ADMIRAL INSURANCE COMPANY
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HEALTH CARE ORGANIZATION & PROVIDER PROFESSIONAL LIABILITY APPLICATION

NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR, APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR WITHIN SIXTY (60) DAYS AFTER THE END OF THE "POLICY PERIOD". IF AN EXTENDED REPORTING PERIOD IS APPLICABLE, SUCH COVERAGE WILL APPLY ONLY TO CLAIMS FIRST MADE AGAINST THE INSURED DURING THE EXTENDED REPORTING PERIOD AND REPORTEDTO THE UNDERWRITER DURING THE EXTENDED REPORTING PERIOD. THE COVERAGE AFFORDED UNDER THIS POLICY DIFFERS IN SOME RESPECTS FROM THAT AFFORDED UNDER OTHER POLICIES. PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.

A. APPLICANT

1. Legal name of facility or hospital: _____
2. Address: _____
3. Telephone number: _____ Website (if applicable): _____
4. Name of Risk Manager: _____ Email address: _____
   Telephone number: _____
5. How many years has the Applicant been in operation? _____
6. How many years has the Applicant been under present ownership? _____
7. Please list all affiliates and subsidiaries to which this insurance is to apply. Please include a complete description of the operations of each affiliate/subsidiary and the relationship to the Applicant. (Please attach a separate sheet if necessary.) (*Note that coverage for such entities is not automatically provided; the terms and conditions of the Policy, if issued, will determine actual coverage.) _____
   _____
   _____

B. GENERAL INFORMATION

Applicant is (please check all appropriate categories):

_____ General Hospital	_____ Operated For-Profit
_____ Children's Hospital	_____ Not-for-Profit
_____ Teaching Hospital	_____ Medicare Approved
_____ Psychiatric Hospital	_____ Partnership
_____ Research Hospital	_____ Corporation
_____ Convalescent or Nursing Home	_____ Licensed by the State
_____ Clinic	_____ Charitable
_____ Community Health Center	_____ Surgicenter
_____ Physical Rehabilitation	_____ Alcohol & Drug Rehabilitation
_____ Governmental	_____ Other (explain): _____

1. Is the Applicant accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)?

_____ Yes _____ No

Date of last accreditation: _____

Accreditation period: _____
(Please attach a copy of the most recent survey.)

Is the Applicant licensed by the State? _____ Yes _____ No
(Please attach a copy of the most recent State license survey)

2. Has the Applicant or other associated entity ever had its license revoked, suspended or been placed on probation by any governmental licensing agency? _____ Yes _____ No If Yes, please explain: _____
_____
_____

3. Has the Applicant ever been investigated by any third party for alleged fraud, erroneous billing or entered into a Compliance Integrity Agreement? _____ Yes _____ No If Yes, please explain: _____
_____

4. Has the Applicant entered into any joint ventures or limited partnerships? _____ Yes _____ No If Yes, please explain: _____

5. Is any part of the Applicant operated/leased by a management corporation? _____ Yes _____ No If Yes, please give the name of the corporation and details of structure: _____
_____
_____
Attach a copy of the management or services agreement.

6. Does the Applicant participate in any teaching programs? _____ Yes _____ No If Yes, please describe the type of programs: _____

Is the program hospital sponsored? _____ Yes _____ No If Yes, please provide the name of the sponsoring institution: _____

7. Does the Applicant participate in any clinical research or clinical trials? _____ Yes _____ No If Yes, please explain and discuss whether the Applicant has an IRRB in place: _____
_____
_____

8. Does the Applicant anticipate any facility or service expansions (for example, an increase in licensed beds) within the next year? _____ Yes_____ No If Yes, please explain:_____
_____
_____

9. Does the Applicant anticipate any sale of assets, mergers, acquisitions, consolidation or change in operations or services within the next twelve (12) months? _____ Yes _____ No If Yes, please explain: _____
_____

C. PERSONNEL

Indicate the number of persons employed by or working under the control of the Applicant in each of the following classifications:

____	Certified Registered Nurse Anesthetists**	____	Nurse Practitioners*
____	Dentists*	____	Paramedics
____	Emergency Medical Technicians	____	Registered Nurses
____	Interns	____	Respiratory Therapists
____	Laboratory or X-ray Technicians	____	Pharmacists
____	Licensed Vocational/Practical Nurses	____	Physician Assistants*
____	Nurse's Aides	____	Physicians and Surgeons**
____	Nurse Midwives*	____	Residents
____	Other (explain): _____		

* Please provide separate listings of names and specialties (and contract, if applicable) for each.
** A separate application will be required for each to evaluate coverage for such professionals.

