



# Correctional Medical Facilities and Contractors

## 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.

**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

1. Name of Applicant (Legal Name): \_\_\_\_\_
2. Physical Address: \_\_\_\_\_
3. Mailing Address: (if different) \_\_\_\_\_
4. Corporate Address: (if different) \_\_\_\_\_
5. City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_
6. Corporate Contact: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Tel. Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Website: \_\_\_\_\_
7. 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
8. In what state(s) is the Applicant registered and licensed to practice? \_\_\_\_\_
9. Please specify any professional societies or associations which you are a member: \_\_\_\_\_
10. Is the firm engaged in, owned by, associated with, or controlled by any other business?  Yes  No
11. Is the firm owned by any physician?  Yes  No
12. Have there been any changes in ownership of the business since the date the entity was established?  Yes  No
13. Does the applicant own any other medical-related business not shown on this application?  Yes  No

14. Gross Revenue:

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

15. How many years has the applicant been in operation? \_\_\_\_\_

16. 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: \_\_\_\_\_

17. Within the past five years has the applicant acquired, sold or discontinued any operations:  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			

**II. COVERAGE/LIMITS/DEDUCTIBLES**

1. Requested Effective Date: \_\_\_\_\_ Requested Prior Acts Date: \_\_\_\_\_

2. Requested Limits of Liability: \$ \_\_\_\_\_ per claim \$ \_\_\_\_\_ aggregate

3. Deductible: \$ \_\_\_\_\_ per claim

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

a. Excess Liability requested limit \$ \_\_\_\_\_ per claim, \$ \_\_\_\_\_ aggregate in excess of primary coverage limits.

b. 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? \_\_\_\_\_

5. Does a 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. 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
- 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	
	Full Time	Part Time	Full Time	Part Time
Administration (Office/Clerical)				
Registered Nurses				
Licensed Practical Nurses				
Physicians				
Physicians Assistants				
Pharmacists				
Dentists				
Certified Nurse Assistants				
Residents				
Interns				
Psychiatrists				
Psychologists				
Other:				
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**

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: \_\_\_\_\_

**VI. CORRECTIONAL FACILITY DATA**

1. How many facilities do you have contracts with: \_\_\_\_\_

**2. Please complete facility specific supplement (pg. 8).**

3. Show the percentage of services at prisons with the following security levels (should equal 100%)

Supermax Security	%
Maximum Security	%
Close Security	%
Medium Security	%
Minimum Security	%

4. What is your patient population's age? (should equal 100%)

Under 20	%
20-30	%
31-40	%
41-50	%
50+	%

5. What is your patient population's sex? (should equal 100%)

Male	%
Female	%

6. Level of health care provided

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# Performed last year?	Comments
Medical Screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Diagnostic	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Referral	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Surgical	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Psych Evaluation	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

7. Explain any specialized services

\_\_\_\_\_

\_\_\_\_\_

8. Are Physical Examinations provided to all inmates upon entrance to the facility?  Yes  No

9. Is security present at all times during service?  Yes  No Please provide details.

\_\_\_\_\_

\_\_\_\_\_

10. What are the reporting and documenting procedures for incidents and claims? Provide copy of incident log.

\_\_\_\_\_

\_\_\_\_\_

11. Does applicant operate an Intensive Care Unit?  Yes  No Please provide details.

\_\_\_\_\_

\_\_\_\_\_

12. What are the protocols for releasing a patient out of the health ward?

\_\_\_\_\_

13. Please provide inmate intoxication protocols (i.e. Drunk Tank).

\_\_\_\_\_

14. Do inmates participate in work release programs?  Yes  No

If yes, please describe nature, locations, and frequency. Please also describe how inmates are cleared for work release.

\_\_\_\_\_

\_\_\_\_\_

**VII. 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 its 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.





# Correctional Medical

## Named Physician Coverage Supplemental Application

Note: a current Curriculum Vitae must accompany each completed and signed application.

