLIGHTING OR WORK PERFORMED OUTSIDE OF THE GROUP CONTRACT. IF COVERAGE FOR WORK OUTSIDE OF THE GROUP CONTRACT AT SCHEDULED LOCATIONS IS NEEDED, PLEASE COMPLETE THE FOLLOWING.

Is Prior Acts coverage requested for work performed on behalf of the Group, but at an unscheduled location? If so, please list location and retroactive period to be covered.

LOCATION - CITY/STATE	START DATE	TERMINATION DATE

Is Prior Acts coverage requested for individual specific physicians for work performed outside of the group contracts? If so, please provide the following:

PHYSICIAN'S NAME	RETROACTIVE DATE	LIMITS DURING RETROACTIVE PERIOD	SPECIALTY	LOCATION

CONDITIONS OF APPLICATION

By applying for Medical Malpractice Insurance from Mt. Hawley Insurance Company, I hereby:

- consent to the inspection by Mt. Hawley Insurance Company or their agents of all documents that may be material to an evaluation of the group's qualifications and competence.
- release from liability Mt. Hawley Insurance Company, their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications;
- release from liability any and all individuals and organizations who provide information to Mt. Hawley Insurance Company, in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

______________________________ X____
Date Applicant's Signature

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