Darwin Professional Underwriters, Inc.

For:

Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

HEALTH CARE ORGANIZATION PROFESSIONAL LIABILITY AND COMMERCIAL GENERAL LIABILITY APPLICATION

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON CLAIMS MADE BASIS AND COMMERCIAL GENERAL LIABILITY COVERAGE WRITTEN ON EITHER A CLAIMS-MADE OR AN OCCURRENCE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THE APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTION BE ANSWERED ACCURATELY AND COMPLETELY.

Please include the following:

1. Loss History: (supply the following)
   a. Claims listing of ten years currently valued, including current year, detailed loss information (preferably in electronic form).
      Please see ADDENDUM A for the format
   b. Carrier loss runs to support information in 1.a. above.
   c. Full details of allegation on all losses paid or outstanding in excess of $50,000.

2. Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies. Please provide copy of original report from agency (not the internet summary).

3. Current audited financial statement.

4. Copy of medical staff by-laws.

5. AHA Survey of Hospitals

6. Risk management and quality improvement plan.

7. Copies of contracts with independent physician's groups.

8. All hold harmless agreements.

9. For self-insured programs:
   a. Copy of trust financial agreement.
   b. Copy of trust coverage wording.
   c. Financial statement of trust fund.
   d. Recent actuarial review supporting the funding of the self-insured retention.
   e. Description of claims handling – In house, TPA with details on process, case reserve setting and claims handling expertise of people involved.

The requested information is required before a firm quotation can be provided.

Producer Name: _____

Address:_____
Street City

Telephone #: (____) _____

Please type or print clearly.

- **Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.**
- **If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.**
- **This form must be completed, dated and signed by the CEO, CFO or Risk Manager of the proposed insured.**

1. GENERAL INFORMATION

Applicant Name:

_____

Business Address: Street _____ City, State _____ ZIP _____

Mailing Address: _____ Telephone #: _____

Website (if applicable) _____ Years in Business: _____

Key Contact at Insured: _____ Title _____ E-mail address: _____

Federal Tax ID: _____

APPLICANT IS (Check all that applies):

A.	B.	C.	D.
☐ Children's Hospital	☐ Individual	☐ Profit	☐ Accredited by JCAHO
☐ Clinic	☐ Partnership	☐ Non-Profit	☐ Licensed by the state
☐ Critical Access Hospital	☐ Corporation	☐ Charitable	☐ Accredited by AOA
☐ General Hospital	☐ Joint Venture	☐ Government	☐ Medicare Approved
☐ Psychiatric Hospital			☐ Member of AHA
☐ Teaching Hospital			☐ Accredited by CARF
☐ Surgi-Center			☐ Other
☐ Other:			

E. Requested Coverage: Effective Date:

Professional Liability (Claims Made Only):

Limit: $_____per claim $_____aggregate _____ Retroactive Date

Deductible: ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other _____

General Liability:

Limit: $_____per claim $_____aggregate _____ Retroactive Date

☐ Occurrence ☐ Claims-Made

Deductible: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other _____

Employee Benefits Liability (Claims Made Only):

Limit: $_____per claim $_____aggregate _____ Retroactive Date

Deductible: ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other _____

F. Self-Insured Retention (if applicable):

1. To what line of coverage will a self-insured retention apply? _____
2. What limit of liability for the self-insured retention?
   $_____per claim $_____ aggregate

3. Are loss adjustment expenses part of or outside the SIR limit? ☐ Yes ☐ No

4. Is there a dedicated trust? ☐ Yes ☐ No
   If No, how is SIR secured? _____
   If Yes, what financial institution manages the trust? _____
   What organization handles claims for the SIR? _____

5. Has an independent actuarial review been completed? ☐ Yes ☐ No
   Valuation Date of Loss Data Used _____

G. Prior Insurance History

Most recent five (5) Years: (separate Primary General Liability, Professional and Excess/Umbrella, if applicable).

