

South Carolina Medical Malpractice Association

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HEALTHCARE FACILITY PROFESSIONAL LIABILITY INSURANCE APPLICATION - NEW

Assessable Policy

Instructions:

IMPORTANT: This is a NEW BUSINESS application for medical professional liability insurance from the SCMMA. It is intended for use by outpatient surgery centers, diagnostic centers, endoscopy centers, free/non-profit clinics and other facilities who are NOT currently insured by the SCMMA. Payment must be received by the SCMMA before coverage can be bound.

1. Please answer ALL questions completely, leaving no blanks. (Use N/A if Not Applicable)
2. If more space is needed for responses, please use the *Additional Comments Section* of this application, or continue on a separate sheet with the question noted.
3. The application must be signed and dated by the applicant and the applicant's insurance agent or broker.
4. Please have your agent submit the completed application, along with required attachments and any additional information to the SCMMA.
5. Please contact the SCMMA Underwriting Department if you have any questions.

IMPORTANT: No action can be taken on this application until it is complete. "Complete" means all questions have been answered, with separate explanations provided as requested. It must be signed and dated in by both the applicant and agent.

A. REQUIRED ATTACHMENTS:

1. Copy of **current medical professional liability insurance declarations page** showing the type of policy form and current retroactive date.
2. Verification of or intent to obtain **Extended Reporting Endorsement** (tail coverage) from current carrier if prior coverage was claims made.
3. Copy of **business letterhead**.
4. **Loss runs** from all previous professional liability insurers for not less than the prior 10 years. The evaluation or date of issue of such loss runs may not be more than 60 days old.

B. AGENT/BROKER INFORMATION

5. The completed application must be submitted to applicant's insurance agent or broker. Please record the name and contact information of applicant's agent or broker below.

Agent/Broker Name: _____

Mailing Address (Street or PO Box): _____

City: _____ State: _____ Zip: _____

Agency Contact Person: _____ Telephone: _____

Agency Contact E-Mail: _____

FOR MMA USE ONLY		
<i>Class Code</i>	<i>Policy Fee</i>	<i>Total Annual Premium</i>
<i>Other</i>	<i>Other</i>	<i>Endorsements:</i>

C. PRACTICE LOCATION AND GENERAL INFORMATION:

6. Applicant is: For Profit Non Profit Free Clinic Governmental
7. Type of Facility: Outpatient Surgery Center Diagnostic Center Endoscopy Center Free/Non Profit Clinic Other
- 7a. If "Other", please describe: _____
8. Briefly describe nature of services provided:

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application.

9. The legal/corporate name of the applicant facility:
 Name: _____ 9a. Federal Tax ID #: _____

10. Preferred Billing Address (Your invoice will be mailed to this address.)
 P.O. Box or Street: _____ Suite #: _____
 City: _____ State: _____ Zip: _____

11. Practice Address:
 Street Address 1: _____ Suite #: _____
 Street Address 2: _____
 City: _____ State: _____ Zip: _____

12. Office Telephone #: _____ 12a. Fax #: _____
 12b. May we contact you by fax? Yes No

13. Contact Name: _____ 13a. Contact Title: _____

14. Contact Email: _____ 14a. May we contact you by email? Yes No

15. Facility/Entity Web Address: _____

16. Do you have additional practice locations not listed above? Yes No
 16a. If "Yes", please list additional offices in *Additional Comments Section*.

D. POLICY AND COVERAGE HISTORY

POLICY LIMITS DESIRED: \$1M/\$3M \$1.2M/\$3.6M \$2M/\$4M \$3M/\$6M

17. Has the applicant ever been insured by the SCJUA / SCMMA before? Yes No

17a. If "yes", prior SCJUA/SCMMA Policy #: _____ 17b. Dates of last MMA coverage: (M/Y) ____ / ____ through ____ / ____

18. Is this application for a re-write? Yes No

19. **Effective Date:** Requested coverage effective date (M/D/Y): ____ / ____ / ____ 12:01 a.m.
 This date cannot be prior to the expiration date of your current policy. Annual policy terms begin and end on the same day of the month.

20. **Expiration date:** Requested coverage expiration date (M/D/Y): ____ / ____ / ____ 12:01 a.m.
 Annual policy terms begin and end on the same day of the month.

21. Has any insurance company (including Lloyds of London) ever cancelled, rescinded, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? Yes No
 21a. If "Yes", please explain in the *Additional Information Section*.
22. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees or has your ability to participate been revoked, suspended, placed on probation or voluntarily surrendered? Yes No
 22a. If "Yes", please explain in the *Additional Comments Section*.
23. Has your facility ever operated without professional liability coverage? Yes No
24. Please provide the following Medical Malpractice Insurer information for the last ten years of operations of the applicant facility.

