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

PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR MULTI-PRACTICE CLINIC OR LARGE GROUP PRACTICE

INSTRUCTIONS: Please complete all sections and sign. If a section or question does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

I. GENERAL INFORMATION

Applicant Name				Tax Identification Number
Location Address	City	State	Zip Code	County
Mailing Address	City	State	Zip Code	County
Website Address	Telephone Number		Facsimile Number	

II. NAMES AND DESCRIPTION OF ALL LEGAL ENTITIES (Indicate below if entity to be insured)

	Name	Description	Entity Type: Corporation/ Partnership	To be Insured? Yes	To be Insured? No	Prior Acts Date (if applicable)
A.				☐	☐	
B.				☐	☐	
C.				☐	☐	

III. ADMINISTRATION

A.	Name of Chief Executive Officer:			
B.	Name of Medical Director:			
C.	Name of Administrator/Risk Manager:			
D.	Name of Contact Person for Claims:		Email Address:	
E.	Name of Contact Person for Billing:		Email Address:	

IV. COVERAGE REQUESTED

Effective Date:	Retroactive Date:	Deductible/SIR:

Limits Desired:

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000

☐ $500,000/$1,000,000 ☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000

A "tail" policy is generally available as an option of your expiring Claims Made Policy.
Is applicant purchasing tail? ☐ Yes ☐ No

V. PROFESSIONAL LIABILITY INSURANCE COVERAGE

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

Has any insurance company canceled, refused to issue, or refused to renew your professional liability insurance policy?

☐ Yes ☐ No If Yes, please explain:

VI. OPERATIONS

A. Fully describe your operations:

B1. Main Location

Street Address		City	State	Zip
☐ Owned ☐ Leased	Sq. ft.	No. of floors	Date Opened	

B2. Additional Locations (Use additional sheets if necessary)

Location No. 2

Street Address		City	State	Zip
☐ Owned ☐ Leased	Sq. ft.	No. of floors	Date Opened	

Type of Operation (if different from Main Location):

Location No. 3

Street Address		City	State	Zip
☐ Owned ☐ Leased	Sq. ft.	No. of floors	Date Opened	

Type of Operation (if different from Main Location):

C.	Date group/entity was established:	
D.	Length of time at Main Location:	
E.	Within the next 12 month period, does applicant plan to:	
	• Obtain another facility or entity?	☐ Yes ☐ No
	• Add to the number of physicians?	☐ Yes ☐ No
	• Expand the number of locations?	☐ Yes ☐ No

IF ANSWER IS YES TO ANY QUESTIONS ABOVE, PLEASE EXPLAIN.

VI. OPERATIONS (continued)

F. Do any of the Named Insureds own or operate any healthcare related business other than that which is described in this application? ☐ Yes ☐ No

If Yes, please explain: _____

G. Provide the following information projected for next year, the current year and for the past three years:

Policy Year	Total # of Patient Encounters	Type of Encounter	Total Gross Receipts
Projected for Next Year			
Current Year			
Prior Years			
Prior Years			
Prior Years			

H. Patient Mix:
1. Fee for service _____ %
2. Pre-paid (HMO, PPO) _____ %
3. Medicare _____ %
4. Medicaid _____ %

I. Does the applicant attract patients because of reputation in any particular field of medicine? ☐ Yes ☐ No

If Yes, please specify: _____

J. Are any research or teaching programs conducted? ☐ Yes ☐ No If Yes, please describe.

K. Is anesthesia administered at your facility? ☐ Yes ☐ No

If Yes, please explain: _____

L. Are any surgical procedures performed? ☐ Yes ☐ No

If Yes, list ALL surgical procedures performed including minor surgery and advise where procedure is performed:

M. Does the applicant manufacture, sell or distribute any pharmaceutical or medical devices or products? ☐ Yes ☐ No
If Yes, please describe and provide receipts.

N. Does the applicant own, control, or staff any of the following:

	1.	Facilities for overnight patient monitor/care	☐ Yes ☐ No
	2.	Surgicenter/Clinic Surgical Outpatient Unit	☐ Yes ☐ No
	3.	Emergency Room	☐ Yes ☐ No
	4.	Birthing Center	☐ Yes ☐ No
	5.	Substance Abuse Programs	☐ Yes ☐ No
	6.	Radiation and/or Shock Therapy	☐ Yes ☐ No
	7.	X-ray Facility (Diagnostic)	☐ Yes ☐ No

VI. OPERATIONS (continued)

	8.	Laboratory (other than Limited Lab facilities for patients only)	☐ Yes ☐ No

IF ANSWER IS YES TO ANY QUESTIONS IN SECTION N ABOVE, PLEASE EXPLAIN.