Primary Coverage

Policy Period	Carrier	Limits (HPL/GL)	Deductible (HPL/GL)	Total Premium	Claims Made or Occurrence	Retro Date
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				

Excess/Umbrella Coverage

Policy Period	Carrier	Limits (HPL/GL)	Deductible (HPL/GL)	Total Premium	Claims Made or Occurrence	Retro Date
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				

H. Is the applicant operating under a management agreement? If so, please provide details on a separate sheet of paper.

II. EXPOSURE DATA

A. Professional Liability Exposures

	Next 12 Months Projected	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior	4th Year Prior	5th Year Prior
# Licensed Beds (not rated)							
# Occupied Beds							
Acute Care Beds							
Bassinets							
Long Term Care Beds							
Rehab Beds							
Psychiatric Beds							
Chemical Dependency Beds							
# Visits (Outpatient)							
ER Visits							
Other Outpatient Visits							
Psychiatric Visits							
Home Health Visits							
# Procedures							
Inpatient Surgeries							
Outpatient Surgeries							
Deliveries							
Employed Mid-level Practitioners							
Physician Assistant							
Nurse Practitioner							
Nurse Midwife							
CRNA							
# Employed Physicians							
# Employed Residents							

Have there been any material changes in exposures during the last 10 years not reflected above? If so, please provide details.

B. Facilities and Services (check all that apply)

☐	Abortion Clinic	☐	Gift Shop	☐	Outpatient Clinic
☐	Ambulance	☐	Home Health	☐	Pathology
☐	Bariatrics	☐	Hospice	☐	Pharmacy
☐	Blood Bank	☐	ICU	☐	Physical Therapy
☐	Burn Unit	☐	Inhalation Therapy	☐	Radiation Therapy
☐	CCU	☐	Long Term Care	☐	Radiology
☐	Cardiac Catheterization Center	☐	Morgue	☐	Restaurant
☐	Coronary Care Unit	☐	Neurosurgery	☐	Sex Change Surgery
☐	Day Care - Adult	☐	Nursery	☐	Swimming Pool
☐	Day Care - Pediatrics	☐	OB/GYN	☐	Swing Beds
☐	Dialysis	☐	Open Heart	☐	Trauma Center
☐	Dietary	☐	Off-site Birthing Center	☐	Urgent Care Centers
☐	DME	☐	Operating Rooms	☐	X-ray
☐	Emergency	☐	Organ Transplants	☐	Other
☐	Experimental Surgery	☐	Outpatient Surgi-centers	☐	Other

C. Other Special Activities

- ☐ Clinical Research
- ☐ Experimental Drugs Administration
- ☐ Biomedical device research and development.
- ☐ Animal research.
- ☐ Clinical site for students (specify all that apply)

Please provide details if any of the above apply:

_____

_____

D. Health care Professionals

1. Professional Employees: (indicate total number of employees in each category)

Position	Full-Time	Total Full-Time Equivalents
Employed physicians	____	_____
Employed surgeons	____	_____
Interns	____	_____
Residents	____	_____
Dentists	____	_____
Podiatrists	____	_____
Physician Assistants/Nurse Practitioners	____	_____
Midwives		
Registered nurses	____	_____
LPNs	____	_____
Student nurses	____	_____
X-Ray technicians	____	_____
Lab technicians	____	_____
Pharmacists	____	_____
Profusionists	____	_____
EMT's/Paramedics	____	_____
CRNAs	____	_____
Other employees	____	_____
Volunteers	____	_____

2. Nurse Staffing

What was the average RN vacancy for the past 12 months? _____ %

What percent of nursing shifts per month were staffed by agency personnel (avg. last 12 months) _____ %

2. Employed Physicians to be included for coverage:

Number	Physician Name	# Years in Practice	Full Time Equivalent	Retroactive Date	Date Hired	Termination/ End Date	CoverageType Claims Made or Occurrence	American Board Certified or Eligible (Y/N)	Specialty*	Surgery - None, Minor or Major
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										

* If specialty is Family Practice, please indicate with or without OB.

