

## APPLICATION FOR MULTI-PRACTICE CLINIC OR LARGE GROUP PRACTICE FOR PROFESSIONAL LIABILITY INSURANCE

INSTRUCTIONS: Please complete all sections and sign. If a section does not apply, please indicate by answering "N/A" as appropriate. Attach additional sheets as needed.

### I. GENERAL INFORMATION

Clinic (Group) Name				Telephone Number	
				Fax Number	
Location Street Address	City	State	Zip Code	County	
Mailing Street / P.O. Box Address	City	State	Zip Code	County	
Tax Identification Number					

### II. NAMES AND DESCRIPTION OF ALL LEGAL ENTITIES (Indicate below if entity to be insured.)

Name	Description	Entity Type:	To be Insured?		Prior Acts Date
			Yes	No	
A			<input type="checkbox"/>	<input type="checkbox"/>	
B			<input type="checkbox"/>	<input type="checkbox"/>	
C			<input type="checkbox"/>	<input type="checkbox"/>	

### III. COVERAGE REQUESTED

Effective Date:	Retroactive Date:	Deductible/SIR:
<input type="checkbox"/> \$100,000/\$300,000	<input type="checkbox"/> \$200,000/\$600,000	<input type="checkbox"/> \$250,000/\$750,000
<input type="checkbox"/> \$500,000/\$1,000,000	<input type="checkbox"/> \$500,000/\$1,500,000	<input type="checkbox"/> \$1,000,000/\$3,000,000
A "tail" policy is generally available as an option of your expiring Claims Made Policy. Are you purchasing a tail? <span style="float: right;"> <input type="checkbox"/> Yes   <input type="checkbox"/> No         </span>		

**IV. PROFESSIONAL LIABILITY INSURANCE COVERAGE** (for previous three year period).

	Current Year	First Prior Year	Second Prior Year
Insurance Company			
Policy Number			
Limits of Liability	\$	\$	\$
Deductible or SIR and Amount	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$	<input type="checkbox"/> Deductible <input type="checkbox"/> SIR \$
Coverage Form	<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
Prior Acts Date			
Policy Period	Fr.:     To:	Fr.:     To:	Fr.:     To:

Has any insurance company canceled, refused to issue or renew your Professional Liability insurance policy(ies)?

Yes  No If yes, explain: \_\_\_\_\_

Main Location

Owned  Leased  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sq. feet \_\_\_\_\_ No. of floors \_\_\_\_\_ Date Acquired \_\_\_\_\_  
 Additional Locations

Location No. 2

Owned  Leased  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sq. feet \_\_\_\_\_ No. of floors \_\_\_\_\_ Date Acquired \_\_\_\_\_  
 Type of Operation (if not a clinic) \_\_\_\_\_

Location No. 3

Owned  Leased  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sq. feet \_\_\_\_\_ No. of floors \_\_\_\_\_ Date Acquired \_\_\_\_\_  
 Type of Operation (if not a clinic) \_\_\_\_\_

Location No. 4

Owned  Leased  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Sq. feet \_\_\_\_\_ No. of floors \_\_\_\_\_ Date Acquired \_\_\_\_\_  
 Type of Operation (if not a clinic) \_\_\_\_\_

If additional space is required, use additional sheet.

- a. Date group entity was established: \_\_\_\_\_
- b. Length of time at main location: \_\_\_\_\_
- c. Within the next 12 month period, does the facility plan to:
- obtain another facility or entity?  Yes  No
  - add to the number of physicians?  Yes  No
  - expand the number of locations?  Yes  No

**IF ANSWER IS YES TO ANY QUESTION ABOVE, PLEASE DESCRIBE ON YOUR LETTERHEAD.**

**V. ADMINISTRATION**

- a. Name of Chief Executive Officer: \_\_\_\_\_
- b. Name of Medical Director: \_\_\_\_\_
- c. Name of Administrator/Risk Manager: \_\_\_\_\_

**VI. PHYSICIANS** (Individual applications required)

a. Please indicate the number of

	Current Year	First Prior Year	Second Prior Year
Full-time Physicians			
Part-time Physicians			
Dentists			
Podiatrists			
Total*			

\* Please explain any year-to-year change that occurred in excess of 10%.

b. Are all physicians, surgeons, dentists and medical personnel duly licensed/certified to practice medicine in your state?  Yes  No

c. Number of Independent Contractors \_\_\_\_\_ (Certificates of Insurance required)

d. If you administer anesthesia, please complete the Anesthesia Supplement.

