



Diagnostic Imaging Facilities

Claims-Made Professional Liability Coverage Application

Instructions:

1. **Please read the instructions carefully.** Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. **All application questions must be fully answered.** If a question does not apply, please write "N/A".
3. **If more space is needed,** continue on a separate sheet of the applicant's letterhead and indicate the question number.
4. **To this application, please attach copies of:**
 - a. Marketing or Advertising brochures or descriptive materials provided to clients.
 - b. Latest annual financial statement.
 - c. Claim loss runs for the past 5 or more years for all coverages being applied for.
 - d. If the applicant is a new business submit professional qualifications (i.e. resume or C.V.) of each owner, partner, officer and key employee.
 - e. Most recent state survey reports and accreditation survey reports as applicable.
 - f. Quality Improvement/Risk Management plan.
5. **This application must be completed, signed and dated** by a principal of the business.

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, podiatrist, osteopath and psychiatrist. These medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

I. GENERAL INFORMATION

1. Name of Applicant (legal name): _____
 2. Physical Address: _____
 3. Mailing Address: (if different) _____
 4. Corporate Address (if different) _____
- City: _____ State: _____ Zip Code: _____ County: _____
5. Corporate Contact: _____ E-Mail Address: _____
- Tel. Number: () _____ Fax Number: () _____ Website: _____
6. Date Established: _____

<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	<input type="checkbox"/> Professional Assoc
<input type="checkbox"/> For Profit	<input type="checkbox"/> Not for Profit	<input type="checkbox"/> Individual
 7. In what state(s) is the Applicant registered and licensed to practice? _____
 8. Please specify any professional societies or associations which you are a member: _____

II. COVERAGE/LIMITS/DEDUCTIBLES

Indicate which coverages you are applying for: (if you are applying for any of the GL coverages, also complete a supplemental application)

- Professional Liability Employee Benefits Liability Non-Owned Auto General Liability Sexual Molestation/Abuse

1. Requested Effective Date: _____
2. Requested Prior Acts Date _____
3. Requested Limits of Liability _____ Each Claim _____ Aggregate
4. Deductible: _____ Each Claim
5. Does the state the applicant is operating in have a Patient Compensation Fund? Yes No
 If yes, is the applicant currently enrolled in the Patient Compensation Fund? Yes No
6. Is the firm engaged in, owned by, associated with, or controlled by any other business? Yes No
7. Is the firm owned by any physician? Yes No
8. Is the firm owned by any hospital, or are any services hospital based? Yes No
9. Have there been any changes in ownership of the business since the date the entity was established? Yes No
10. Description of services provided: _____
11. Does the applicant have any point of care operations? Yes No

If yes, please explain: _____

12. Does the applicant own any other medical-related business not shown on this application? Yes No

13. Gross Revenue:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Gross Revenue	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

14. How many years has the applicant been in operation? _____

15. Within the next twelve month period, does the applicant plan to: (If yes to any of the below, please explain)

- Obtain another operation or entity? Yes No
- Add to the number of employees? Yes No
- Expand the number of locations? Yes No
- Eliminate/add current services? Yes No
- Operate in other states? Yes No

16. Within the past five years has the applicant acquired, sold or discontinued any operations: Yes No

If yes, please explain: _____

17. Are all services provided by a medical prescription or physician order? Yes No

18. Where does the applicant provide services for the client? Must equal 100%

- | | | |
|--|--|--|
| <input type="checkbox"/> Applicant's Locations _____ % | <input type="checkbox"/> Patient's Homes _____ % | <input type="checkbox"/> Physician Offices _____ % |
| <input type="checkbox"/> Long Term Care Facility _____ % | <input type="checkbox"/> Hospital _____ % | |
| <input type="checkbox"/> Mobile Facility _____ % | <input type="checkbox"/> Schools _____ % | |
| <input type="checkbox"/> Jail/Prison _____ % | <input type="checkbox"/> Other (explain) _____ % | |

Organizational Accreditation/Certification

Accredited*? Yes No If yes, by what organization and specific to what operation? _____

Certified? Yes No If yes, by what organization and specific to what operation? _____

