LAMMICO

One Galleria Blvd., Suite 700 ♦ Metairie ♦ Louisiana ♦ 70001
Phone: 504-831-3756 ♦ 800-452-2120
Fax: 504-841-5300 ♦ 504-841-5205
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HOSPITAL APPLICATION FOR PROFESSIONAL LIABILITY, GENERAL LIABILITY AND EXCESS COVERAGES

Instructions:

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space for your responses, continue in the Comments Section indicating question number.

Please check below the coverage(s) for which you are applying and complete the associated section(s) of the application.

- ☐ Section 1: General Demographic and Contact Information (required)
- ☐ Section 2: Professional Liability Coverage
- ☐ Section 3: General Liability Coverage (Occurrence Basis Only)
- ☐ Section 4: Employee Benefits Liability
- ☐ Section 5: Non-Owned & Hired Automobile
- ☐ Section 6: Employers Liability (Excess Coverage Only)
- ☐ Section 7: Supplement for Limited Pollution Coverage

Please attach the following:

1. Carrier Loss History:
   a. Ten years of historical PL and GL losses including current year.
   b. Date of loss valuation must be within the past 90 days.
   c. Loss run must include carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL) and narrative of claim.
   d. Full details of allegations on all losses paid or outstanding in excess of $100,000.
2. For Louisiana submissions, include a copy of the completed Patient's Compensation Fund Hospital Application.
3. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or, if accrediting agency reports are unavailable, please submit the state licensure report with recommendations and the institution's response to any contingencies.
4. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.
5. Copy of current risk management and quality improvement plan.
6. Copy of current organizational chart (corporate and risk management).
7. Copy of claim management procedures.
8. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.
9. Copy of current PL and GL policies, including Declarations Pages and Endorsements.

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10. For Excess/Umbrella coverages, please provide copies of underlying policy Declaration Pages for all applicable coverages (auto, employers' liability, helipad, etc.). Please also provide a 10 year loss run for each underlying coverage.
11. If applicable, copy of underlying auto carrier's loss run for the past five years including the following information: carrier, date of loss, report date, total incurred, status (open or closed) and a narrative of claim. Date of loss valuation must be within the past 90 days.
12. Medical Staff By-laws and Rules and Regulations

The above information is mandatory before an indication can be released. This application must be completed, signed and dated by an authorized officer of the entity. The application is subject to review and acceptance by LAMMICO and does not bind coverage. Additional information may be requested by LAMMICO.

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (1) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

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SECTION 1: GENERAL INFORMATION

☐ New Application ☐ Renewal Application – Expiring Policy Number: _____

Please complete a separate application for EACH hospital location if multiple locations exist. If additional space is needed to answer any questions fully, use the Comments Section or attach a separate page.

Agency Name: (If using Agent)	Agency Address: *(City, State, Zip)*	Producer:

A. APPLICANT INFORMATION

Hospital Name:	NPI Number:	Tax ID# (TIN)

Applicant Mailing Address: *(Street, City, State, Zip)*	Website Address:

Primary Contact Person:	Primary Contact Title:	Primary Contact Phone:	Primary Contact Fax:	Primary Contact Email:

Contact Person (Accounting):	Contact Title (Accounting):	Contact Phone (Accounting):	Contact Fax (Accounting):
Contact Person (Risk Management):	**Contact Title (Risk Management):**	**Contact Phone (Risk Management):**	**Contact Fax (Risk Management):**

Type of Hospital:

☐ General ☐ Children's ☐ Psychiatric ☐ Women's ☐ Rehab ☐ Specialty(type)_____ ☐ Other _____

Applicant's legal structure *(Check all that apply)*:

☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Governmental ☐ Charitable ☐ For Profit ☐ Not for Profit ☐ Medicare Approved

For teaching hospitals, please identify in the Comments Section the type of training program(s) and the number of trainees enrolled in each program in the past 12 months.

Complete the following information for each location you own. Location No. 1 should be the business address for the primary hospital.

Business Name & Address *(Street, City, State, Zip)*	Your Ownership Percentage	Description of Operations	Is this location a subsidiary?	Is coverage desired for this location?
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

List the following details for each **medical professional** that has a financial interest in your hospital.

Name	Profession	Policy No.* *(if LAMMICO insured)*	Interest *(Owner, director, etc.)*	Patient Care For the Facility	Patient Care Outside Practice
				%	%
				%	%

**If not LAMMICO insured please attach copy of current certificate of insurance.*

Indicate the number of years the primary facility has been:

Operating: _____ Owned by present owners: _____ Managed by Present Management: _____

List all licenses held by your facility, including type and expiration dates.	List all accreditations (e.g., JCAHO, DHHS, CAP) and association memberships held by your facility

Has your license been suspended, revoked or placed under probation within the last three years?
(If "yes", please indicate the date and provide details below. Use the Comments Section for additional space if necessary). ..... ☐ Yes ☐ No

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B. CURRENT INSURANCE PROGRAM

Type	Carrier or Self-Insured	Effective Date	Limits	Retro Date	Claims-Made Or Occurrence	Deductible/ SIR	Premium
Primary Prof. Liability							
Primary General Liability							
Excess Coverage							
Umbrella Coverage							
Auto Liability							
Employers' Liability							
Helipad / Aviation							
Other:_____							

Has any insurer cancelled, declined to issue, or non-renewed any of the coverages listed above?..... ☐ Yes ☐ No

(If "Yes", please attach an explanation including the name of the carrier, the date and the reason)

C. PRIOR INSURANCE HISTORY

1. Please list all hospital professional liability and general liability policies for the past ten years.

Policy Period	Carrier	PL Limits (Primary) (per occ / agg)	GL Limits (Primary) (per occ / agg)	Claims-Made Or Occurrence	Deductible/ SIR Amount	Premium

2. Please list all excess / umbrella policies for the past five years.

Policy Period	Insurer	Limits	Retro Date (if applicable)	Premium

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D. PRIOR CLAIMS HISTORY

Is any claim listed in your 10 year claims history subject to a deductible or self-insured retention? ☐ Yes ☐ No

If "Yes", are the amounts shown in your loss history **inclusive** or **exclusive** of the deductible or self-insured retention? _____

If "inclusive", what is the amount of the deductible or self-insured retention? $_____

E. INSURANCE COVERAGE DESIRED

Primary Coverage	Requested Effective Date	Requested Retro Date	Desired Limits	
			Per Claim	Annual Aggregate
Professional Liability (PL)			$	$
General Liability (GL)			$	$
Limited Pollution Liability ($1M max limits)			$	$
Excess / Umbrella				
Excess			$	$
Umbrella			$	$

Include the following as underlying coverages on the Excess/Umbrella (if applicable). Policy information must be indicated in Item B, "Current Insurance Program" section above. Provide policy declaration pages for all applicable coverages.