1. Name of Applicant: \_\_\_\_\_
2. Organization Name: \_\_\_\_\_
3. Are you requesting Prior Acts Coverage?  Yes  No If yes, specify Retroactive Date: \_\_\_\_\_
4. Does your employment with the above organization require that you provide services to any other organization?  
 Yes  No (If yes, provide details in Comments Section.)
5. Medical School/State: \_\_\_\_\_ Degree:  M.D.  O.D.  Other: \_\_\_\_\_  
Month/Year Graduated: \_\_\_\_\_  
Are you currently a resident, intern, or fellow?  Yes  No If yes, dates you will complete training: \_\_\_\_\_
6. List all states where you are licensed to practice and license numbers:  
State/License Number: \_\_\_\_\_ / \_\_\_\_\_ State/License Number: \_\_\_\_\_ / \_\_\_\_\_  
State/License Number: \_\_\_\_\_ / \_\_\_\_\_ State/License Number: \_\_\_\_\_ / \_\_\_\_\_
7. Indicate percentage of thee devoted to the following medical and/or surgical activities (total = 100%):

- \_\_\_\_\_ Allergy & Immunology
- \_\_\_\_\_ Anesthesiology
- \_\_\_\_\_ Broncho-Esophagology
- \_\_\_\_\_ Cardiovascular Disease
- \_\_\_\_\_ Colon & Rectal
- \_\_\_\_\_ Dermatology
- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Emergency Medicine
- \_\_\_\_\_ Endocrinology
- \_\_\_\_\_ Family Practice or General Practice, Excl OB
- \_\_\_\_\_ Family Practice or General Practice, Incl OB
- \_\_\_\_\_ Fetal & Maternal Medicine
- \_\_\_\_\_ Foot & Ankle Surgery
- \_\_\_\_\_ Gastroenterology
- \_\_\_\_\_ General Preventative Medicine
- \_\_\_\_\_ Geriatrics
- \_\_\_\_\_ Gynecology
- \_\_\_\_\_ Hand
- \_\_\_\_\_ Head & Neck
- \_\_\_\_\_ Hematology
- \_\_\_\_\_ Infectious Diseases
- \_\_\_\_\_ Intensive Care Medicine
- \_\_\_\_\_ Internal Medicine
- \_\_\_\_\_ Larynology
- \_\_\_\_\_ Limited General Practice
- \_\_\_\_\_ Legal Medicine
- \_\_\_\_\_ Neoplastic Diseases
- \_\_\_\_\_ Nephrology
- \_\_\_\_\_ Neurology
- \_\_\_\_\_ Nuclear Medicine

- \_\_\_\_\_ Nutrition
- \_\_\_\_\_ Obstetrics/Pre-Natal Care
- \_\_\_\_\_ Oncology
- \_\_\_\_\_ Opthamology
- \_\_\_\_\_ Oral-Maxillofacial Surgery
- \_\_\_\_\_ Orthopedics
- \_\_\_\_\_ Otology
- \_\_\_\_\_ Otorhinolaryngology
- \_\_\_\_\_ Pain Management
- \_\_\_\_\_ Pathology
- \_\_\_\_\_ Pharmacology
- \_\_\_\_\_ Physiatry
- \_\_\_\_\_ Physician-NOC
- \_\_\_\_\_ Physical Medicine and Rehabilitation
- \_\_\_\_\_ Psychiatry
- \_\_\_\_\_ Psychoanalysis
- \_\_\_\_\_ Psychosomatic Medicine
- \_\_\_\_\_ Public Health
- \_\_\_\_\_ Pulmonary Diseases
- \_\_\_\_\_ Radiology
- \_\_\_\_\_ Rheumatology
- \_\_\_\_\_ Rhinology
- \_\_\_\_\_ Teleradiology
- \_\_\_\_\_ Thoracic
- \_\_\_\_\_ Urology
- \_\_\_\_\_ Weight Reduction/Control
- \_\_\_\_\_ Other (list): \_\_\_\_\_

- SURGERY**
- \_\_\_\_\_ Abdominal
  - \_\_\_\_\_ Bariatric
  - \_\_\_\_\_ Cardiac
  - \_\_\_\_\_ Cardiovascular
  - \_\_\_\_\_ Colon & Rectal
  - \_\_\_\_\_ Dermatology
  - \_\_\_\_\_ Endocrinology
  - \_\_\_\_\_ Foot & Ankle
  - \_\_\_\_\_ Gastroenterology
  - \_\_\_\_\_ General
  - \_\_\_\_\_ Gynecology
  - \_\_\_\_\_ Hand
  - \_\_\_\_\_ Head & Neck
  - \_\_\_\_\_ Laryngology
  - \_\_\_\_\_ Neonatal
  - \_\_\_\_\_ Neoplastic
  - \_\_\_\_\_ Nephrology
  - \_\_\_\_\_ Neurology
  - \_\_\_\_\_ Obstetrics
  - \_\_\_\_\_ Ophthalmology
  - \_\_\_\_\_ Orthopaedic Excl Spine
  - \_\_\_\_\_ Orthopaedic Incl Spine
  - \_\_\_\_\_ Otorhinolaryngology
  - \_\_\_\_\_ Perinatology
  - \_\_\_\_\_ Plastic
  - \_\_\_\_\_ Plastic-Otorhinolaryngology
  - \_\_\_\_\_ Thoracic
  - \_\_\_\_\_ Traumatic
  - \_\_\_\_\_ Urological
  - \_\_\_\_\_ Vascular
  - \_\_\_\_\_ Other (list): \_\_\_\_\_