D. OPERATIONS

1. EXPOSURES (Please complete for the current year and five (5) previous years.)

	Current Year Estimated Average Annual Occupancy/Visits	Prior Years 1	2	3	4	5
a. **Beds**						
Total Hospital Beds	_____	____	____	____	____	____
Total Average Annual	_____	____	____	____	____	____
Occupancy Breakdown Capacity						
_____ Acute Care Beds	_____	____	____	____	____	____
_____ Cribs	_____	____	____	____	____	____
_____ Bassinets	_____	____	____	____	____	____
_____ Extended Care	_____	____	____	____	____	____
_____ Skilled Nursing Beds	_____	____	____	____	____	____
_____ Psychiatric	_____	____	____	____	____	____
_____ Rehabilitation	_____	____	____	____	____	____
_____ Chemical Dependency	_____	____	____	____	____	____
_____ Hospice	_____	____	____	____	____	____
_____ Other	_____	____	____	____	____	____
b. **Outpatient Services**						
Emergency Room Visits	_____	____	____	____	____	____
Outpatient Surgery	_____	____	____	____	____	____
Other Outpatient Visits (per Patient per Registration Day)	_____	____	____	____	____	____
Home Health Care Visits	_____	____	____	____	____	____
Clinic Visits	_____	____	____	____	____	____
Reference Laboratory	_____	____	____	____	____	____
Tests	_____	____	____	____	____	____
c. **Inpatient Surgeries**	_____	____	____	____	____	____
d. **Deliveries**(excluding cesarean sections)	_____	____	____	____	____	____
(i) Cesarean Sections	_____	____	____	____	____	____
(ii) VBAC's	_____	____	____	____	____	____

a. Other:

Is coverage requested for the following? If Yes, please indicate name and profession:

Nurse Anesthetist: _____ Yes _____ No

Physician Assistants: _____ Yes _____ No

Employed or contract physicians (see question 3 below for Emergency Room Physicians).

b. If the Applicant provides professional liability coverage for Emergency Room Physicians, what is the total estimated number of patients examined or treated for the current year and the actual number for the five (5) previous years?

Current Year	Prior Years				
	1	2	3	4	5
_____	____	____	____	____	____

c. State sources and amount of total revenue:

Source	**Amount Last Policy Year**	**Est. Amount This Policy Year**
A. Charitable Contributions	$ _____	$ _____
B. Government Funding	$ _____	$ _____
C. Fee For Service	$ _____	$ _____
D. _____	$ _____	$ _____
E. _____	$ _____	$ _____
TOTAL GROSS REVENUE:	$ _____	$ _____

d. Number of patient encounters last 12 months _____ and/or patient tests carried out _____. (NOTE: "Patient encounters refers to number of visits — not number of patients).

e. Number of estimated patient encounters next 12 months _____ and/or patient tests carried out _____. (NOTE: "Patient encounters refers to number of visits — not number of patients).

4. SERVICES (Please indicate if the Applicant presently provides, plans to provide, or presently operates any of the following):

____ Abortion Clinic	____ Day Care	____ Lifeline
____ Ambulance Service	____ Dental Services	____ Mobile Unit (blood-mobiles, mammography, CAT scan units, etc.)
____ Base Hospital	____ Emergency Room	
____ Blood Bank	____ Managed Care Services	
____ Burn Units	____ Home Health Care	
____ Cardiac Catheterization Centers	____ Hospice	____ Nursery
____ Coronary Care Unit	____ Inhalation or Respiratory Therapy	____ Neonatal
____ Dialysis		____ Off-Premises Food Services
____ Ob/Gyn	____ Intensive Care Unit	
____ Oncology	____ Organ Bank	____ Off-Premises Labs
____ Cardiovascular Surgery	____ Organ Transplants	____ Pharmacy
____ Off-Premises Clinics	____ Outpatient Surgicenters	____ Transportation (other than ambulance)
____ Other (explain): _____		

5. ANESTHESIA SERVICES

a. Staffing is by: ____ Contracted Physicians ____ Employed Physicians ____ Residents
____ Contracted Certified Registered Nurse Anesthetists (CRNAs)
____ Employed CRNAs ____ Staff Physicians

b. Are all physicians board certified or eligible? _____ Yes _____ No If No, please explain: _____
_____

c. If services are provided via contract, to whom is staffing contracted? Please explain and attach a copy of the contract: _____

d. Are contract physicians required to carry professional liability insurance? _____ Yes _____ No If Yes, what limits are required? _____

