



# Diagnostic Imaging Facilities

## Professional & General Liability Coverage Application

### Instructions:

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

The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate. A separate physician application is required for all physicians requesting coverage under this policy.

### I. GENERAL INFORMATION

- Name of Applicant (Legal Name): \_\_\_\_\_
- Physical Address: \_\_\_\_\_
- Mailing Address: (if different) \_\_\_\_\_
- Corporate Address: (if different) \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_
- Corporate Contact: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Tel. Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Website: \_\_\_\_\_
- Date Established: \_\_\_\_\_
 

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

### II. COVERAGE/LIMITS/DEDUCTIBLES

- Indicate which coverages you are applying for:
- Professional Liability    Employee Benefits Liability    Non-Owned Auto    General Liability    Sexual Molestation/Abuse
- Requested Effective Date: \_\_\_\_\_
  - Requested Prior Acts Date: \_\_\_\_\_
  - Requested Limits of Liability: \$ \_\_\_\_\_ per claim   \$ \_\_\_\_\_ aggregate

4. Deductible: \$ \_\_\_\_\_ per 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
<b>Gross Revenue</b>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

14. How many years has the applicant been in operation? \_\_\_\_\_
15. Within the next twelve month period, does the applicant plan to:
- 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

If yes, please explain: \_\_\_\_\_

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 <sup>st</sup> Prior Year	2 <sup>nd</sup> 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"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence	<input type="checkbox"/> Claims Made <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: \_\_\_\_\_

### III. ADMINISTRATION AND STAFF

*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

*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

- 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 \$ \_\_\_\_\_ per 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
- 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:						

**IV. HIRING/SCREENING/TRAINING PROCEDURES**

- Do your screening/hiring procedures contain any of the following?
  - Educational background  Yes  No
  - Previous employers/employment history  Yes  No (PRIOR to hiring or placement)
  - 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
- Are each of your hiring procedures indicated above followed and documented?  Yes  No
- 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
- What training is provided for new staff (e.g. aides, volunteers, technicians)? \_\_\_\_\_
- Are written job descriptions established for all employees and volunteers?  Yes  No
- Before staff can provide care, is a competency based checklist used to assess and document their skills?  Yes  No

**V. RISK MANAGEMENT/QUALITY ASSURANCE**

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

**MEDICAL/PATIENT RECORDS**

- Are records stored:  Electronically  Paper Files  Both
- How long are records stored? \_\_\_\_\_
- If electric, how often are backups made? \_\_\_\_\_
- 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: \_\_\_\_\_

**VI. 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 <sup>st</sup> Prior Year Visits	1 <sup>st</sup> 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**

1. Are there policies and procedures regarding the use of contrast agents and localization markers?  Yes  No

2. If the applicant is injecting contrast media, complete the following:

Ionic \_\_\_\_\_% of use

Nonionic \_\_\_\_\_% of use

Low Osmolar \_\_\_\_\_% of use

3. 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

4. If the applicant is injecting contrast media is a physician present during the procedure?  Yes  No

If no, explain level of supervision: \_\_\_\_\_

5. Is informed consent for special or invasive procedures including injection of contrast or other media obtained?  Yes  No

6. Is the informed consent documented in the medical record?  Yes  No

7. Before any contrast media is administered, is the patient asked about previous allergic responses or sensitivity?  Yes  No

8. Is there a written policy for handling allergic reactions including cardiac or respiratory arrests?  Yes  No

9. Is emergency resuscitation equipment (oxygen, suction, defibrillator, monitor, emergency drugs) available?  Yes  No

10. Are all technologists directly supervised by a radiologist during all invasive procedures?  Yes  No

### **POLICIES AND PROCEDURES**

1. Are all results reviewed by an employed/contracted radiologist?  Yes  No

2. Does the same radiologist interpret the film, dictate and sign the report?  Yes  No

3. Is there a procedure to properly match the correct patient with the correct diagnostic exam?  Yes  No

4. Is there a written procedure for communicating results to patients and the patients' practitioner via letters or phone calls?  
 Yes  No

5. Is there a recall or reminder system for repeat exams?  Yes  No

6. Is there a policy and procedure to ensure communication of abnormal findings with referring healthcare providers?  
 Yes  No

7. 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

8. Is there a policy and procedure for the release of original mammogram films at the patient's request?  Yes  No

9. Does the policy include a procedure for copying released original films and tracking and return of released original films?  
 Yes  No

10. Is there a policy and procedure for referral of self-referred patients to a physician when clinically indicated?  Yes  No

11. 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

12. Has the applicant implemented a digital PAC radiology system?  Yes  No

13. 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**

1. Do technicians/technologists hold specialized certificates?  Yes  No

If yes, please list: \_\_\_\_\_

2. 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

3. Are all technologists state registered or licensed?  Yes  No

4. Do technicians performing mammograms meet the education and training requirements of MQSA regulations?  Yes  No

5. Are any technicians "grandfathered" or hold limited permits?  Yes  No

6. Qualifications of radiation safety officer: \_\_\_\_\_

### **TELE-RADIOLOGY**

1. Is Tele-radiology used?  Yes  No

If yes, answer the following:

- a. Are films transmitted interstate?  Yes  No
- b. Are all radiologists participating in Tele-radiology credentialed?  Yes  No
- c. 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

- a. Does the reading physician reside outside of the US and its territories?  Yes  No

If yes, explain: \_\_\_\_\_

- b. Is there a Tele-radiology policy concerning maximum amount of image compression needed to ensure accurate transmission of images for diagnostic purposes?  Yes  No
- c. 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**

- 1. Does the applicant transport any radiology equipment?  Yes  No

If yes, answer the following:

- a. What is the percentage of service overall that mobile radiology represents? \_\_\_\_\_%
- b. Do you provide services using mobile equipment at off site locations?  Yes  No

If yes, to whom: \_\_\_\_\_

What services are you providing? \_\_\_\_\_

**PATIENT SAFETY**

- 1. 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**

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

## VII. PHYSICAL PLANT

Please furnish the following information for all owned or leased property operated or occupied by you. A separate summary of locations/exposures is acceptable, provided the information outlined below is furnished:

Address of Property to be Insured	Use/ Occupancy	Square Footage	Age	Type of Construction	# of Stories	Fire Protection*
Patient Care Buildings:						

Other Buildings:


\* For each building indicate if there is a:  
 Sprinkler System – full, partial or no sprinkler system  
 Smoke Detector, Heat Detector  
 Fire Alarm – Central Station or Local Alarm

1. Do all facilities comply with the National Fire Protection Association (NFPA) 101 Life Safety Code 2000 Edition or newer?  
 Yes  No

If no, please explain: \_\_\_\_\_

## VIII. GENERAL LIABILITY

Do you desire general liability coverage?  Yes  No *If yes, complete this section. If no, skip to Section XI.*

1. Is there a preventive and corrective maintenance program in place for the bio-medical equipment and surgical machines or devices at the facility?  Yes  No

a. How often are non-expendable medical or surgical machines or devices inspected and maintained?  
 \_\_\_\_\_

b. Who performs the maintenance of the above equipment?  Employees  Independent Contractors

c. If independent contractor, what is the minimum general liability limit that you require them to carry?  
 \$ \_\_\_\_\_ / \$ \_\_\_\_\_

d. Do you obtain a certificate of insurance annually to verify this coverage is in place?  Yes  No

2. Is any of the bio-medical equipment used at your facility owned by physicians?  Yes  No

If yes, who is responsible for the preventive maintenance, inspection and repair of the equipment?  
 \_\_\_\_\_

3. Do you lend or donate your bio-medical equipment to others for their use?  Yes  No

If yes, describe: \_\_\_\_\_

4. Do you rent or lease medical equipment from others?  Yes  No

If yes, who is responsible for the maintenance of the equipment? \_\_\_\_\_

5. Do you use an advertising agency?  Yes  No

If yes, what is the minimum professional liability limit that you require them to carry? \$ \_\_\_\_\_ / \$ \_\_\_\_\_

a. Are you included as an additional insured on the advertising agency's policy?  Yes  No

b. Is there a hold harmless agreement in the contract in favor of your facility?  Yes  No

6. Are there any plans for new construction or renovations during the next 12 months?  Yes  No

If yes, please describe the changes planned including the time frame and the estimated cost: \_\_\_\_\_

7. Please indicate below which of the following apply and specify the corresponding projected number or amount of receipts for the next 12 months:

Habitational Risk: Indicate if an:  Apartment  Dwelling  Hotel

Number of units: \_\_\_\_\_ Year built: \_\_\_\_\_

- a. Are there at least two exits located remotely from each other?  Yes  No
- b. For apartment buildings and hotels, are there lighted emergency exit signs?  Yes  No
- Pay parking Receipts per year: \_\_\_\_\_
- Special athletic or fund raising events Receipts per year: \_\_\_\_\_

Describe planned events for the upcoming year and indicate if alcohol will be served: \_\_\_\_\_

8. Do you lease or rent space to others?  Yes  No

If yes, indicate the following:

City, State and Zip Code: \_\_\_\_\_

Square Footage: \_\_\_\_\_ Occupancy/Use of Space: \_\_\_\_\_

- a. Does your lease require the tenant to carry general liability insurance with at least a \$1,000,000 limit?  
 Yes  No
- b. Do you obtain a certificate of insurance annually to verify this coverage is in place?  Yes  No
- c. Is the tenant required to list you as an additional insured on their general liability policy?  Yes  No

### IX. EXCESS LIABILITY

Do you desire excess liability coverage?  Yes  No *If yes, complete this section. If no, complete application.*

- 1. Excess Liability requested limit \$ \_\_\_\_\_ per claim, \$ \_\_\_\_\_ aggregate in excess of primary coverage limits.
- 2. Have your excess professional or commercial general liability limits been increased within the last five years?  
 Yes  No

If yes, what was the prior limit and when was it increased? \_\_\_\_\_

### X. 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** \_\_\_\_\_

Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

*(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.