VII. STAFF(Individual applications may be required for physicians)

A. PHYSICIANS

Specialty	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Anesthesiology				
Emergency Medicine				
Family Practice				
Hospitalist				
Internal Medicine				
Pediatrics				
Psychiatry				
Radiology				
Surgery – General				
Surgery – Neurosurgery				
Surgery – OB/GYN				
Surgery – Oral				
Surgery - Ophthalmology				
Surgery – Orthopedics				
Surgery – Plastic				
Surgery – Urology				
Surgery – Vascular/Thoracic				
Other – List Type:				
Other – List Type:				

B. ALLIED HEALTHCARE PROFESSIONALS

Type	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Audiologist				
Chiropractor				
Dentist				
Laboratory Technician				
Medical Assistant				
Midwife				
Nurse Anesthetist				
Nurse Practitioner				
Nurse (RN and LPN)				

VII. STAFF (continued)

Type	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
Optometrist				
Paramedic				
Perfusionist				
Physical Therapist				
Physician Assistant				
Podiatrist				
Psychologist				
Pulmonary Therapist				
Registered Pharmacist				
Surgeon Assistant				
X-Ray Technician (with therapy)				
X-Ray Technician (without therapy)				
Other Miscellaneous Medical Personnel (specify)				

C.	1.	Are contracted staff required to carry their own Professional Liability insurance?	☐ Yes ☐ No
	2.	Are Certificates of Insurance required as evidence?	☐ Yes ☐ No
	3.	What minimum limits of Professional Liability are required?	$_____/$_____
D.		Are all staff licensed in accordance with applicable state and federal regulations?	☐ Yes ☐ No
E.		Do hiring procedures for all staff include a check of the following:	
	1.	Educational background/Licenses	☐ Yes ☐ No
	2.	Previous employment	☐ Yes ☐ No
	3.	Personal references	☐ Yes ☐ No
	4.	Criminal background	☐ Yes ☐ No
	5.	Hospital privileges for physicians	☐ Yes ☐ No
	6.	License suspensions or revocations or other disciplinary actions	☐ Yes ☐ No
	7.	Drug/alcohol abuse	☐ Yes ☐ No
	8.	Medical professional liability claims history	☐ Yes ☐ No
	9.	If an individual has had a previous claim, license or privilege suspension or revocation, or history of substance abuse, describe how that impacts your procedures for hiring that person. Describe any additional criteria used in the decision process.	
F.		Before staff can provide care, is a competency based checklist used to assess and document their skills? ☐ Yes ☐ No	
G.		What is the turnover rate for physicians?	_____%

VII. STAFF (continued)

H.	What percentage of physicians are American Board Certified?	_____%
I.	Have any physicians been involved in an impaired physician program for substance abuse or mental or nervous disorder? ☐ Yes ☐ No If Yes, please attach details.	
J.	Have any physicians had a license suspended or revoked, or hospital privileges suspended or revoked? ☐ Yes ☐ No If Yes, please attach details.	
K.	Specify hospitals at which the physicians hold staff or courtesy privileges:	

Hospital Name	JCAHO or ADA APPROVED	Type of Privileges
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

VIII. LOSS CONTROL

A.	Does applicant have a Loss Control program? ☐ Yes ☐ No Please describe nature of program.	
B.	Does a Peer Review Committee exist? ☐ Yes ☐ No	
C.	List all accreditations and association memberships held by the applicant and include copies of most recent survey, certification or accreditation.	
D.	Please describe how fee related complaints are handled: _____	
E.	Are informed consent forms used? ☐ Yes ☐ No	
F.	Does applicant use Electronic Medical Records? ☐ Yes ☐ No If no, please describe: _____	
G.	How are records keeping deficiencies handled? _____	
H.	Are all records kept at the Main Facility Location? ☐ Yes ☐ No If No, indicate where and by whom they are kept:	

IX. CLAIMS INFORMATION (Attach current and prior carrier loss runs)

A.	Has a claim or suit for alleged malpractice ever been brought against the applicant or any of its employed or contracted physicians? ☐ Yes ☐ No If Yes, in addition to carrier loss runs, complete a claims supplement for each claim with paid or reserved amounts greater than $50,000.	
B.	Is applicant aware of any circumstances which might reasonably lead to a claim or suit? ☐ Yes ☐ No If Yes, please provide details. Have these circumstances been reported to the current carrier? ☐ Yes ☐ No	

X. CONDITIONS OF APPLICATION

By applying for Professional Liability Insurance from Mt. Hawley Insurance Company, I hereby:

- consent to 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 or their agents, in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;
- hereby certify that if Prior Acts coverage is being requested, we have no knowledge of any professional liability claims which have been asserted against us, or any affiliated professional association, corporation or subsidiary, or of any occurrence, incident, or circumstance likely to result in such claim on or after the requested initial effective date of the Prior Acts coverage, except the following. (Provide a brief description of each such claim, occurrence, incident or circumstance):

_____

_____

_____

_____

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 to Mt. Hawley Insurance Company.

Officer of Applicant	Title	Date

Signing this application does not obligate Mt. Hawley Insurance Company 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 will be void if you withheld any information from us, mislead us, or attempted to defraud or lie to us about any matter contained in this application.