Does the Applicant obtain a certificate of Insurance? _____ Yes _____ No

e. Describe the minimum qualifications required for administration of general anesthesia: _____
_____

f. CRNAs

(i) Do CRNAs provide anesthesia service? _____ Yes _____ No
If Yes, please describe the relationship between the Applicant and the CRNAs below:
Are they: Employed by the applicant? _____ Yes _____ No
Employed by the Anesthesiologist? _____ Yes _____ No
Employed by the Surgeon? _____ Yes _____ No
Independent? _____ Yes _____ No

(ii) Do CRNAs work under the direct supervision of an anesthesiologist? _____ Yes _____ No
If No, please submit written guidelines developed with the collaborative physician or qualified physician designee of the primary physician or the dentist responsible for the patient's immediate care.

6. RADIOLOGY SERVICES

a. Staffing is by: ____ Residents ____ Employed Physicians ____ Contracted Physicians
Are all physicians board certified or eligible? _____ Yes _____ No
If No, please explain: _____

b. If under contract, to whom is staffing contracted? _____
Are contract physicians required to carry professional liability insurance? _____ Yes _____ No
If Yes, what limits are required? _____
Does the Applicant obtain a Certificate of Insurance? _____ Yes _____ No

c. Please state the number of X-ray machines owned or operated, and whether they are used for diagnosis or treatment or both. Please state by whom treatment is given: _____
_____
_____

7. OBSTETRICS

a. Is the Applicant a regional referral center for either high-risk OB or newborns requiring intensive care?
_____ Yes _____ No

b. Number of labor rooms: _____

c. Number of delivery rooms: _____

d. Does the Applicant have a separate birthing center? _____ Yes _____ No

e. Is the delivery room suite separate from the surgical suite? _____ Yes _____ No

f. Can cesarean sections be performed within thirty (30) minutes at all times? _____ Yes _____ No

g. Is an anesthesiologist or CRNA available in-house twenty-four (24) hours per day for the obstetrical suite?
_____ Yes _____ No
If No, what is the maximum time for arrival at hospital? _____

h. Is an obstetrician available in-house twenty-four (24) hours per day for the obstetrical suite?
_____ Yes _____ No
If No, what is the maximum time for arrival at hospital? _____

i. Do Family Physicians or Nurse Midwives perform obstetrical services? _____ Yes _____ No
If Yes, please describe delivery protocols or attach applicable policy: _____
_____

j. Do Family Physicians or Nurse Midwives perform VBACs or C-Sections? _____ Yes _____ No
If Yes, please describe delivery protocols or attach applicable policy: _____
_____

k. If the Applicant has a neonatal intensive care unit (NICU), state:
(i) total number of neonates admitted to NICU in the past twelve (12) months: _____
(ii) total number of neonates admitted to NICU who were transferred from other facilities: _____
(iii) whether full-time attending neonatologist is on-site in NICU twenty-four (24) hours per day?
_____ Yes _____ No

l. If the Applicant does not have NICU, please state the total number of neonates transferred from the institution to other facilities in the past twelve (12) months: _____

8. EMERGENCY ROOM

Does the Applicant provide emergency room (ER) service? _____ Yes _____ No
If Yes, please answer the following questions:

a. What level of service does the Applicant provide (based on the standard of the JCAHO)? (Check all that apply)
____ I (Tertiary ____ II (Comprehensive ____ Trauma Center
____ III (Basic) ____ Stand-by services only

b. Is the Applicant's emergency room open and staffed 24 hours a day, 7 days a week, 365 days a year? If No, please explain: _____

c. Is the ER service operated by the Applicant? _____ Yes _____ No

d. If under contract, to whom is staffing contracted?_____
Are contract physicians required to carry professional liability insurance? _____ Yes _____ No
If Yes, what limits are required? _____
Does the Applicant obtain a Certificate of Insurance? _____ Yes _____ No

e. Staffing is by: ____ Residents
____ Employed Physicians
____ Contracted Physicians
Are physicians board certified or eligible? _____ Yes _____ No If No, please explain: _____
_____