***If accredited, please provide a copy of your most recent report**

19. Has the applicant's accreditation, certification or license been suspended or revoked? Yes No

If yes, please explain: _____

Please provide information on your professional liability insurance history:

	Current Year	1 st Prior Year	2 nd Prior Year
Policy Year			
Company			
Limits of Liability			
Liability Deductible (if any) or Self-Insured Retention	<input type="checkbox"/> Deductible \$ <input type="checkbox"/> SIR \$	<input type="checkbox"/> Deductible \$ <input type="checkbox"/> SIR \$	<input type="checkbox"/> Deductible \$ <input type="checkbox"/> SIR \$
Claims Made or Occurrence	<input type="checkbox"/> CM <input type="checkbox"/> Occurrence	<input type="checkbox"/> CM <input type="checkbox"/> Occurrence	<input type="checkbox"/> CM <input type="checkbox"/> Occurrence
If Claims Made, Retroactive Date			
Premium			

20. Has any insurance carrier canceled or refused to renew coverage? _____ Yes No

If yes, please explain: _____

IV. ADMINISTRATION AND STAFF

A. Provide information for the Medical Director providing services at applicant's facility.

Attach additional sheet if necessary.

Medical Director	Specialty Board Certification	Ins. Carrier, Policy Number and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month
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B. Provide information for the physician/surgeon providing services at applicant's facility. Attach additional sheet if necessary.

Physicians/Surgeons	Specialty Board Certification	Ins. Carrier, Policy Number and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month
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- Are physicians and licensed independent practitioners credentialed? Yes No
- Is credentialing and privileging formalized? Yes No
- Is new technology included in the delineation of privileges? Yes No
- Does the applicant require employed or contracted physicians and surgeons to carry professional liability insurance?
 Yes, in by-laws Yes, in contract No (If no, please explain) _____
- Indicate minimum professional liability insurance limits required for:
 Employed/Contracted Physicians/Surgeons \$ _____ Each Claim \$ _____ Aggregate
- How often do you verify Professional Liability Insurance? _____
- Has there **ever** been any review by a state medical board or other federal, state, or non-governmental oversight entity of any health care professional with privileges at the applicant's facility? Yes No
- Has any health care professional with privileges in the applicant's facility **ever** had their license suspended, revoked or voluntarily surrendered?
 Yes No

DIAGNOSTIC IMAGING, CONTINUED

9. Has any health care professional with privileges in the applicant's facility **ever** had their DEA license suspended, revoked or voluntarily surrendered? Yes No
10. Have any limitations or conditions **ever** been imposed on any health care professional's privileges? Yes No

Allied Healthcare Professionals

Indicate number of personnel in each applicable category:

	Employees		Contractors		Volunteers	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
Administration (Office/Clerical)						
Nurses						
Technologist - Nuclear						
Technologist - Radiologic						
Technologist - Ultrasound (Sonographers)						
Other:						

V. HIRING/SCREENING/TRAINING PROCEDURES

1. Do your screening/hiring procedures contain any of the following?
- Educational background Yes No
 - Previous employers/employment history (PRIOR to hiring or placement) Yes No
 - Personal references Yes No
 - How are references checked? Written Verbal Both
 - Hospital privileges for physicians Yes No
 - How often do you update your list of specific privileges?
 - Pending license suspensions, revocations Yes No
 - Pending disciplinary actions by other facilities Yes No
 - Criminal background check County State Federal None
 - Medical professional claims history Yes No
2. Are each of your hiring procedures indicated above followed and documented? Yes No
3. If an individual has had a previous claim, license suspension or revocation, how does that impact your procedures for hiring that person?
Are any additional criteria applied? Yes No
4. What training is provided for new staff (e.g. aides, volunteers, technicians)?
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5. Are written job descriptions established for all employees and volunteers? Yes No
6. Before staff can provide care, is a competency based checklist used to assess and document their skills? Yes No

VI. RISK MANAGEMENT/QUALITY ASSURANCE

1. Does the applicant utilize a formal written Quality Improvement? Yes No
2. Does the applicant utilize a formal written Risk Management Program? Yes No
3. Does the governing body periodically review the program for effectiveness and approve necessary changes? Yes No
4. Is there a peer review process in place? Yes No