☐ Auto Liability ☐ Employers' Liability ☐ Helipad/Aviation ☐ Other:_____

F. DEDUCTIBLE / SELF-INSURED RETENTION*

(Deductible / SIR amount applies separately to Professional and General Liability)

☐ **Deductible** ☐ Indemnity Only ☐ Indemnity & Expense

Professional Liability (PL) ☐ None ☐5K/15K ☐ 10K/30K ☐ 25K/75K ☐ 50K/150K ☐ 100K/300K ☐ Other: _____

General Liability (GL) ☐ None ☐5K/15K ☐ 10K/30K ☐ 25K/75K ☐ 50K/150K ☐ 100K/300K ☐ Other: _____

☐ **Self-Insured Retention**

COMPLETE THE FOLLOWING IF CHOOSING THE SIR OPTION

Please provide a copy of the following documents (if applicable):

- Most recent actuarial funding study
- Trust agreement of the self-insured retention or policy form(s) for captive or RRG
- Claims handling policy and procedure manual
- Trust fund or Captive / RRG financials

i. What are the limits of liability for the SIR / Captive / RRG?

$_____ per claim $_____ aggregate

ii. What coverages are contemplated? Specify the claims basis for each line of business:

_____

_____

iii. Is there a dedicated trust? ☐ Yes ☐ No

iv. Has an independent actuarial funding study been completed? ☐ Yes ☐ No

v. Does the ALAE erode the limits of the SIR / Captive / RRG? ☐ Yes ☐ No

vi. Who handles the claims within the SIR / Captive / RRG? _____

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vii. Does the applicant have written policies and procedures regarding incident reporting, claims handling and reserve philosophy?..... ☐ Yes ☐ No

Provide authority levels for setting reserves and determining whether cases are tried or settled:

viii. Is there a specific law firm used to defend claims?..... ☐ Yes ☐ No

If "Yes", provide the name and address of law firm: _____

**Reimbursement amount means the amount you would reimburse LAMMICO following a loss and / or loss adjustment expense payment on your behalf. A letter of credit or deposit may be required to secure deductible. Provider will remain responsible for payment of deductible amounts even after termination of coverage.)*

G. ADDITIONAL ENTITIES REQUIRING COVERAGE

Identify related entities or subsidiaries to be considered for coverage on the policy or attach a list from your current policy. Please use Comments Section for additional entities if needed.

Entity Name: _____

Address: _____

_____

Tax ID No: _____ Retroactive Date: _____

Ownership and relationship to the policyholder: _____

_____

Description of all operations and activities: _____

_____

SECTION 2: PROFESSIONAL LIABILITY INSURANCE

PART I: DESCRIPTION OF SERVICES

i. **MEDICAL PROFESSIONAL SERVICES PROVIDED** *(Check each box that applies for the primary facility listed in this application)*

☐ Abortions	☐ Emergicenter (Free Standing)	☐ Neonatal Intensive Care	☐ Physician's Clinic
☐ Ambulance Services	☐ Fertility Clinic	☐ Nursing Home	☐ Psychiatric
☐ Assisted Living	☐ Gender Reassignment Surgery	☐ Nursery	☐ Pulmonary Rehab Services
☐ Bariatrics	☐ Genetic Counseling/Research	☐ Observation Unit	☐ Radiation Therapy
☐ Bariatric Surgery	☐ HMO	☐ OB/GYN	☐ Refractive Surgery
☐ Birthing Center	☐ Home Health Care	☐ Occupational Health	☐ Robotic Surgery
☐ Blood Bank	☐ Hospice	☐ Offsite Food Service	☐ Skilled Nursing Care
☐ Burn Unit	☐ Hospital Foundation	☐ Oncology	☐ Sleep Disorder Services
☐ Cardiac Cath Lab	☐ Hyperbaric Treatment	☐ Offsite - Other	☐ Sports Medicine
☐ Vascular Lab	☐ Inhalation Therapy	☐ Open Heart Surgery	☐ Surgery (General)
☐ Cardiac Rehab Services	☐ Intensive Care Unit	☐ Organ/Tissue Transplant	☐ Transportation Services
☐ Complimentary Medicine	☐ Laboratory	☐ Outpatient Surgi-Center	☐ Trauma
☐ Coronary Care Unit	☐ Lifeline	☐ Pain Management	☐ Urgent Care (Hospital Based)
☐ Day Care (Adult/Child)	☐ Long Term Care	☐ Pastoral Care	☐ Urgent Care (Free Standing)
☐ Department of Corrections	☐ Medical Advice Line/ TeleMed	☐ Pediatrics	☐ Weight Loss Center
☐ Dialysis	☐ Mobile Units/Services	☐ Pediatric ICU	☐ Wellness/Fitness Services
☐ Emergency Services	(Bloodmobile, Mammography, CT)	☐ Pharmacy	☐ Other _____

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ii. **INPATIENT SERVICES**

BED TYPE	Total # Licensed Beds	Average ADC*	Projected ADC*
1. Acute – Adult			
2. Acute – Pediatric			
3. OB / Maternity (LDRP)			
4. Cribs / Bassinets			
5. ICU / CCU			
6. PICU / NICU			
7. Long Term Acute Care (LTAC) / Extended Care			
8. Psychiatric – Adult			
9. Psychiatric – Adolescent			
10. Chemical Dependency			
11. Trauma Rehab			
12. Skilled Nursing			
13. Swing Beds			
14. Hospice			
15. Other: _____			

**ADC: Average Daily Census: Total annual Inpatient days divided by 365*

SERVICES / PROCEDURES	Number in Current Year	Number in Projected 12 Months
1. Inpatient Surgeries		
2. Births (includes C-Sections & VBAC's)		
3. C-Sections		
4. VBAC's		
5. Other *(Please Specify)* _____		

iii. **OUTPATIENT SERVICES**

SERVICES / PROCEDURES	Number in Current Year	Number in Projected 12 Months
1. Outpatient Surgeries		
2. Outpatient Clinic Visits		
3. Emergency Room Visits		
4. Emergicenter (Free Standing) Visits		
5. Fast Track Visits		
6. All Other Hospital-Based Outpatient Visits* (Radiology, Laboratory, Physical / Occupational Therapy, Psychiatric, Alcohol / Drug Therapy, Counseling, Endoscopic Procedures, etc.)		
7. Home Care – Personal Care		
8. Home Care – Skilled Care		
9. Home Care – Rehabilitation		
10. Home Care – Intravenous Therapy		
11. Home Care – Durable Equipment		
12. Urgent Care (Free Standing) Visits:		
13. Outpatient **Surgery Center** Surgeries		

**Outpatient Visits: Each appearance of an outpatient in a hospital outpatient unit, regardless of the number of procedures / treatments performed within each unit (AHA Def.). Report VISITS to outpatient units, NOT "occasions of service." Report number of visits to patient homes for home health care services. Outpatients are persons, not lodged in the hospital, who receive medical, dental or other health-related services*

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iv. **CLINICS**: List all clinics operated and/or staffed by applicant including all school based clinics. Attach additional schedule if more space needed.

