

HUDSON SPECIALTY INSURANCE COMPANY Medical Group Application Guidelines

Documents which form part of this application:

- Fraud Statements(s)
? Sign appropriate statement based on your State

- Supplemental Claim Information Form
? Complete for every claim/suit paid at \$50,000 or more reported within the past 6 years, and for every open claim/suit reserved at \$50,000 regardless of when it was reported

- Professional Employee Roster (**format on Page 9**)
? Complete if coverage is requested for any Professional Employee referenced on page 4 of the application

Attach copies of the following with this application:

- ? Current Audited Financial Statement
- ? Written Risk Management Plan
- ? Current professional liability policy (**Page 2 of application**)
- ? Current Loss Run(s) (valued within 60 days on the insurer's format for the current year and a minimum of 5 additional years)
- ? Copies of all agreements where other parties are indemnified

Attach copies of the following with this application as they apply to your coverage requests:

SIR (Page 3 of application)

- ? Actuarial Review for this year
- ? Trust Agreement

Excess Umbrella Liability (Page 3 of application)

- ? Schedule of owned autos if applicable
- ? Certificates of insurance verifying underlying coverage for Employers Liability and Auto Liability
- ? Currently valued auto loss runs

Employed Physicians, Dentists & Residents (Page 4 of application)

- ? Current Hudson Specialty Insurance Company application for each of these employees

Departed Physician Coverage (Page 5 of application)

- ? Attach evidence of current coverage for each physician (such evidence might consist of a policy endorsement or certificate of insurance)

HUDSON SPECIALTY INSURANCE COMPANY
Medical Group Application
for surplus lines coverage

PRODUCER INFORMATION

Agency name _____
Mailing address _____ City/State/Zip _____
Producer name _____ Telephone _____ Fax _____

APPLICANT INFORMATION

Named Insured _____ County _____
Primary address _____ City/State/Zip _____
CEO _____ Risk Manager _____ Medical Director _____
Authorized representative for insurance matters: _____ Telephone _____
Website: _____

LEGAL ENTITIES

List all owned (50% or more) entities to be considered as a Named Insured, or attach a separate list:

<u>Name</u>	<u>Type/Purpose of facility</u>	<u>Retroactive Date</u>
_____	_____	_____
_____	_____	_____

1. Within the next 12 month period, does your group plan to grow by acquisition of another group or entity? Yes No
If "Yes", explain: _____

OFFICE LOCATIONS

1. List any additional office location, or attach a separate list:

Office location _____ City/State/Zip _____
Telephone _____ County _____

Office location _____ City/State/Zip _____
Telephone _____ County _____

Office location _____ City/State/Zip _____
Telephone _____ County _____

2. Within the next 12 month period, does your group plan to add additional locations? Yes No

If "Yes", explain: _____

INSURANCE COVERAGE REQUEST

1. Requested coverage effective date _____

2. Requested limits

Professional Liability: \$ _____ / \$ _____ Claims Made Retroactive Date: _____
per claim aggregate

General Liability: \$ _____ / \$ _____ Claims Made Retroactive Date: _____
per claim aggregate Occurrence coverage

3. Deductible None

Professional Liability: \$ _____ / \$ _____ General Liability: \$ _____ / \$ _____
per claim aggregate per claim aggregate

4. *Self-insured retention None (*refer to application guidelines for required attachments)

\$ _____ / \$ _____
per claim aggregate

a) What coverage does the SIR contemplate? Professional Liability GL Other _____

b) Is there an Insurance Trust? Yes No

c) Is there an Insurance Captive? Yes No

d) What organization handles claims for the SIR? _____

e) What legal firm is responsible for defending claims against the insured? _____

5. Straight Excess / *Excess Umbrella Liability (circle one) None (*refer to application guidelines for required attachments)

Limits \$ _____ / \$ _____ Retroactive Date _____

6. Employee Benefits Administration Liability None

Limits \$ _____ / \$ _____ Retroactive Date: _____

Total number of employees _____

INSURANCE HISTORY

Complete the following professional liability insurance history:

***Current carrier** _____ Claims Made Occurrence

Effective date _____ Expiration date _____ Retroactive Date _____

Limits \$ _____ / \$ _____ Deductible/SIR \$ _____

Expiring premium(s) \$ _____ (*attach copy of current policy - see application guidelines)

1st Prior carrier _____ Claims Made Occurrence

Effective date _____ Expiration date _____ Retroactive Date _____

2nd Prior carrier _____ Claims Made Occurrence

Effective date _____ Expiration date _____ Retroactive Date _____

If you are currently insured on a claims made policy, are you obtaining Extended Reporting Period (Tail) Coverage from your current insurance carrier? Yes No

Note: To prevent possible gaps in your Claims Made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.

PRACTICE INFORMATION

1. The entity is:

- Multi-Physician Shareholder Medical Corporation
- Medical Partnership with formal written agreement
- Staffing Agency/Locum Tenens Firm
- Other (IPA, PPO, Association, etc. specify) _____

2. Indicate extent of professional relationship between the physician members (check all that apply):

- Common letterhead
- Common billing statements (as opposed to utilizing the same billing service)
- Share profits
- Share professional employees (e.g., R.N., Technician)
- See each other's patients on a regular basis
- Share overhead expenses
- All physicians' names appear together on the office door
- Other (describe) _____

3. Indicate below the number of each type of professional employed or contracted by the entity:

NOTE: No coverage is afforded to Professional Employees unless specifically requested

Number of Professional Employees

Number of Other Healthcare Employees

	Employees	Independent Contractors		Employees	Independent Contractors
*Employed Physician/Dentist			Marriage, Family & Child Counselor		
*Employed Resident			Nurse		
Nurse Anesthetist			Optometrist		
Nurse Midwife			Perfusionist		
Nurse Practitioner			Physical Therapist		
Physician Assistant			Athletic Trainer		
Podiatrist			Chiropractor		
Psychologist			EMT/Paramedic		
			Licensed Clinical Social Worker		
			Independent Medical Staff (excl. employees)		

(* if coverage is requested, refer to application guidelines for required attachments)

4. Departed Physicians

*List the full names of departed physicians for whom you are requesting coverage:

**(refer to application guidelines for required attachments)*

Name	Specialty	Retroactive Date	Employment	
			Start Date	End Date

UNDERWRITING INFORMATION

If you answer “Yes” to any of the questions below, provide an explanation in the Comment section, or on a separate sheet of paper:

1. Has any company ever declined, cancelled, refused to renew, restricted, or surcharged your professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your group or any health care professional rendering services on its behalf ever been notified of its involvement in a malpractice claim, suit, or incident, either directly or indirectly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is your group or any health care professional rendering services on its behalf aware of any conduct, circumstances, occurrences, incidents, or accidents that are likely to or reasonably could be expected to give rise to a claim <u>that has not yet been reported</u> to the entity’s current and/or prior insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has your group ever been investigated or audited by a governmental or regulatory agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any physician, patient, or insurance plan filed a complaint of any kind against your group with a medical society, foundation or state/federal agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does your group or any of your practitioners have any written contracts or agreements with a Medical Practice Foundation, Management Services Organization, or similar entity to provide services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are there an physician or allied healthcare professionals in your group who are not licensed or who have restricted licensure or privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are credentials for physicians and allied healthcare professionals checked and approved prior to joining the group?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is there a probationary period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Are new practitioners proctored?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Does any physician or allied healthcare professional have coverage independent of the group?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. If “Yes” to number 11 above, are annual certificates of insurance required for proof of professional liability coverage and are specific limits required? Limits required: \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Are all physician and allied healthcare professional’s privileges reviewed at least once every two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are all foreign medical graduates certified by the Educational Council for Foreign Medical School Graduates or have they passed the FLEX?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Does the entity own, operate, or control any specialized, medically related unit, such as a pharmacy, laboratory, physical therapy center, free-standing surgery center, office based surgical suite, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Does the entity have an ongoing quality assessment and/or improvement plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Does the entity have an ongoing risk management plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes”, how often is it updated? _____	

COMMENTS/EXPLANATIONS

AUTHORIZATION

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

For FL, KY, MN, NJ, OH and PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person who 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. For NY residents only: And shall also be subject to a civil penalty not to exceed five thousand (\$5,000) dollars and the stated value of the claim for each such violation.