**VII. SUPPORT STAFF**

Employees and Contractors Total \_\_\_\_\_

Please enter the total number of full-time equivalent employees/contractors by classification on page 4.

## CLASSIFICATIONS

	I. Number of FTE Employees	II. Number of FTE Contractors
Section A		
Midwife	_____	_____
Nurse Anesthetist	_____	_____
Nurse Practitioner	_____	_____
Operating Room Technician (Surgical)	_____	_____
Operating Room Technician (Non-Surgical)	_____	_____
Paramedic	_____	_____
Physician Assistant**	_____	_____
Scrub Nurse	_____	_____
Surgeon Assistant**	_____	_____
Total Ancillary Personnel	_____	_____
Section B		
Audiologist	_____	_____
Laboratory Technician	_____	_____
Nurse (R.N. & L.P.N.)	_____	_____
Optometrist	_____	_____
Perfusionist	_____	_____
Physical Therapist	_____	_____
Psychologist	_____	_____
Pulmonary Therapist	_____	_____
Registered Pharmacist	_____	(Inc. Pharmacy) _____
X-Ray Technician (w/o Therapy)	_____	_____
X-Ray Technician (with Therapy)	_____	_____
Other Miscellaneous Medical Personnel	_____	_____
Medical Assistants	_____	_____
Clerical	_____	_____
Total Miscellaneous Medical Personnel	_____	_____

\*\* This classification applies to physician or surgeon assistants who have completed an approved course of study leading to university certification, national certification if required by the state, and who perform their duties under the direct supervision of a licensed physician or surgeon, assisting in the facility and/or research endeavors of the physician or surgeon.

**VIII. OPERATIONS**

a. Are any of the named insureds a party to any agreement or contract with any entity/individual which is not a part of this entity?  Yes  No  
If yes, explain: \_\_\_\_\_

b. Patient Mix:

1. Fee for service	_____	10	_____	%
2. Pre-paid (HMO, PPO)	_____	30	_____	%
3. Medicare	_____	15	_____	%
4. Medicaid	_____	45	_____	%

Please explain the medical services that are not on a "fee for service" basis: \_\_\_\_\_

c. Average annual patient load: \_\_\_\_\_ (audited at policy expiration)  
Percentage of transient patients \_\_\_\_\_ %

d. Does the clinic attract patients because of reputation in any particular field of medicine?  Yes  No  
If Yes, please specify \_\_\_\_\_

- e. Does the clinic own control, or staff ore or more of the following:
- a. Facilities for overnight patient monitor/care  Yes  No
  - b. Hospital  Yes  No
  - c. Surgicenter/Clinic Surgical Outpatient Unit  Yes  No
  - d. Emergency Room  Yes  No
  - e. Birthing Center  Yes  No
  - f. Substance Abuse Programs  Yes  No
  - g. Radiation and/or Shock Therapy  Yes  No
  - h. Laboratory (Limited Lab facilities for patients only)  Yes  No
  - i. X-ray Facility (Diagnostic)  Yes  No
  - j. Pharmacy – Annual gross sales if Druggists Liability is requested \$  Yes  No
  - k. Optical Goods Store – If Yes, indicate annual gross sales \$  Yes  No
  - l. Hearing Aid Store – If Yes, indicate annual gross sales \$  Yes  No

IF ANSWER IS YES TO ANY QUESTIONS ABOVE, PLEASE DESCRIBE ON YOUR LETTERHEAD.