Name & Address of Clinic	Name of MD/PA/NP/Other	Employed (Y/N)	Insured By	Est. Pt. Visits (Current)	Est. Pt. Visits (Proj.)

v. Does the Applicant anticipate any facility expansions (increase in licensed beds, new services) within the next year? ☐ Yes ☐ No

If yes, please provide details: _____

vi. Are any medical services provided by the facility performed in other states? *If yes, please explain and list other states in the Comments Section (i.e., home health, outpatient,* ***telemedicine****, etc.)*..... ☐ Yes ☐ No

vii. Do you provide services to correctional facility inmates?..... ☐ Yes ☐ No

If yes, how often? _____ Name of Facility serviced: _____

viii. Do you use any non-expendable medical, dental or surgical machines or devices for diagnostic monitoring or treatment purposes?..... ☐ Yes ☐ No

If yes, how often is the equipment inspected and maintained? _____

The maintenance is performed by: ☐ Facility Employees ☐ Independent Contractors

If Independent contractor, what limits of liability insurance do you require them to carry? _____

ix. Do you sell or lease any medical equipment or other products in connection with your operation? ..... ☐ Yes ☐ No

If yes, answer the questions below and describe the equipment in the Comments Section.

Do you repackage or redesign the equipment you sell or lease? ..... ☐ Yes ☐ No

If yes, describe in the Comments Section.

Do you service the equipment you sell or lease? ..... ☐ Yes ☐ No

If no, who provides preventative maintenance? _____ *What limits of liability insurance do you require them to carry?* $ _____

What are your annual receipts from the sale or lease of medical equipment? ..... $ _____

For the following questions, please explain all "Yes" answers in the Comments Section.

x. Do you conduct or assist in conducting training programs for other Institutions (Universities, Colleges, etc.)? ..... ☐ Yes ☐ No

xi. Do you conduct formal clinical research under the auspices of an Institutional Review Board (IRB)?..... ☐ Yes ☐ No

xii. Do you conduct medical and / or surgical experimentation that is not approved by an Institutional Review Board (IRB)?..... ☐ Yes ☐ No

xiii. Do you administer non-FDA approved pharmaceuticals (experimental drugs)? ..... ☐ Yes ☐ No

xiv. Do you conduct bio-medical device research and development? ..... ☐ Yes ☐ No

xv. Do you conduct animal research?..... ☐ Yes ☐ No

xvi. Do you purchase separate coverage for clinical trials? ..... ☐ Yes ☐ No

xvii. Is the primary facility named in this application an additional insured under a sponsor's clinical research policy? ..... ☐ Yes ☐ No

xviii. Have you ever received a Regulatory Letter from the Office of Human Research Protections or from the Department of Health & Human Services or any other Regulatory organization? ..... ☐ Yes ☐ No

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PART II – ADMINISTRATION AND STAFF

A. Medical Director

Do you employ / contract a medical director? ☐ Yes ☐ No

If yes, does your Medical Director have direct patient contact? ☐ Yes ☐ No

Name of Medical Director	Specialty	Insurance Carrier and Policy Number*	Board Status	Employment Status
			☐ Board Certified ☐ Eligible	☐ Employee ☐ Contractor

B. Physicians and Surgeons** *(Please complete for each specialty. Use the Comments Section for additional specialties)*

Specialty	Number of Employed Physicians & Surgeons	Number of Contract Physicians & Surgeons	Number of Staff With Privileges

If not LAMMICO insured please attach copy of current certificate of insurance.
****Attach copy of Physician Service Contracts. Separate LAMMICO application is required for coverage.***

C. Allied Health Care Professionals – *Indicate the number of personnel in each applicable category.*

	Employees		Contract			Employees		Contract	
	Full-Time	Part-Time	Full-Time	Part-Time		Full-Time	Part-Time	Full-Time	Part-Time
CRNA's*					Lab Technicians				
Interns*					LPN / LVN's				
Midwives*					Paramedics / EMT's				
Nurse Practitioners*					RN's				
Pharmacists*					X-Ray Technicians				
Physician's Assistants*					Other (describe)				
Perfusionists*									
Residents / Fellows*									
Surgeon's Assistants*									

**Separate LAMMICO application is required for coverage*

Do the pharmacists that are employed by your facility dispense prescriptions to:

Discharged patients ☐ Yes ☐ No
Non-hospital patients ☐ Yes ☐ No

D. Insurance Requirements for the Applicable Staff Listed in B and C Above – *Please explain any "No" answers in the Comments Section.*

1. Are all staff members required to maintain medical professional liability insurance? ☐ Yes ☐ No
2. Is this requirement stated in the staff bylaws?* ☐ Yes ☐ No
3. What limits are required? _____
4. What evidence of compliance is required? _____
5. Are the hospital's Department Chairmen Board Certified in their respective specialties? ☐ Yes ☐ No
6. What percent of the hospital's physicians are Board Certified? _____
7. Are Nurse Midwives subject to the hospital's credentialing process? ☐ Yes ☐ No

If this is a new business submission, or if you have had a change in your bylaw this past year, please submit a copy of the staff bylaw.

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E. Hiring / Screening Procedures

Check below each of the procedures you use when hiring professionals and clinical support staff to provide patient care services at your facility.

☐ Verify educational background, or residency program, when applicable.
☐ Check previous employers.
☐ Check personal references.
☐ Confirm hospital privileges for physicians, oral surgeons and dentists.
How often do you update your list of specific privileges? _____
☐ Check for any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
☐ Check criminal history.
☐ Require information regarding medical professional claims history that resulted from the performance or failure to perform professional services.
If an individual has had a previous claim, how does that impact your procedures for hiring that person? Are any additional criteria applied?

_____

_____

Are each of the above procedures you follow documented? ..... ☐ Yes ☐ No
(If no, please explain in the Comments Section.

What training do you provide for new clinical support staff (e.g., aides, technicians)?