3. Employed Residents to be included for coverage

Resident Name	Residency Year	Specialty	Surgery (None, Minor or Major)

4. Credentialing

Criteria for qualifications of employed physicians and surgeons:

a. Is history of previous employment verified? ☐ Y or ☐ N
b. Are references checked? ☐ Y or ☐ N
c. Has the license of any employed physician or surgeon ever been restricted or suspended? ☐ Y or ☐ N
d. If yes, please provide details_____
e. Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff? ☐ Y or ☐ N
e. How many employed physicians are board certified or board eligible? _____
f. Do employed physicians, employed surgeons, interns and residents carry own insurance? ☐ Y or ☐ N
g. Are employees to be included as additional insured? ☐ Y or ☐ N

5. Staff Privileges of Private Practitioners:
a. Are credentials of doctors approved by the medical staff and/or hospital review board before privileges are granted? ☐ Y or ☐ N
b. Is there a probationary period of at least six months for all staff doctors? ☐ Y or ☐ N
c. Are staff doctors' performances periodically reviewed by medical staff and/or hospital review board? ☐ Y or ☐ N
d. How frequently are staff privileges evaluated?_____
e. Do hospital by-laws require staff doctors to carry medical malpractice insurance? ☐ Y or ☐ N
If yes, what are limits required? _____ per claim _____ aggregate
f. Are all privileges granted to staff doctors detailed in writing? ☐ Y or ☐ N
g. Has the license of any staff physician ever been restricted or suspended? ☐ Y or ☐ N
If yes, please provide details: _____

_____

6. Anesthesiology

a. Is anesthesiology department staffed by: # of each

____ Employed Physicians _____
____ Contract Group _____
____ Employed CRNAs _____
____ Staff Physicians _____
____ Staff CRNAs _____

b. If under contract, name of group: _____
If contract group, are certificates of insurance required? ☐ Y or ☐ N
If yes, what are limits required? _____ per claim _____aggregate

c. Are all anesthesiologists required to be board certified or eligible in Anesthesiology? ☐ Y or ☐ N

d. Is the anesthesia care performed by CRNAs supervised and reviewed by the anesthesiologists? ☐ Y or ☐ N
If no, please explain: _____

e. Do any of the anesthesia services staff routinely work more than a 12-hour duty shift? ☐ Y or ☐ N
If yes, please explain: _____

7. Radiology

a. Is radiology department staffed by: # of each

_____ Employed Physicians _____
_____ Contract Group _____
_____ Staff Physicians _____

b. If under contract, name of group: _____
If contract group, are certificates of insurance required? ☐ Y or ☐ N
If yes, what limits are required? _____ per claim _____ aggregate

c. Are all radiologists required to be Board Certified or eligible in Radiology and/or Nuclear Medicine? ☐ Y or ☐ N

8. Emergency Department

a. How is emergency department classified according to JCAHO standards:

Level I (tertiary)____ Level II (comprehensive)___ Trauma Center____
Level III (basic)____ Other _____
N/A _____

b. Is emergency department staffed by: # of each

_____Employed Physicians _____
_____Contract Group _____
_____Rotating Staff _____

c. If under contract, name of group: _____
If contract group, are certificates of insurance required? ☐ Y or ☐ N
If yes, what are limits required? _____ per claim _____ aggregate

d. Are all physicians board certified or eligible in emergency medicine? ☐ Y or ☐ N
If No, are they ACLS or PALS certified? ☐ Y or ☐ N

e. Are the emergency physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution? ☐ Y or ☐ N

f. Is the emergency room equipped with the following:
Emergency resuscitation care equipped with defibrillator? ☐ Y or ☐ N
Electrocardiograph machine ☐ Y or ☐ N
Dedicated triage area and staff ☐ Y or ☐ N
Dedicated trauma room(s) ☐ Y or ☐ N

g. Is the Emergency Room open and staffed by a physician 24 hours/day,7 days/week? ☐ Y or ☐ N

h. Do any of the emergency department staff routinely work more than a 12-hour duty shift? ☐ Y or ☐ N
If yes, please explain: _____