	<u>NAME OF CARRIER</u>	<u>TYPE OF COVERAGE</u>	<u>EFFECTIVE/EXPIRATION DATES</u>
a.	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made	____/____ - ____/____
b.	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made	____/____ - ____/____
c.	_____	<input type="checkbox"/> Occurrence <input type="checkbox"/> Claims-made	____/____ - ____/____

E. FOR-PROFIT FACILITY RATING INFORMATION: (COMPLETE SECTION "E" ONLY IF APPLICANT IS A FOR-PROFIT ENTITY)

25. Please indicate the annual number of patient visits for the applicant facility:

<u>FACILITY TYPE</u>	<u>NUMBER PER YEAR</u>
a. Outpatient Surgery Centers	
ai. Outpatient surgeries	_____
aii. Pain management procedures	_____
b. Diagnostic Centers – outpatient visits	_____
c. Endoscopy Centers – outpatient visits	_____
d. Medical Research Centers – outpatient visits	_____
e. Other Facility - outpatient visits	_____

26. Do you participate in pharmaceutical testing programs/clinical investigation studies with drugs that are not FDA approved? Yes No
 26a. If "Yes", do you have coverage under a separate policy for this exposure? NA Yes No
 26b. If "Yes", provide details in the *Additional Comments Section* and attach verification of coverage, if applicable, and copy of the indemnification agreement provided by the pharmaceutical company.

27. Please list below the names of all **physicians/dentists/podiatrists/optometrists** and **pharmacists** who have privileges at your facility. You must check whether the participant is an owner (an individual who has an ownership interest in the facility), or a non-owner (an individual who does not have an ownership interest).

	<u>NAME</u>	<u>SPECIALTY</u>	<u>OWNER</u>	<u>NON-OWNER</u>	<u>MMA INSURED</u>
a.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
b.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
c.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
d.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
e.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
f.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
g.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application. Please inform the MMA of any changes as they occur.

IMPORTANT: If "NO" is indicated under "MMA Insured" for any medical professional listed above, please attach a copy of that individual's most recent medical professional liability insurance declarations page or certificate of insurance with this application.

28. Please list any additional owners of the applicant facility not shown in question #27 above.

<u>NAME</u>	
a. _____	d. _____
b. _____	e. _____
c. _____	f. _____

29. A facility may incur vicarious liability for the actions of its employee(s) or independent contractors (I/C). Additional charges may be applied to a facility policy to reflect this exposure. Does the applicant facility employ or contract any of the following?

	<u>NA</u>	<u>Employed</u>	<u>I/C</u>	<u>How Many?</u>
a. Surgical Technician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____
b. Other Technician: (x-ray, nuclear, path, sono, other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____
c. Anesthesiologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____
d. Nurse Anesthetist / Anesthesia Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____
e. Nurse Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____
f. Physician Assistant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____

30. If applicant facility employs or contacts any professionals in "c" through "f" above, please list the individual name(s), specialty, carrier, policy number and the limits of coverage in the space provided below. The SCMMA Facility Policy does NOT extend individual coverage to these individuals.

<u>Employee Name</u>	<u>Specialty</u>	<u>Carrier Name</u>	<u>Policy #</u>	<u>Limits</u>
a. _____	_____	_____	_____	_____
b. _____	_____	_____	_____	_____
c. _____	_____	_____	_____	_____

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application. Please inform the MMA of any changes as they occur.

31. The **Employees as Additional Insureds** ("Staff Coverage") **Endorsement** extends individual coverage to *eligible* employees for claims that arise from duties performed within the scope of their work for the covered facility. It also extends coverage to the employer for vicarious liability that may be imputed to them by these employees' actions. *Eligible* employees include RNs, LPNs, surgical techs, medical assistants, lab techs, X-ray techs, hygienists, dental assistants, and administrative staff. Most facilities should have this coverage.

Do you wish to add the **Employees as Additional Insureds Endorsement**? Yes No

IMPORTANT: *Physicians, dentists, podiatrists, optometrists, pharmacists, chiropractors, physician assistants, nurse practitioners, nurse midwives, nurse anesthetists, anesthesia assistants, and perfusionists are NOT eligible for individual coverage under this endorsement.*

All of the above (except chiropractors and perfusionists) may apply for individual coverage from the MMA. Different applications may be required depending on medical specialty. Contact the MMA Underwriting Department or visit WWW.SCMMA.NET for more information and applications.