_____

_____

Indicate the type of employees for which you have written job descriptions? ☐ Professionals ☐ Clinical Support Staff ☐ None

PART III – CONTRACTUAL AGREEMENTS

A. Does your facility have any signed contracts which require your facility to name another party as additional insured or extend contractual indemnity coverage? *(If "yes", please include a copy of contract)* ..... ☐ Yes ☐ No

B. Do you lease or rent any medical equipment from others? ..... ☐ Yes ☐ No

If yes, describe. _____

If yes, do you indemnify (hold harmless) the owner for liability? ..... ☐ Yes ☐ No

C. Have you signed any contractual agreements where you have agreed to provide services to others? ..... ☐ Yes ☐ No

If yes, describe the types of services. _____

D. Have you signed any contractual agreements where others are providing services to you? ..... ☐ Yes ☐ No
(If "yes", please specify below and include the minimum professional liability limits required)

	Limit		Limit
☐ Emergency Room	$ _____	☐ Physical / Occupational Therapy	$ _____
☐ Laboratory / Pathology	$ _____	☐ Respiratory Therapy	$ _____
☐ Pharmacy	$ _____	☐ Nursing Services	$ _____
☐ Radiology / Nuclear Medicine	$ _____	☐ Housekeeping	$ _____
☐ Anesthesia	$ _____	☐ Laundry	$ _____
☐ Home Health Care	$ _____	☐ Other _____	$ _____
☐ Ambulance Services	$ _____	☐ Other _____	$ _____

Do you require proof of this coverage? *If no, please explain in the Comments Section* ..... ☐ Yes ☐ No

E. Is any part of your facility operated/leased by a management corporation?
(If "yes", please include a copy of contract). ..... ☐ Yes ☐ No

F. Is your facility involved in the management of any other facility, hospital services or health care provider?
(If "yes", please include a copy of contract). ..... ☐ Yes ☐ No

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PART IV – RISK MANAGEMENT

A. Do you have a full-time Risk Manager? ☐ Yes ☐ No

If "*Yes*", please provide a job description and Curriculum Vitae for your current Risk Manager. If other than full-time, indicate nature of employment activities *(i.e., Quality Improvement, Safety Coordinator, etc.)*

B. Is there a written, formalized Risk Management program? *(If yes, please attach a copy of the program)* ☐ Yes ☐ No

Is the program reviewed for effectiveness and necessary changes implemented? ☐ Yes ☐ No

C. Do you have a formalized Quality Improvement program? *(If yes, please attach a copy of the program)* ☐ Yes ☐ No

D. Do you have a formalized Patient Safety program? *(If yes, please attach a copy of the program)* ☐ Yes ☐ No

E. Do you have a formalized Evacuation Plan? *(If yes, please attach a copy of the plan)* ☐ Yes ☐ No

PART V – ADMISSION / DISCHARGE CRITERIA

A. Is there an admission policy in place? *If no, please explain in the Comments Section* ☐ Yes ☐ No ☐ N/A

B. Are there record and chart protocols in place? *If no, please explain in the Comments Section* ☐ Yes ☐ No ☐ N/A

C. Is there a discharge policy in place? *If no, please explain in the Comments Section* ☐ Yes ☐ No ☐ N/A

D. How long are orders, consent forms and charts maintained? _____

PHYSICAL / SEXUAL ABUSE COVERAGE

PART I – GENERAL INFORMATION

A. Do you have Abuse Coverage with your current carrier? ☐ Yes ☐ No

If 'Yes', please provide a copy of the current endorsement or policy language.

What are the current Abuse limits on your policy? _____

B. Are you aware of any type of abuse (physical, emotional, financial, sexual, etc.) that has occurred in your facility? ☐ Yes ☐ No

C. Do background checks of prospective employees and volunteers include information on all criminal convictions, abuse registry / sex related or child-abuse related offenses? ☐ Yes ☐ No

D. Are employment related references verified during hiring? ☐ Yes ☐ No

E. Is there a written policy outlining management's commitment to sexual abuse prevention? *(If 'Yes', please attach a copy)* ☐ Yes ☐ No

F. Are all staff and volunteers trained in policies and procedures related to sexual abuse prevention and the consequences of non-adherence at all locations? *(If 'No', please explain in Comments Section)* ☐ Yes ☐ No

PART II – LOSS HISTORY

A. Are you aware of any facts, incidents, circumstances, or allegations that may result in an abuse or molestation claim against you? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

B. Have you, any employee, counselor, independent contractor, sub-contractor, volunteer, 'others' or officers currently seeking coverage been involved in an allegation or claim relating to abuse or molestation? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

C. In the past 5 years, have any employees, counselors, independent contractors, sub-contractors, volunteers, 'others' or officers been disciplined, terminated or transferred due to their suspected or actual involvement in abusive behavior? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

PART iii – POLICIES & PROCEDURES

A. Are the below items included in the code of conduct handbook for all employees, contractors and volunteers?

i. Zero tolerance statement for abuse perpetrated on children or other persons in the applicant's care *(Please attach a copy)* ☐ Yes ☐ No

ii. Written policy that defines appropriate and inappropriate displays of affection. *(Please attach a copy)* ☐ Yes ☐ No

iii. Written procedure governing interactions between employees, contractors and volunteers when alone with children or other persons in your care. *(Please attach a copy)* ☐ Yes ☐ No

B. Do you have a written procedure for responding to reports of suspicious or inappropriate behavior or allegations of abuse? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

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C. Do you have a designated investigator with specialized training in charge of handling sexual misconduct investigations? ☐ Yes ☐ No

D. Do you use a standardized incident reporting form across all locations and programs? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

E. Are management / staff and volunteers training in policies and procedures relating to the abuse and molestation program? ☐ Yes ☐ No

F. Are complete records maintained documenting adherence to all applicable policies and procedures (e.g., hiring & screening, code of conduct, training, incident & follow up, etc.)? ☐ Yes ☐ No

G. Is there a formal procedure concerning when appropriate law enforcement authorities are called when there is a suspected incident of abuse or molestation? *(If 'Yes', please explain in Comments Section)* ☐ Yes ☐ No

INPATIENT MEDICAL SERVICES

PART VI – ANESTHESIA SERVICES ☐ N/A

A. Anesthesia Staffing is provided by: *(Check all that apply)*

☐ Employed Physicians ☐ Contract Physicians ☐ Residents ☐ CRNA's

B. If you checked "CRNA's" in question A, indicate the relationship between the Applicant and the CRNA's below.

Employed by the Applicant ☐ Yes ☐ No

Employed by the Anesthesiologist ☐ Yes ☐ No

Employed by the Surgeon ☐ Yes ☐ No

Independent ☐ Yes ☐ No

Do CRNA's work under the direct supervision of an anesthesiologist? ☐ Yes ☐ No

If "*No*", please submit written guidelines developed with the collaborative physician or qualified physician designee of the primary physician or the dentist responsible for the patient's immediate care.