Specify hospitals at which the clinic physicians hold staff or courtesy privileges:

Hospital Name	General	Child	JCAHO or ADA APPROVED	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**IX. LOSS CONTROL**

- a. Does the clinic have a Loss Control program?  Yes  No  
 If Yes, show date of last site inspection \_\_\_\_\_  
 Also, please describe nature of program on your letterhead.
- b. Does the clinic have an arbitration plan?  Yes  No  
 If Yes, please describe nature of program on your letterhead.
- c. Does a Peer Review Committee exist?  Yes  No
- d. Please describe how fee related complaints are handled. \_\_\_\_\_

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- e. Does the clinic provide for continuing education programs?  Yes  No
- f. Are any research or teaching programs conducted?  Yes  No  
 If Yes, please describe on your letterhead.
- g. Is there a Credentials Committee?  Yes  No
- h. Are informed consent forms used?  Yes  No
- i. Describe how you dispose of contaminated materials, human tissue, nuclear materials, or other hazardous materials. \_\_\_\_\_

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- j. Do you have an EPA Registration Number?  Yes  No  
 If Yes, attach the RCRA or Super Fund application Forms.
- k. Are oxygen and other gas cylinders used?  Yes  No  
 If Yes, indicate where stored. \_\_\_\_\_
- l. Radiation  
 Does the clinic use radium or other isotopes?  Yes  No  
 If Yes, describe on your letterhead safety precautions taken.  
 Describe type and frequency of tests for stray X-Ray radiation.
- m. Do floor and ceiling of room in which radium and X-Ray are used have lead lining or equivalent protection?  Yes  No
- n. Does the clinic edit or sell publications, video tapes or other media?  Yes  No  
 If Yes, please explain. \_\_\_\_\_

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**X. NEW PHYSICIANS**

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a. How are qualifications of new physicians checked? (Describe)

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b. Are all prospective physicians required to be Certified or Board Eligible?  Yes  No  
If No, explain reasons on your letterhead.

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**XI. MEDICAL RECORDS PROCEDURES (Check those applicable)**

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- a.
- Terminal Dicit
  - Color Coded
  - Alphabetic
  - Numerical with Cross Reference File
  - Centralized
  - Fastened in Folder
  - Loose Leaf Binder
  - Progress Notes Written (signed and dated by Physician)
  - Progress Notes Types (signed by Dictating Physician)
  - Drug Allergies Noted in Patient File
  - Medical Records Librarian
  - Medical Records Supervisor
  - Medical Records Committee
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b. How are records keeping deficiencies handled?

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c. Are all records kept at the Main Facility Location?  Yes  No  
If No, indicate where and by whom they are kept.

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**XII. ACCREDITATION**

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a. Are you a member of a national organization?  Yes  No  
Explain: \_\_\_\_\_

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b. Is the clinic certified or accredited a national organization?  Yes  No  
Explain: \_\_\_\_\_

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(Include copy of most recent survey, certification, or accreditation.)

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**XIII. CLAIMS INFORMATION**

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Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim of suit?  Yes  No If yes, complete a claims supplement for each claim. Total Number of Claims Open Closed

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We hereby certify that if Prior Acts coverage is being requested, we have no knowledge of any professional liability claims which have been asserted against us, or any affiliated professional association, corporation or subsidiary, or of any occurrence, incident, or circumstance likely to result in such claim on or after the requested initial effective date of the Prior Acts coverage, except the following. (Provide a brief description of each such claim, occurrence, incident or circumstance):

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I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers.

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Chief Executive Officer or  
Chief of Medical Staff  
(Signature Required)

Date

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Clinic Administrator  
(Signature Required)

Date

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

# **CBMALAGA**

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## Insurance Services LLC

### APPLICATION FOR MULTI-PRACTICE CLINIC OR LARGE GROUP PRACTICE FOR PROFESSIONAL LIABILITY INSURANCE

#### SUBMISSION CHECKLIST

- Fully completed application.
- On a separate sheet, list names, specialty field, state of license, and number of hours worked of all employed physicians, surgeons, interns and residents.
- Breakdown of surgical procedures being performed at the facility annually, by type.
- JCAHO report with recommendations including status of recommendations.
- Current financial statement.
- Copy of by-laws of the clinic.
- Job description of the risk manager.
- Copy of all hold harmless agreements.
- Actuarial review for the S.I.R.
- Trust agreement for the S.I.R.
- Copies of all contracts with independent physician groups.
- Contracts with area hospitals.

1-877-245-5887

Return application by fax or email

fax: (310) 796-9054

email: [info@cbmalagains.com](mailto:info@cbmalagains.com)