F. NON-PROFIT FACILITY RATING INFORMATION: (COMPLETE SECTION "F" ONLY IF APPLICANT IS A NON-PROFIT ENTITY)

32. For underwriting purposes, a Full Time Equivalent (FTE) "Slot" is equal to 1,600 Employee/Volunteer hours per year. One Full Time Equivalent (FTE) Slot could cover several providers.

<u>TYPE</u>	<u>NUMBER</u>
1. Physician FTE Slots	_____
2. Nurse Practitioner FTE Slots	_____
3. Dentist FTE Slots	_____
4. Pharmacist FTE Slots	_____
5. Physician Assistant FTE Slots	_____

33. Please indicate the annual number of patient visits at your facility: _____

34. What are your hours of operation? _____

35. Please list the names of all licensed healthcare providers who volunteer at your clinic, their specialty, whether they are still in private practice or retired, and if they are currently insured by the MMA.

	<u>NAME</u>	<u>SPECIALTY</u>	<u>Private Practice</u>	<u>Retired/Other</u>	<u>MMA INSURED</u>
a.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
b.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
c.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
d.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
e.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N
f.	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application. Please inform the MMA of any changes as they occur.

IMPORTANT: If “NO” is indicated under “MMA Insured” for any medical professional listed above, please attach a copy of that individual’s most recent medical professional liability insurance declarations page or certificate of insurance with this application. Their employer paid medical malpractice insurance may not extend to a volunteer activity; therefore, the provider may need to have coverage under an FTE Slot.

36. A facility may incur vicarious liability for the actions of its employee(s) or volunteers. Additional charges may be applied to a facility policy to reflect this exposure. Does your facility utilize any of the following?

	<u>NA</u>	<u>Employed</u>	<u>Volunteer</u>	<u>How Many?</u>
a. X-ray Technician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____
b. Pathology Technician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____
c. Psychologist/Counselor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	# Full Time _____ # Part Time: _____

37. Do you use any anesthesia services? Yes No

37a. If “yes”, please describe: _____

38. The **Employees as Additional Insureds (“Staff Coverage”) Endorsement** extends individual coverage to *eligible* employees and volunteers for claims that arise from duties performed within the scope of their work for the covered facility. It also extends coverage to the facility for vicarious liability that may be imputed to them by these employees’ or volunteers’ actions. *Eligible* employees and volunteers include RNs, LPNs, surgical techs, medical assistants, lab techs, X-ray techs, hygienists, dental assistants, and administrative staff. Most facilities should have this coverage.

Do you wish to include staff coverage with the **Employees as Additional Insureds Endorsement**? Yes No

IMPORTANT: Physicians, dentists, podiatrists, optometrists, pharmacists, chiropractors, physician assistants, nurse practitioners, nurse midwives, nurse anesthetists, anesthesia assistants, and perfusionists are **NOT** eligible for individual coverage under this endorsement. All of the above (except chiropractors and perfusionists) may apply for individual coverage from the MMA. Contact the MMA Underwriting Department or visit WWW.SCMMA.NET for more information and applications.

39. Please list the names of the individuals who serve on your Board:

<u>NAMES</u>	
a. _____	g. _____
b. _____	h. _____
c. _____	i. _____
d. _____	j. _____
e. _____	k. _____
f. _____	l. _____

If more space is required, please continue on a separate sheet or in the Additional Comments Section of this application.

G. ADDITIONAL COMMENTS SECTION:

<u>Section</u>	<u>Question #</u>	<u>Explanation/Comments</u>
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____
_____	_____	_____ _____ _____

H. AGREEMENT AND AUTHORIZATION:

I hereby warrant that the information contained in this application is accurate and complete to the best of my knowledge. I understand that this application does not bind the MMA to complete the insurance, but it is agreed that this form shall be the basis of the contract should the policy be issued and shall be considered a part of my insurance policy with the South Carolina Medical Malpractice Association.

Signature of Applicant (Authorized Representative)

____/____/____
Date

Title

Agent/Broker must sign this application -

I certify that I am duly licensed by an insurer authorized in South Carolina to write liability insurance other than automobile.
I certify that I have reviewed this application.

Signature of Agent/Broker

____/____/____
Date

The information contained in this application is privileged and confidential. It is intended only for the use of the MMA. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this application is strictly prohibited. If you have received this application in error, please notify the South Carolina MMA immediately by telephone and return the original message to us via the U.S. Postal Service. Thank you.