C. Describe the minimum qualifications required for the administration of general anesthesia

_____

_____

PART VII – EMERGENCY DEPARTMENT ☐ N/A

A. What level of service is the Emergency Department?

☐ Level I (Tertiary) ☐ Level II (Comprehensive) ☐ Level III (Basic) ☐ Trauma Center ☐ Stand-by Services Only

☐ Other (Describe): _____

B. Emergency Department staffing is provided by: *(Check all that apply)*

☐ Employed Physicians ☐ Contract Physicians ☐ Residents ☐ Rotating Staff ☐ Mid-level Providers

☐ Other (Describe): _____

If under contract, to whom is staffing contracted? _____

C. If contract group, are certificates of insurance required? ☐ Yes ☐ No

D. If contract group, what are the minimum required limits of insurance? $ _____ Per claim $ _____ Aggregate

E. If in a Patients' Compensation Fund state, do all members of the contract group participate in the PCF? ☐ Yes ☐ No

F. Are all physicians board certified or eligible in emergency medicine? ☐ Yes ☐ No

G. If *"No"*, are they ACLS or PALS certified? ☐ Yes ☐ No

H. Are the emergency physicians required to respond to cardia/respiratory arrests or other medical emergencies occurring in the facility? ☐ Yes ☐ No

I. Do Emergency Department physicians write admitting orders? ☐ Yes ☐ No

J. Is a patient triage system present? ☐ Yes ☐ No

K. Who performs triage? _____

L. Are clinical pathways present for conditions such as chest pain, CHF, women with abdominal pain, children with fever, etc.? ☐ Yes ☐ No

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M. Is the Emergency Department open and staffed by a physician 24 hours/day, 7 days/week? ☐ Yes ☐ No

N. Are paramedics / EMT's in radio contact with an ED physician for orders? ☐ Yes ☐ No

O. Do paramedics / EMT's execute treatment according to standard and approved protocols? ☐ Yes ☐ No

P. Do any of the emergency department staff routinely work more than a 12-hour shift? ☐ Yes ☐ No

Q. Has the hospital ever been cited for violating EMTALA? ☐ Yes ☐ No

If "*Yes*" please provide details: _____

PART VIII – RADIOLOGY SERVICES ☐ N/A

A. Radiology staffing is provided by: *(Check all that apply)*

☐ Employed Physicians ☐ Contract Physicians ☐ Residents

B. Are all physicians board certified or eligible? ☐ Yes ☐ No

C. If under contract, to whom is staffing contracted? _____

D. If a contract group, what are the minimum required limits of insurance? _____

E. If in a Patients' Compensation Fund state, do all members of the contract group participate in the PCF? ☐ Yes ☐ No

F. If Employed Radiologists, do they provide services to other entities? If yes, please describe below ☐ Yes ☐ No

_____

G. If Tele-radiology is in use, please describe how below: ☐ N/A

_____

PART IX – SURGERY ☐ N/A

A. Is there any surgical involvement with residents? ☐ Yes ☐ No

If "*Yes*", to what extent? _____

B. Can a resident perform surgery without the direct supervision of an attending physician? ☐ Yes ☐ No

If "*Yes*", please provide details in the "Comments" Section of the application

C. Are any of the following procedures performed at your facility?

☐ Experimental Surgery ☐ Pediatric Surgery ☐ Neuro Surgery ☐ Transplants

If any of these procedures are performed at your facility, please provide full details as to the specific procedure(s) performed and the number of each performed on an annual basis.

D. Does an informed consent discussion take place between the patient and surgeon that includes the possible risks and alternatives? ☐ Yes ☐ No

E. Is the informed consent discussion documented in the medical record? ☐ Yes ☐ No

F. Is a written policy / procedure present for surgical site identification? ☐ Yes ☐ No

G. Is a time-out called in the OR prior to the beginning of the procedure? ☐ Yes ☐ No

H. Are sponge, needle and instrument counts performed in the course of a surgical procedure? ☐ Yes ☐ No

If "*Yes*", at what intervals of the operation? _____

I. Are patients called following discharge from ambulatory surgery? ☐ Yes ☐ No

If "*Yes*", how is it documented? _____

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PART X – BARIATRICS ☐ N/A

A. Do you perform Bariatric surgeries at your facility? ☐ Yes ☐ No

B. Do you follow the guidelines from the American Society for Bariatric Surgery (ASBS)? ☐ Yes ☐ No

C. Do you have a well-documented procedure for selecting surgical candidates? ☐ Yes ☐ No

D. Are physicians performing this procedure credentialed specifically for Bariatric surgery? ☐ Yes ☐ No

PART XI – TRANSPLANT ☐ N/A

A. Number of tissue donations: _____ Past 12 months Projected next 12 months: _____

B. Number of organ donations: _____ Past 12 months Projected next 12 months: _____

C. Accredited by: ☐ Assn. of Organ Procurement Organization ☐ Eye Bank Assn. of America
☐ American Assn of Tissue Banks ☐ Other: _____

D. Does the hospital have a formal policy regarding the informed consent process? ☐ Yes ☐ No

E. Has the hospital been involved in any tissue FDA recalls? ☐ Yes ☐ No
If "*Yes*", please explain: _____

F. Has the hospital initiated any voluntary tissue recalls in the past 5 years? ☐ Yes ☐ No
If "*Yes*", please explain: _____

G. Are any tissues procured / recovered from outside the U.S.? ☐ Yes ☐ No
If "*Yes*", please explain: _____

H. Are any non-human tissues used in any way in the hospital? ☐ Yes ☐ No
If "*Yes*", please explain: _____

I. Do you accept "John Doe" donors? ☐ Yes ☐ No

J. Do you participate in a living donor program? ☐ Yes ☐ No

PART XII – OBSTETRICS (OB) ☐ N/A

A. What level of Maternal care do you provide to the community?

☐ Birthing Center ☐ Level I / Basic (Birthing Ctr & limited High Risk) ☐ Level II / Specialty (Higher Risk-OB Provider & Anesthesia 24/7)

☐ Level III / Subspecialty (Complex Risk) ☐ Level IV / Regional Perinatal Health Care Center (Critical Risk)

If your facility is a Maternal level of care I – III, does the hospital have a written procedure governing the transferring of all high risk mothers and / or babies the hospital is not qualified to treat? ☐ Yes ☐ No

B. What level of Newborn care do you provide to the community?

☐ Level I / Well Newborn Nursery ☐ Level II / Special Care Nursery ☐ Level III / NICU ☐ Level IV / Regional NICU

C. Is a full-time neonatologist on duty 24 hours-per-day ☐ Yes ☐ No

D. If the hospital does not have a NICU, how many neonates are transferred to other hospitals annually? _____

E. Is electronic fetal monitoring (EFM) utilized on all patients in active labor? ☐ Yes ☐ No
If "*No*", please explain in the Comments Section

F. Is there an obstetrician on site 24 hours-per-day? ☐ Yes ☐ No
If "*No*", is there an obstetrician on call 24 hours-per-day? ☐ Yes ☐ No
If "*No*", please explain in the Comments Section

G. Can caesarean sections be performed within 30 minutes at all times? ☐ Yes ☐ No

H. Does a pediatrician attend emergency caesarean sections ☐ Yes ☐ No
If "*No*", is another physician or other qualified person skilled in neonatal resuscitation available and dedicated to the neonate? ☐ Yes ☐ No