Medical/Patient Records

1. Are records stored: Electronically Paper Files Both
2. How long are records stored? _____
3. If electric, how often are backups made? _____
4. If paper, where are records stored? On site Off site
5. Do the buildings in which paper records are stored contain sprinklers? Yes No
6. Who has the overall responsibility for Risk Management & Quality Assurance?
 Name _____
 Title _____
 Telephone Number _____
 E-Mail Address _____

VII. PROFESSIONAL LIABILITY EXPOSURES

Please describe the type of procedure or imaging being performed (in revenue):

Type of Imaging Procedure	Projected Visits	Projected Revenue	Current Year Visits	Current Year Revenue	1 st Prior Year Visits	1 st Prior Year Revenue
Angiography						
Bone Density Scan						
MRI						
CAT/CT						
Mammogram						
Sonograms, Ultrasound						
X-Ray						
PET Scan						
EKG and EEG						
ESI, Electron Microscopic Imaging						
Fluoroscopy						
Gamma Camera						
Non-Vascular Interventional						
Vascular Interventional						
Particle Accelerators						
Stress Tests						
Terahertz Radiation						
Therapeutic Radiology, Cobalt						
Other (describe)						

For any "No" answers, please explain:

Contrast Media

- a. Are there policies and procedures regarding the use of contrast agents and localization markers? Yes No
- b. If the applicant is injecting contrast media, complete the following:
- Ionic _____ % of use
- Nonionic _____ % of use
- Low Osmolar _____ % of use
- c. Are there protocols for the use of contrast media?
- Ionic Yes No N/A
- Nonionic Yes No N/A
- Low Osmolar Weight Yes No N/A
- d. If the applicant is injecting contrast medial is a physician present during the procedure? Yes No
- If no, explain level of supervision: _____
- e. Is informed consent for special or invasive procedures including injection of contrast or other media obtained? Yes No
- f. Is the informed consent documented in the medical record? Yes No
- g. Before any contrast media is administered, is the patient asked about previous allergic responses or sensitivity? Yes No
- h. Is there a written policy for handling allergic reactions including cardiac or respiratory arrests? Yes No
- i. Is emergency resuscitation equipment (oxygen, suction, defibrillator, monitor, emergency drugs) available? Yes No
- j. Are all technologists directly supervised by a radiologist during all invasive procedures? Yes No

Policies and Procedures

- a. Are all results reviewed by an employed/contracted radiologist? Yes No
- b. Does the same radiologist interpret the film, dictate and sign the report? Yes No
- c. Is there a procedure to properly match the correct patient with the correct diagnostic exam? Yes No
- d. Is there a written procedure for communicating results to patients and the patients' practitioner via letters or phone calls? Yes No
- e. Is there a recall or reminder system for repeat exams? Yes No
- f. Is there a policy and procedure to ensure communication of abnormal findings with referring healthcare providers? Yes No
- g. Are there policies and procedures for written communication of mammogram results directly to patients as well as to referring healthcare providers within 30 days? Yes No
- h. Is there a policy and procedure for the release of original mammogram films at the patient's request? Yes No
- i. Does the policy include a procedure for copying released original films and tracking and return of released original films? Yes No
- j. Is there a policy and procedure for referral of self-referred patients to a physician when clinically indicated? Yes No
- k. Is there a policy and procedure for archiving films of x-ray image data in an accessible format for a specific period of time? Yes No
- l. Has the applicant implemented a digital PAC radiology system? Yes No
- m. Are there policies and procedures to ensure compliance with the security and privacy regulations of identifiable healthcare information under the healthcare Insurance portability and Accountability Act? Yes No

Staffing

- a. Do technicians/technologists hold specialized certificates? Yes No
 If yes, please list: _____
- b. Are all technologists graduates of formal education programs or appropriately certified (e.g. by the American Registry of Radiologic Technologists or by the American Registry of Clinical Radiograph Technologists)? Yes No
- c. Are all technologists state registered or licensed? Yes No
- d. Do technicians performing mammograms meet the education and training requirements of MQSA regulations? Yes No
- e. Are any technicians “grandfathered” or hold limited permits? Yes No
- f. Qualifications of radiation safety officer: _____