8. Medical Specialty:  
Are you certified by an approved specialty board?  Yes  No  
If yes – American Board of \_\_\_\_\_ Cert # \_\_\_\_\_  
Date Issued: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Primary Medical Specialty: \_\_\_\_\_ Sub Specialty: \_\_\_\_\_

If your practice limited to your sub-specialty?  Yes  No

**If you are NOT board eligible or certified, please explain in the Comments section below.**

9. Profile Questions: **Please provide details to any "Yes" responses in the Comments section below.**

a. Has any organization ever denied, restricted, suspended, or revoked your privileges or practice; have you ever voluntarily surrendered your privileges; or has probation or a consent order ever been invoked?  Yes  No

b. Has any organization notified you of its intention of consider imposing any change of status, penalties, privileges, participation, certification, or membership?  Yes  No

c. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered or has probation been invoked?  Yes  No

d. Have you been asked to participate in or have you volunteered to participate in an impaired physician program? (If Yes, please attach a copy of your recovery plan document.)  Yes  No

e. Have you ever been denied a medical license or been denied certification by a specialty board?  Yes  No

f. Do you have knowledge of any claims, potential claims, or suits in which you may become involved, including without limitation knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim?  Yes  No

**If yes, have these been reported to your present carrier?**

**Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit or provide a recent carrier claim history.**

g. Has any medical professional liability insurance ever been declined, canceled, non-renewed, surcharged or conditioned?  Yes  No

**NOTE: MISSOURI APPLICANTS DO NOT RESPOND**

Comments Section:

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\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date:

**CLAIM INFORMATION FORM**

Complete and attach a Claim Information Form for EACH claim, potential claim, or suit.

Claimant First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Age: \_\_\_\_\_ Gender:  Male  Female

Date(s) of treatment and/or surgery, which lead to the allegations against you: \_\_\_\_\_

Nature of the allegations in the claim or suit: \_\_\_\_\_

Was suit ever filed:  Yes  No If yes, when was it filed? \_\_\_\_\_

Name of other doctor(s) and hospital(s), if any, involved in claim or suit: \_\_\_\_\_

Disposition or current status of claim or suite:  Open  Closed

If open, indicate case value established by carrier: \$ \_\_\_\_\_

If closed, was payment made?  Yes  No If no, was claim or suit withdrawn?  Yes  No

If payment was made, indicate total amount of settlement or award: \_\_\_\_\_

How much was on your behalf: \_\_\_\_\_

Name of insurance carrier defending you: \_\_\_\_\_

Narrative description of the medical facts (must include the type of treatment and/or surgery and your involvement). Please give as complete a narrative description as possible.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Claimant First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Age: \_\_\_\_\_ Gender:  Male  Female

Date(s) of treatment and/or surgery, which lead to the allegations against you: \_\_\_\_\_

Nature of the allegations in the claim or suit: \_\_\_\_\_

Was suit ever filed:  Yes  No If yes, when was it filed? \_\_\_\_\_

Name of other doctor(s) and hospital(s), if any, involved in claim or suit: \_\_\_\_\_

Disposition or current status of claim or suite:  Open  Closed

If open, indicate case value established by carrier: \$ \_\_\_\_\_

If closed, was payment made?  Yes  No If no, was claim or suit withdrawn?  Yes  No

If payment was made, indicate total amount of settlement or award: \_\_\_\_\_

How much was on your behalf: \_\_\_\_\_

Name of insurance carrier defending you: \_\_\_\_\_

Narrative description of the medical facts (must include the type of treatment and/or surgery and your involvement). Please give as complete a narrative description as possible.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_