I. Who provides anesthesia during labor and delivery? _____

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J. Is an anesthesiologist or CRNA dedicated to labor and delivery? ☐ Yes ☐ No

If "*Yes*", are they available on site 24 hours-per-day? ☐ Yes ☐ No

If "*No*", what is the maximum time for arrival at the hospital? _____

K. Please indicate below who else besides obstetricians are privileged to perform deliveries, caesarean sections and VBAC's

	Deliveries	C-Sections	VBAC's
Family Practitioner	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Certified nurse mid-wife	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Resident	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Year of residency & area of practice			
Other: _____	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

L. Are elective procedures, inductions or caesarean sections performed at 40 completed weeks or greater? ☐ Yes ☐ No

M. Are deliveries performed outside of the hospital? ☐ Yes ☐ No

If "Yes", please explain: _____

N. Is there a hospital security system to limit infant abduction with constant uninterrupted monitoring? ☐ Yes ☐ No

O. Are abduction drills conducted? ☐ Yes ☐ No P. How frequently are drills conducted? _____

Q. Have you ever had an infant abduction? ☐ Yes ☐ No

If "*Yes*", describe changes made to prevent future abductions: _____

R. Are nurses required to participate in electronic fetal monitoring training and testing? ☐ Yes ☐ No How often? _____

S. Are physicians required to participate in electronic fetal monitoring training and testing? ☐ Yes ☐ No How often? _____

T. If RN's perform medical screening exams (MSE's) independently, do they receive special training that includes physician supervision prior to performing independently? ☐ Yes ☐ No

PART XIII – BEHAVIORAL HEALTH SERVICES ☐ N/A

A. Are inpatient behavioral health services provided? ☐ Yes ☐ No

If "*Yes*", please provide the following percentage of patients:

Geriatric: _____ % Adult: _____ % Adolescent: _____ % Pediatric: _____ % Other: _____ _____ %

B. Are patients separated based on age, gender or other criteria? ☐ Yes ☐ No

If "*Yes*", please explain in the Comments Section

C. Are patients admitted with a primary diagnosis of chemical dependency? ☐ Yes ☐ No

D. Are patients separated based on age, gender or other criteria? ☐ Yes ☐ No

E. Are policies and procedures present to address patient security? ☐ Yes ☐ No

F. Are elopement drills conducted? ☐ Yes ☐ No

G. Is the medical director board certified in psychiatry? ☐ Yes ☐ No

H. Is there a policy / procedure for management of medically ill patients? ☐ Yes ☐ No

I. Is electroconvulsive therapy (ECT) performed? ☐ Yes ☐ No

If "*Yes*", are policies / procedures present to address informed consent, sedation, post procedure monitoring, etc.? ☐ Yes ☐ No

J. Are outpatient behavioral health services provided? ☐ Yes ☐ No

If "*Yes*", please explain in the Comments Section

K. Is service to clients provided in group homes or other residential settings? ☐ Yes ☐ No

If "*Yes*", please explain in the Comments Section

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OTHER SERVICES

PART XIV – AMBULANCE SERVICE ☐ N/A

A. Does your hospital own or operate an Ambulance Service? ☐ Yes ☐ No

If "Yes", please complete the following below

B. # of Vehicles: _____ C. # of Runs to your facility per Year: _____ D. # of Runs to other facilities per year: _____

E. # of Paramedics, EMTs, etc. (FTE – Full-time equivalents) _____ F. Number of EMT students _____

G. Does your ambulance service pickup and deliver to other Emergency rooms besides yours? ☐ Yes ☐ No

H. Are paramedics/EMTs in radio contact with and ED physician for orders? ☐ Yes ☐ No

I. Do paramedics/EMTs execute treatment according to standard and approved protocols? ☐ Yes ☐ No

J. Does the hospital have a transport team (ground or air)? ☐ Yes ☐ No

PART XV – BLOOD BANKS ☐ N/A

A. Do you own and / or operate a blood bank? ☐ Yes ☐ No

If "*No*", what organization(s) is your supplier? _____

B. Please identify the screening test(s) utilized by the hospital: _____

C. Accredited by: ☐ AABB ☐ ARC ☐ ABC ☐ CAP ☐ CCBC ☐ ABRA ☐ Other: _____

D. Is any blood or blood product bought or obtained from outside the U.S.? ☐ Yes ☐ No

If "*Yes*", please explain: _____

E. Does the blood bank outsource its blood testing? ☐ Yes ☐ No

If "*Yes*", please provide details: _____

F. Annual number of volunteer and paid donations: _____ G. Annual number of pheresis procedures: _____

H. Annual number outpatient transfusions: _____ I. Annual number of therapeutic plasma exchanges: _____

PART XVI – DAY CARE ☐ N/A

A. Do you own or operate a day care center? ☐ Yes ☐ No

On Premises? ☐ Yes ☐ No Open to the Public? ☐ Yes ☐ No

Avg. Number of children / day: _____ Number of days / week: _____ Ratio of caregivers to children: _____

Maximum number of children the facility will accommodate? _____ Age Range? _____

B. Is a copy of the center's Discipline Policy posted? ☐ Yes ☐ No

C. Is the Center licensed by the state? ☐ Yes ☐ No

D. Is the Center currently in good standing? ☐ Yes ☐ No

E. Are all Day Care Center employees screened prior to hiring? (criminal background checks, drug screens) ☐ Yes ☐ No

If "*Yes*", by what process? _____

F. Is there a playground on site? ☐ Yes ☐ No

If "*Yes*", what type of impact attenuation materials were used on the surface? _____

How is the site made secure for children? _____

G. Has the center been tested for lead levels? ☐ Yes ☐ No

If "*No*", please explain _____

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PART XVII – HOME HEALTH ☐ N/A

A. Do you provide Home Health Services? ☐ Yes ☐ No

B. What are the types of visits? ☐ Skilled ☐ Personal ☐ Respiratory ☐ Rehabilitation ☐ Intravenous Therapy
☐ Durable Medical Equipment (Receipts) ☐ All Other: _____

C. Describe the scope of service (i.e., ventilators, dialysis, IV therapy, chemotherapy, DME, home care, pharmacy, etc.):

_____

D. Is certification required for home health aides by NAHC or other? ☐ Yes ☐ No

Please provide your policy / procedure for on-site scheduled and unscheduled supervisory visits.

PART XVIII– LONG TERM CARE ☐ N/A

A. Are the long-term care beds located within the hospital? ☐ or in a stand-alone facility? ☐

B. Is the stand-alone facility located on the hospital premises? ☐ Yes ☐ No

C. Does the stand-alone facility fall under the hospital's Risk Management? ☐ Yes ☐ No

D. Does the stand-alone facility follow policies and procedures established by the hospital? ☐ Yes ☐ No

SECTION 3: GENERAL LIABILITY INSURANCE

Please attach a separate schedule of locations including address, primary function (clinical, administrative, storage, etc.) and square footage.