9. SPECIAL SERVICES

Does the Applicant provide the following services:

a. Ambulance: _____ Yes _____ No If Yes, Number of vehicles _____
Number of runs per year _____

b. Blood Bank: _____ Yes _____ No If Yes, Number of donors (pints) _____
Number of pints purchased from others _____

c. Organ Tissue Bank: _____ Yes _____ No If Yes, Number of donors _____
Number of organ tissue donations per year _____

d. Day Care: _____ Yes _____ No If Yes, Number of children per day _____
Number of days per week _____
On-hospital premises _____ Yes _____ No
Open to the public _____ Yes _____ No

e. Dialysis Unit: _____ Yes _____ No If Yes, Number of procedures per year _____

E. STAFF PRIVILEGES

1. Please indicate the number of staff physicians in each of the following categories:
____ Active ____ Consulting ____Emeritus
____ Associate ____ Courtesy ____ Probationary

2. Are credentials for new staff members checked and approved prior to granting staff privileges?
_____ Yes _____ No If Yes, by whom? _____
How are the potential staff applicants' degree(s) and experience verified? _____
_____
_____
_____

3. Are privileges provisional or at least six (6) months for all new staff members? _____ Yes _____ No

4. Does the Applicant have any staff members who are not licensed or who have restricted licenses or privileges?
_____ Yes _____ No If Yes, please explain: _____

5. Do department heads evaluate the work of their staff members? _____ Yes _____ No

6. Is an ongoing medical audit maintained on all staff members' clinical work? _____ Yes _____ No

7. Are all staff privileges reviewed each year? _____ Yes _____ No If No, how frequently are staff privileges evaluated? _____

8. Does the Applicant require all foreign school graduated to be certified by the Educational Council for Foreign Medical School Graduates? _____ Yes _____ No

9. Staff members' professional liability insurance:

a. Are all staff members required to maintain professional liability insurance? _____ Yes _____ No

b. Is this requirement stated in the staff bylaws? _____ Yes _____ No

c. What limits are required? _____

d. What evidence of compliance is required? _____
_____

Please include a copy of the medical staff bylaws stating the insurance requirements for staff members.

F. RISK MANAGEMENT

1. Is there a written, formalized risk management program? _____ Yes _____ No If Yes, please provide a synopsis of the program: _____
_____
_____

2. Is the program periodically reviewed for effectiveness and necessary changes implemented?
_____ Yes _____ No

3. Who is in charge of implementing this program and any changes? _____
_____

4. Does the Applicant have a formalized quality assurance program? _____ Yes _____ No If Yes, please provide a synopsis of the program: _____
_____
_____

G. CONTRACTUAL AGREEMENTS

1. a. Does the Applicant lease or rent any equipment from others? _____ Yes _____ No If Yes, please provide a description of the equipment: _____
_____
_____

b. Does the Applicant indemnify (hold harmless) the owner for liability? _____ Yes _____ No If Yes, please submit a copy of the agreement.

2. a. Please identify and contract professional services performed for the Applicant:
____ Housekeeping ____ Pathology
____ Laboratory ____ Pharmacy
____ Laundry ____ Other (explain): _____

b. Does the Applicant require these contractors to provide evidence of insurance? _____ Yes _____ No If Yes, what limits of liability does the Applicant require? _____
Please submit a copy of each contract.

3. a. Are there any other service contracts in effect? _____ Yes _____ No If Yes, please describe services:
_____

H. PYSICAL PREMESIS

1. Please list all the buildings the Applicant owns, controls, or occupies. Where fixed features exist for a building, please list wings, floors or areas separately. Please attach a separate schedule if more space is needed.

a. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? _____ Yes _____ No Smoke detectors? _____ Yes _____ No

b. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? _____ Yes _____ No Smoke detectors? _____ Yes _____ No

c. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? _____ Yes _____ No Smoke detectors? _____ Yes _____ No

d. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? _____ Yes _____ No Smoke detectors? _____ Yes _____ No

e. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? _____ Yes _____ No Smoke detectors? _____ Yes _____ No

f. Address: _____

Year built: _____ No. of stories: _____ Purpose: _____

Construction (brick, fire-resistive, etc.): _____

Total sq. ft.: _____

Complete sprinkler system? _____ Yes _____ No Smoke detectors? _____ Yes _____ No

2. Does the Applicant have a heliport/helipad? _____ Yes _____ No If Yes, where is the pad located (e.g., parking lot, top of building, etc.)? _____
_____

How far is it from the Applicant? _____

Please list the dimensions of helipad: _____

Please describe the type of construction: _____

3. Are security measures used to control unauthorized access or entrance to any of Applicant's facilities? _____ Yes _____ No If Yes, please describe: _____
_____

I. PROFESSIONAL LIABILITY INSURANCE

1. Applicant's current professional liability coverage:
   a. Carrier: _____

   b. Policy period: _____

   c. Limits of liability (per claim and aggregate): _____

   d. Deductible or retention: _____

   e. Present coverage is: Occurrence _____ Yes _____ No Claims Made _____ Yes _____ No
   Prepaid Claims-Made_____ Yes _____ No Includes General Liability _____ Yes _____ No

   f. Current retro date: _____

MISSOURI APPLICANTS/AGENTS: DO NOT ANSWER QUESTION 2.