This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company.

Signature in full

Date

Print name

HUDSON SPECIALTY INSURANCE COMPANY

A. GENERAL FRAUD STATEMENT

(Not applicable in Colorado, Ohio, Oklahoma and Utah)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 subjects the person to criminal and (NY: substantial) civil penalties.

Applicant's Signature

Date

Print Name/Title

B. FRAUD STATEMENT(S)

UTAH FRAUD STATEMENT

(Workers' Compensation)

For your protection, Utah law requires the following to be included in this application:

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

OKLAHOMA FRAUD STATEMENT

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OHIO FRAUD STATEMENT

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

COLORADO APPLICATION SUPPLEMENT

This Notice is a part of your application for:

- | | |
|-----------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> HOMEOWNERS INSURANCE | <input type="checkbox"/> COMMERCIAL INSURANCE |
| <input type="checkbox"/> PERSONAL LINES PACKAGE INSURANCE | <input type="checkbox"/> PERSONAL UMBRELLA INSURANCE |
| <input type="checkbox"/> PERSONAL INLAND MARINE INSURANCE | <input type="checkbox"/> DWELLING INSURANCE |
| <input type="checkbox"/> PERSONAL AUTO INSURANCE | <input type="checkbox"/> AGRICULTURE INSURANCE |
| <input type="checkbox"/> WATERCRAFT INSURANCE | <input type="checkbox"/> MOBILE HOME INSURANCE |

FRAUD WARNING

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicant's Signature

Date

Print Name/Title

HUDSON SPECIALTY INSURANCE COMPANY

Supplemental Claim Information Form

(make copies of this page as needed)

1. Full name of applicant: _____

2. Full name of claimant: _____

3. Indicate whether: Claim _____ Suit _____ Incident _____

4. Date of incident: _____ 5. Date claim was reported: _____

6. Additional defendants: _____

7. If closed:

Total loss paid including deductible: \$ _____ Defense costs: _____

Indicate whether: Court judgment _____, or Out of court settlement _____

Date closed: _____

8. If pending:

Claimant's settlement demand: \$ _____

Defendant's offer for settlement: \$ _____

Insurer's loss reserve: \$ _____

Deductible amount: \$ _____

Is claim in suit? Yes _____ No _____

If "Yes", amount asked in summons: \$ _____

9. Insurance carrier: _____

10. Description: (Provide enough information to allow evaluation. Use reverse side or additional sheet if required.)

A. Alleged acts, error or omission upon which claimant bases claim:

B. Description of case and events:

C. Description of the type and extent of injury or damage allegedly sustained:

Signature of applicant

Date

HUDSON SPECIALTY INSURANCE COMPANY
Professional Employee Roster
 (make copies of this page as needed)

	Last Name	First Name	M.I.	Specialty	Surgery Level	Retro Date
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Part-Time Employees

Indicate average number of hours worked on a weekly basis

Surgery Level(s)

No Surgery (NS)

Includes normal office procedures as commonly found in a family practice. Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered "No Surgery". This includes administration of local or topical anesthesia and circumcision. No invasive procedures or special procedures room activities are done.

Major Surgery (S)

Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, any other operation, which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life, removal of tumors, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation done using general anesthesia, and the administration of anesthesia other than local or topical.

Minor Surgery (MS)

Includes all listed in definition of "No Surgery", as well as assisting in major surgery, D&C, and vasectomies. Invasive procedures are done, but the procedures do not open or enter a major body cavity.