NOTE: THIS IS OCCURRENCE COVERAGE ONLY

PART I – APPLICANT FACILITIES

Location	Total Area (sq. ft.)	Age	Type of Construction	Number of Floors	Type of Fire Protection*
Patient Care Building(s):					
Other Buildings:					
Garages:					
Parking Lots:					
Vacant Lots:					

***Fire protection key:** AS – Approved Sprinkler S – Smoke Detector H – Heat Detector A – Automatic Alarm

PART II – APPLICANT OPERATIONS

Do any of the facilities listed in Part I above have: *(Explain all "Yes" answers in the Comments Section)*

A. An exposure to flammables, explosives, chemicals? ☐ Yes ☐ No

B. A catastrophe exposure? ☐ Yes ☐ No

C. An exposure to radioactive materials? ☐ Yes ☐ No

D. Any operations involving the storage, treatment, discharge, application, disposal or transport of hazardous materials? ☐ Yes ☐ No

E. Any elevators or escalators that are owned by you? ☐ Yes ☐ No

(If "Yes", please indicate the model and if the elevator and / or escalator is serviced by you under a maintenance contract)

_____

F. Parking facilities? ☐ Yes ☐ No

(If "Yes", please indicate if the parking facilities are owned or rented) ☐ Owned ☐ Rented ☐ Maintained

G. Recreation Facilities / Health Club? ☐ Yes ☐ No

(If "Yes", please indicate the annual number of members / users of the facility) _____ *Estimated Annual Gross Receipts:* _____

Are the Recreation Facilities / Health Club open to the public? ☐ Yes ☐ No

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H. A swimming pool on the premises? ☐ Yes ☐ No

(If "Yes", please describe how and when used) _____

Are there supervising staff? ☐ Yes ☐ No

Are the supervising staff CPR certified? ☐ Yes ☐ No

I. Any sponsored sporting or social events? ☐ Yes ☐ No

(If "Yes", please indicate the annual number of events) _____ *(Is alcohol served at any of these events?)* ☐ Yes ☐ No

J. Any off-site events such as health fairs or screenings? ☐ Yes ☐ No

K. A Heliport? ☐ Yes ☐ No

(If "Yes", state by location where each pad is located (e.g., parking lot, top of building, etc)):

_____

Please describe the type of construction: _____

Is the heliport separately insured? ☐ Yes ☐ No

Does the hospital obtain a certificate of insurance from the helicopter service? ☐ Yes ☐ No

Is the hospital named as an additional insured on the helicopter service's policy? ☐ Yes ☐ No

Is the heliport: ☐ Owned? ☐ Leased? *(Please check one)* What is the number of annual landings? _____

L. A Gift Shop? ☐ Yes ☐ No

M. A Cafeteria? ☐ Yes ☐ No

N. Security Guards? ☐ Yes ☐ No

If "Yes", are the Security Guards armed? ☐ Yes ☐ No

(If the Security services are contracted, please provide a copy of any contract agreements)

O. Does the facility's Attorney review and approve all sales literature, advertisements and brochures prior to their use? *(Attach copies of your sales and advertising materials)* ☐ Yes ☐ No

P. Does the facility's Risk Manager review and approve all sales literature, advertisements and brochures prior to their use? *(Attach copies of your sales and advertising materials)* ☐ Yes ☐ No

PART III – PRODUCT / SERVICES INDEMNIFICATION

A. Estimated annual sales of medical equipment supplies: $ _____

B. Estimated annual receipts from any Retail Pharmacy operation $ _____

C. Estimated annual rental receipts of medical equipment: $ _____

D. Estimated annual receipts from servicing equipment of others: $ _____

E. Do you obtain revenue from contracting with others for services (i.e., laundry, food, maintenance)? ☐ Yes ☐ No

If yes, sales from service contract: $ _____

F. Do you modify the design or function of any medical equipment? ☐ Yes ☐ No

If yes, please explain:

_____

_____

G. Describe any other products or services _____

_____

_____

PART IV – ADDITIONAL INTEREST / CERTIFICATE RECIPIENT

A. Does your facility have any signed contracts which require your facility to name another party as an additional insured or extend contractual indemnity coverage? *(If "Yes", please include a copy of contract)* ☐ Yes ☐ No

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SECTION 4: EMPLOYEE BENEFITS LIABILITY

PART I – LIMITS DESIRED

A. PRIMARY EMPLOYEE BENEFITS LIABILITY LIMITS

☐ $100,000 Per Claim / $300,000 Total Annual Aggregate
☐ $500,000 Per Claim / $500,000 Total Annual Aggregate
☐ $1,000,000 Per Claim / $3,000,000 Total Annual Aggregate

PART II – CURRENT CARRIER INFORMATION

A. Name of Employee Benefits Carrier: _____

B. Policy Number: _____ C. Expiring Limits: _____ D. Expiration Date: _____ E. No. of Employees: _____

F. Are Employee Benefits Self-Administered? ☐ Yes ☐ No

If "Yes", what is the name of the vendor? _____

SECTION 5: EXCESS AUTOMOBILE COVERAGE

Minimum primary limits required for Excess Coverage are $1M. A copy of your current Automobile Coverage Declarations Page is mandatory for Excess Coverage to be provided.

PART I – EXCESS AUTO LIABILITY LIMITS DESIRED

☐ $1,000,000 Per Claim ☐ $2,000,000 Per Claim ☐ $3,000,000 Per Claim ☐ $4,000,000 Per Claim
☐ Higher Limits (refer to company)

A. Number of hospital owned autos / emergency vehicles _____ B. Expiring Auto Liability Premium $ _____

C. Name of primary insurance co. on those owned vehicles: _____

D. Policy Number: _____ E. Expiring Limits: _____

F. Expiration Date: _____ G. Uninsured Motorists (yes or no) ☐ Yes ☐ No

PART II – VEHICLE INFORMATION – COMPLETE OR ATTACH SEPARATE LISTING:

Vehicle Type	# of Vehicles	Use / Purpose
A. Private Passenger		
B. Light Truck / Van (non-patient transport)		
C. Van / Small Bus (non-emergency transport)		
D. Bus (include # of passengers in "Use / Purpose)		
E. Emergency Ambulance		
F. Other		

In the past five years, have you had any automobile losses that exceeded $100,000? ☐ Yes ☐ No

Please provide a copy of your automobile loss runs for the last five years

PART III – NON-OWNED AUTO AND HIRED AUTO LIABILITY INSURANCE

A. Does your current Automobile policy include Non-owned and Hired Liability Coverage? ☐ Yes ☐ No

If "Yes", please complete items B and C below. If "No", skip to item D.