2. Past Coverage:
   Has any insurer canceled or declined to issue professional liability insurance for the Applicant?
   _____ Yes _____ No If Yes, please explain: _____

3. Gross Annual Receipts/Revenue:

Next Year	$_____
This Year	$_____
Last Year	$_____

4. Claims History:
   a. Has any individual or entity proposed for coverage ever submitted to a liability insurer or risk transfer instrument any claim or given notice of any fact, situation, transaction, event, act error or omission for malpractice claim, suit or incident, either directly or indirectly? _____ Yes _____ No

      If Yes, please attach information about such losses for the last ten (10) years, including the current year and a breakdown of total incurred losses, paid losses, and outstanding losses, separated by year for professional liability and general liability. Please provide full details of any claim paid or outstanding during this period in excess of $100,000 (paid) or $50,000 (outstanding).

   b. Other than claims or potential claims that have been reported to a previous liability insurer or risk transfer instrument is any individual or entity proposed for coverage aware of any fact, circumstance, situation, transaction, event, act, error or omission which they know or reasonably should know may result in a claim that may fail within the scope of the proposed insurance? For the purposes of the questions,

"reasonably should know" includes any act, error, omission or occurrence that alleged sexual, physical or emotional abuse or misconduct; or was the subject of any peer review; professional or specialty association investigation or review; FDA MedWatch report; internal review or investigation; inquiry by any accreditation or licensing entity; local state or federal investigation; JCAHO "near miss" notification or demand by legal counsel or matter submitted to legal counsel; mandatory report on professional conduct; or similar investigation or review. _____ Yes _____ No If Yes, please provide details: _____
_____
_____
_____

NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS AND REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM, OR RELATED CLAIM, ARISING OUT OF ANY FACT, CIRCUMSTANCE, SITUATION, TRANSACTION, EVENT, ACT, ERROR, OR OMISSION THIS IS OR SHOULD HAVE BEEN DISCLOSED IN RESPONSE TO QUESTIONS 3a OR 3b IS EXCLUDED FROM THE PROPOSED INSURANCE.

5. Requested Limit of Liability: _____ Per Claim _____ Annual Aggregate

   Requested Retention: _____ Per Claim _____ Annual Aggregate

   Desired effective date of coverage: _____

PLEASE DISCLOSE ANY INFORMATION MATERIAL TO THE RISK WHICH HAS NOT OTHERWISE BEEN ADDRESSED IN THIS APPLICATION. (PLEASE ATTACH ADDITIONAL SHEETS OF PAPER IF NECESSARY).

Please include copies of the following:
1. The Applicant's most recent annual report
2. A copy of the Applicant's most recent JCAHO report and response to any contingencies
3. The Applicant's most current audited financial statement
4. A copy of the Applicant's current balance of the self-insured trust fund*
5. A copy of the Applicant's Trust agreement*
6. Recent actuarial study supporting the funding of the Applicant's self-insured trust*
7. A copy of the Applicant's Medical Staff Bylaws
8. Carrier Claim report(s) for the Applicant for the past ten (10) years, including amounts paid and reserved.

*These items apply if Applicant has set up a self-insured trust fund.

Notice to Applicant – Please read carefully.

For the purposes of this Application, the undersigned authorized agent of the person(s) and the entity(ies) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Application and any attachments or information submitted with this Application (together referred to as the "Application") are true and complete. The Underwriter considers the Application, which is on file with the Underwriter, physically attached to any policy issued. The Underwriter will have relied upon this Application in issuing the policy.

The Applicant authorizes the Underwriter to make any inquiry in connection with this Application. Accepting this Application does not bind the Underwriter to complete, or the Applicant to purchase, the insurance.

If the information in this Application materially changes between the date of the Application and the policy effective date, the Applicant will notify the Underwriter which may modify or withdraw any quotation or agreement to bind insurance.

I hereby declare that the above statements and particulars are true and that I have not omitted or misstated any material facts and I agree that this Application shall be the basis for any insurance policy that is issued.

Date: _____ Signature of Applicant: _____

Title: _____

NOTE: This Application must be signed by the Chairman and/or President of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.