9. Obstetrics: Do you have any OB exposure? ☐ Y or ☐ N
If an OB exposure exists, please complete ADDENDUM B attached.

10. Pharmacy
a. Does the facility utilize the unit dose system of dispensing medicine? ☐ Y or ☐ N
b. Is a Pyxis or other dispensing system used? ☐ Y or ☐ N
c. Is the pharmacy for patient use only? ☐ Y or ☐ N
If no, annual receipts for nonpatients medications are $_____
d. Is the pharmacy staffed by a contract group? ☐ Y or ☐ N
If yes, please explain: _____

E. Commercial General Liability Exposure

1.a (Attach separate sheet if needed)

Location	Area	Age	Type of Construction	# of Floors	Type of Fire Protection (City, State)
Patient Care Buildings					
Other Buildings					
Parking Lots					
Vacant Lots					
Fire Protection Key: AS = Approved sprinkler; S = Smoke detector; H = Heat detector A = Automatic Alarm					

b. Are all overnight care buildings Fire Resistive and Sprinklered? ☐ Y or ☐ N
If not, explain _____

2. Employee Benefits Liability Exposures
a. Number of Employees? _____
b. Is Employee benefits Self Administered? ☐ Y or ☐ N

3. Other Exposures

a. Has the hospital planned any new construction and/or abatement for this year? ☐ Y or ☐ N
If yes, please provide details: _____

b. Are there elevators or escalators on any premises owned, leased or occupied by the insured? ☐ Y or ☐ N
If so, how many? _____

c. Does the hospital have a heliport? ☐ Y or ☐ N
# of landings per year _____

d. List all owned, leased or chartered aircraft: _____

e. Does the hospital have separate insurance coverage for heliport, owned, leased or chartered? ☐ Y or ☐ N
If yes, provide details of coverage for each to include carrier, limits and policy periods.

f. Does the hospital own or operate an ambulance or other emergency use vehicles? ☐ Y or ☐ N

g. List the number and type of owned or leased vehicles: _____

h. List all owned, leased and non-owned watercraft:_____

i. If hospital owns or operates a blood bank:
i. Number of volunteer donations
ii. Number of paid donations
iii. Number of pheresis procedures
iv. Number of outpatient transfusions
v. Number of therapeutic plasma exchanges
Is coverage desired for blood bank operations? _____
If "yes", please attach testing procedures. _____
If hospital does not own or operate a blood bank, from where is the blood or blood product obtained?

_____

j. If hospital operates a Day Care:
_____ Number of children per day
_____ Number of adults per day
_____ Number of days per week
On hospital premises? ☐ Y or ☐ N
Open to the public? ☐ Y or ☐ N
_____ Ratio of caregivers to children
Please describe hiring practices for caregivers _____

_____

k. Does hospital operate a Dialysis Unit ☐ Y or ☐ N
If yes, number of procedures per year _____

4. Hold Harmless and Indemnification Agreements

a. Has the hospital agreed to hold harmless or indemnify others under contract? ☐ Y or ☐ N
b. Does the hospital rent or lease any equipment from others? ☐ Y or ☐ N
If a. or b. is yes, please explain: _____

5. Risk Management/Performance

a. Who coordinates your risk management program?

Name: _____Title: _____

Telephone: (_____) _____ E-mail: _____

b. Is there a written, risk management program that has been approved by a governing body? ☐ Y or ☐ N

c. Is there a written performance improvement program that has been approved by a governing body? ☐ Y or ☐ N

d. Does the governing body review the effectiveness of the program and approve necessary changes?

e. Is the risk manager accountable and solely responsible for risk management?

If no, explain other responsibilities: _____

f. Does the risk management program include the following:
___Occurrence reporting
___Claim management
___Formal link to quality management
___Safety program and safety committee
___Review and participation in medical staff committees
___Contract review and evaluation

III. EXCESS OR UMBRELLA

If interested in Umbrella or Excess coverage, please provide the following information:

Underlying Information:

Coverage	Carrier	Policy Dates	Limit	Policy Number
Automobile				
Employers Liability				
General Liability				
Heliport Liability				
Non-Owned Aircraft Liability				

Please provide loss information for the above if these lines are being requested.