B. Do any of the Hospital's Executive Officers, employees, volunteers and / or students use their owned autos in the course of the hospital's business? ☐ Yes ☐ No

If "Yes",

i. How often does this occur on a monthly basis?

ii. Are patients ever transported in personal vehicles? *(If "Yes", please explain in Notes section)* ☐ Yes ☐ No

iii. Does the hospital require such personnel to maintain personal automobile liability insurance with limits equal to, or greater than, the applicable state's minimum financial responsibility law? ☐ Yes ☐ No

(If "No", please explain in Notes section)

C. How often per month does the hospital or its members lease, hire, rent or borrow an auto? _____

D. What is the average monthly expense to lease, hire, rent or borrow an auto? _____

E. Do you require primary Non-owned and Hired Liability Coverage? *(If "Yes" complete separate Supplemental Application to determine if coverage can be provided)* ☐ Yes ☐ No

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SECTION 6: EMPLOYERS LIABILITY (EXCESS ONLY)

Minimum primary limits required for Excess Coverage are $1M.

PART I – EXCESS EMPLOYERS LIABILITY LIMITS DESIRED

☐ $1,000,000 Per Claim ☐ $2,000,000 Per Claim ☐ $3,000,000 Per Claim ☐ $4,000,000 Per Claim
☐ Higher Limits (refer to company)

PART II – CURRENT WORKERS COMPENSATION / EMPLOYERS LIABILITY COVERAGE

A. Name of Workers' Compensation Carrier: _____

B. Policy Number: _____ C. Expiring Limits: _____ D. Expiration Date: _____ E. No. of Employees: _____

SECTION 7: SUPPLEMENT FOR LIMITED POLLUTION COVERAGE

PART I – ADDITIONAL INFORMATION REQUIRED

Please include the following additional information with your application:

1. State Certification for Incinerator, if applicable.
2. Any contracts for disposal of infectious waste.
3. Copy of maintenance records demonstrating state compliance for leak detection.
4. Certification of installation for *each* storage tank.
5. Copies of Certificate of Insurance furnished you by others providing other insurance for any item(s) mentioned in the "*Storage Tanks*" section below.

PART II – INCINERATORS

A. Do you operate an incinerator? ☐ Yes ☐ No

If yes, who is responsible for disposal of infectious waste and maintenance of incinerator?

_____

B. Do you contract for services? ☐ Yes ☐ No

If yes, with what company? _____

Please indicate the EPA # of the company named above: _____

PART III – NUCLEAR MEDICINE / HAZARDOUS WASTE

A. What kinds of pollutant or toxic wastes do you generate and dispose of (check all that apply)?

i. Chemical: Toxic ☐ Yes ☐ No
Reactive ☐ Yes ☐ No
Corrosive ☐ **Yes** ☐ **No**

ii. Organic (i.e., bacteriologic, viral, etc.): ☐ Yes ☐ No

iii. Radioactive: ☐ Yes ☐ No

iv. Other: _____ ☐ Yes ☐ No

B. Do you operate a nuclear medicine department at this facility (or any subsidiary, site or location listed in "Section 1 – General Information" at the beginning of this application? ☐ Yes ☐ No

C. If "*Yes*", list below and indicate what substance(s) are used and disposed of on a regular basis

_____

_____

D. Does this facility have and promulgate a policy on the handling, disposal and management of pollutants? ☐ Yes ☐ No

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PART IV – STORAGE TANKS

A. Do you have storage tanks? ..... ☐ Yes ☐ No

If "*Yes*", please complete the following questions.

1. Do you own the tanks? ..... ☐ Yes ☐ No
2. Please complete the chart below for each tank

TANK	1	2	3	4	5	6	7	8	9	10
Capacity of tank (gallons)										
Age of tank (years)										
Installation date (month / year)										
Was the tank new upon installation (Y / N)?										
Was tank precision tested after installation (Y / N)?										
Is tank below ground (Y / N)?										
Material stored in tank (indicate by "X" under appropriate tank)										
Gasoline										
Diesel										
Kerosene										
Heating Oil										
Other:										
Construction of tank (indicate by "X" under appropriate tank)										
Tank in vault										
Double walled tank										
Fiberglass Steel Coated										
Cathodically protected steel										
Fiberglass										
Fiberglass lined steel tank										
Spill / Overfill protection (Y / N)?										
Leak detection (Y / N)?										
Are tanks in compliance w/ State & Federal regs (Y / N)?										
How often are tanks tested?										

B. Environmental Factors:

i. What is the distance to the nearest surface water source? _____

ii. What is the distance to the nearest drinking water source? _____

iii. What is the depth to the groundwater? _____

iv. What is the distance to the sewer line hook-up? _____

LAMMICO

One Galleria Blvd., Suite 700 ♦ Metairie ♦ Louisiana ♦ 70001
Phone: 504-831-3756 ♦ 800-452-2120
Fax: 504-841-5300 ♦ 504-841-5205
www.lammico.com

SECTION 8: APPLICANT NOTICE AND DECLARATION

The Applicant expressly represents and warrants that the above statements and facts are true and correct and that no material facts have been suppressed or misstated. Applicant specifically acknowledges that LAMMICO has relied on statements contained in this application to issue coverage, particularly as to claims made and prior acts or retro coverage as to disclosing all incidents occurring in the last ten (10) years where Applicant knows or has reason to believe a claim may be made in the future. Any failure to disclose material facts affecting coverage, losses and premiums, including incidents that have occurred at the time of this application, but not made until after coverage is instituted may constitute a material misrepresentation or fraud causing the denial of coverage.

I understand the submission of this application does not bind LAMMICO to issue me, or our institution to purchase, this insurance. By signing below, I grant permission (1) to LAMMICO to contact third parties and (2) for third parties to release to LAMMICO information which relates to the issuance and continuation of this coverage. I also understand that knowingly providing false, incomplete or misleading information to LAMMICO the purpose of defrauding LAMMICO may constitute a crime punishable by imprisonment, fines, and/or a denial of insurance benefits.

I represent the information provided in this application (and attachments) is true. I understand (1) that this application and any previous applications are the basis of and will become a part of the coverage contract with LAMMICO; (2) that the application information I provided is material to LAMMICO; (3) that LAMMICO is relying on this information in determining whether to issue a coverage contract and in establishing the premium to charge for the contract; and (4) that LAMMICO may rescind or void the coverage contract if this application or any previous application contains any misrepresentations or omission. Furthermore, I understand that my failure to disclose to LAMMICO any material fact that I become aware of subsequent to the completion of this application but prior to the effective date of the coverage may also void the contract.

Applicant Signature	Title	Date

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application of insurance is guilty of a crime and may be subject to fines and confinement in prison.

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COMMENTS SECTION