Tele-radiology

- a. Is Tele-radiology used? Yes No
 If yes, answer the following:
- Are films transmitted interstate? Yes No
 - Are all radiologists participating in Tele-radiology credentialed? Yes No
 - Is the “reading” physician licensed in all states in the service area? Yes No
- Please list all states that services are provided in: _____
- Please list all physicians providing Tele-radiology services and the states:

Physician Name	State

- Does the reading physician reside outside of the US and its territories? Yes No
 If yes, explain: _____
- Is there a Tele-radiology policy concerning maximum amount of image compression needed to ensure accurate transmission of images for diagnostic purposes? Yes No
- Do you provide or are you contracted with a “nighthawk” radiology service? Yes No
 If yes, provide a copy of your contract.

Mobile Radiology Services

- a. Does the applicant transport any radiology equipment? Yes No
 If yes, answer the following:
1. What is the percentage of service overall that mobile radiology represents? _____%
 2. Do you provide services using mobile equipment at off site locations? Yes No
 If yes, to whom: _____
- What services are you providing? _____

Patient Safety

- Are patient safety precautions taken, including:
- a. Identifying the patient and the exam? Yes No
 - b. Wearing gonad shields and lead aprons (when appropriate)? Yes No
 - c. Asking all female patients if they could be pregnant, notifying the physician, and recording this information in the patient’s medical record?
 Yes No
 - d. Identification of patients who cannot be safely scanned by MRI? Yes No

Equipment Safety

- a. Is there a comprehensive quality assurance/safety program that includes calibrating equipment, identifying operating irregularities, utilizing controls/phantoms, etc? Yes No
- b. Is there complete documentation of proper use and maintenance of equipment? Yes No
 If yes, does documentation include:
 - 1. Records of periodic calibrations? Yes No
 - 2. Monthly inspection and preventive maintenance activities? Yes No
 - 3. Documentation of routine safety surveys? Yes No
- c. Is there a documented radiologic internal disaster plan available that is reviewed and tested at least yearly? Yes No
- d. Are carbon dioxide or other approved fire extinguishers available in the facility? Yes No
- e. Is there a policy and procedure for use, administration, and disposal of radio-pharmaceuticals? Yes No

VIII. LITIGATION/CLAIMS HISTORY/SANCTIONS/FINES

If the response is yes to any question below, additional information must be provided on the applicant's letterhead. Please submit actual loss runs from the previous carriers for the past five or more years.

- 1. Has the applicant had any Professional or General Liability claims or suits brought against them in the past five years? Yes No
- 2. Is the applicant aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier? Yes No
- 3. Has the facility/operations license ever been suspended, revoked or voluntarily surrendered? Yes No
- 4. Has any Insurance Company declined, canceled or refused to renew or accept any of the applicant's liability insurance? Yes No
- 5. Has the Company with whom the applicant been previously affiliated with become insolvent? Yes No
- 6. Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the applicant's organization? Yes No
- 7. Has the applicant ever been sanctioned or decertified by Medicare? Yes No
- 8. Has the organization or any of it's officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional medical society, accreditation agency or other governmental or non-governmental oversight entity? Yes No

Provide the following for each claim, suit or incident (attach additional sheets if necessary):

Date of Accident:	Date of Notice:
Amount Paid or Reserved: \$	Claimant:
Insurance Carrier:	
Allegations:	
Description of Treatment Rendered:	

Date of Accident:	Date of Notice:
Amount Paid or Reserved: \$	Claimant:
Insurance Carrier:	
Allegations:	
Description of Treatment Rendered:	

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

This application does not bind the Applicant to buy, or the Company to issue the Insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the Company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

SIGNATURE OF APPLICANT X _____

DATE X _____

(Must be signed by principal partner or officer of group or individual applying for insurance.)

Producer: _____

Phone Number: _____

Producer's Address: _____

Tax I.D. Number: _____

Notice to New York Applicants. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Note: The professional liability coverage being applied for is Claims Made. If there are questions concerning these coverages, please contact your insurance agent.