IV. CLAIMS HISTORY

1. Have any claims ever been made against you? ☐ Y or ☐ N
   If yes, please provide currently valued carrier loss runs

2. Are you aware of any incident, circumstance or loss which has occurred after the proposed retroactive date, which is likely to result in a claim? ☐ Y or ☐ N

   If yes, please provide details

   Have they been reported to your current or previous carrier(s)? ☐ Y or ☐ N

Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in Questions 1 and 2 is excluded from the proposed coverage.

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONALEXPOSURES.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: 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, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: 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.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: 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 MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY 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 SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: 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.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signature of Applicant: _____

Title: _____

Date: _____

Signature of Producer: _____

License #: _____

Date: _____

Addendum A – Claims Information

Name of Insured _____

Date of Loss Run _____

												Unlimited Ground Up $				
Claim #	Insurance Company	Defendant Name	Policy Eff Date	Policy Exp Date	Incident Date	Report Date	Claimant Name	Description	Status	Date Closed	Ded/SIR	Indemnity Paid	Indemnity Reserve	Expense Paid	Expense Reserve	Total

Addendum B – Obstetrics

9. Obstetrics

1. Is the facility a regional referral center for high risk pregnancies or newborns requiring intensive care? ☐ Y or ☐ N
   If no, does a written procedure exist for transferring all high-risk mothers and/or babies who the hospital is not qualified to treat? ☐ Y or ☐ N

2. Can cesarean sections be performed within 30 minutes at all times? ☐ Y or ☐ N

3. Is an anesthesiologist or CRNA available in house at all times? ☐ Y or ☐ N
   If no, please provide details _____

4. Do Nurse Midwives provide OB services? ☐ Y or ☐ N
   If yes, are they privileged to perform c-sections or VBAC's ☐ Y or ☐ N
   If yes to either question, please attach delineation of privileges

5. Do Family Practitioners provide OB services? ☐ Y or ☐ N
   If yes, are they privileged to perform c-sections or VBAC's ☐ Y or ☐ N
   If yes to either question, please attach delineation of privilege

6. Do nurse midwives deliver babies at patient's homes? ☐ Y or ☐ N

7. Do you have the following nurseries:
   Level I: Well baby Number of bassinets _____
   Level II: Intermediate care Number of bassinets _____
   Level III: Neonatal intensive care Number of bassinets _____

8. How many births at your facility (previous 12 months)? _____

9. How many cesarean sections (previous 12 months)? _____

10. How many vaginal births after C-section (VBACs) (previous 12 months)? _____

11. Are physicians, who are capable of performing a c-section, 'immediately available' for VBAC patients in active labor? ☐ Y or ☐ N
    Please attach copies of:
    - VBAC Policy including facility's definition of 'immediately available'
    - VBAC Informed Consent policies and procedures and form
    - Electronic Fetal Monitoring competencies and training policies and procedures.

12. Please provide the following information using data from the last 12 months:

    Number of live births with inductions (i.e. pitocin only) _____
    Number of births using either forceps or vacuum extractions _____
    Number of birth related injuries _____
    Number of births with 5 minute Apgar score of less than 7 _____
    Number of neonatal deaths (age < 28 days) _____
    Number of maternal deaths _____

13. Please provide the nurse/patient ratio for the following:
    a. Patients in early labor _____
    b. Patients undergoing induction or augmentation of labor _____
    c. Patients in the 2nd stage of labor and beyond _____
    d. Newborns in normal newborn nursery _____
    e. Newborns requiring level 2 (continuing/intermediate) care _____
    f. Newborns requiring level 3 (intensive) care _____

14. How many physicians have OB privileges? _____

15. How many are board certified in OB _____

16. Are nurses required to participate in electronic fetal monitoring training and testing? ☐ Y or ☐ N
    How often? _____

17. Are physicians required to participate in electronic fetal monitoring training and testing? ☐ Y or ☐ N
    How often? _____