



Please complete this Application, provide the supporting document and return by overnight or registered mail to:  
 Yellowstone Insurance Exchange, RRG  
 Attn: Eric J. Gardzina, CPHRM  
 4301 Hillsboro Pike, Suite 310  
 Nashville, Tennessee 37215  
 Telephone 866-216-7433

**Yellowstone Insurance Exchange, RRG  
 HOSPITAL PROFESSIONAL / GENERAL LIABILITY APPLICATION**

Name of Hospital (or System): \_\_\_\_\_

(Attach a complete list of subsidiaries and affiliates to be covered including a description of operations and relationship.)

Mailing Address: \_\_\_\_\_

Phone: Fax: \_\_\_\_\_

Contact Person & Title: \_\_\_\_\_

(Name)

(Title)

Email: \_\_\_\_\_

Location Address: \_\_\_\_\_

County:

Web Site Address:

1. Applicant is: (Please check all applicable boxes.)

- Individual     Medicare Approved     AHA Member     Partnership
- Corporation     State Licensed     Joint Venture     Multi-Hospital System
- Governmental     Charitable     Not for Profit     Profit     Other

If other, give brief description: \_\_\_\_\_

2. Requested effective date: \_\_\_\_\_

3. Facility has/is: \_\_\_\_\_

- A.  Acute Care Hospital     Nursing/Convalescent Home     Clinic, Dispensary, Infirmary
- Abortion Clinic     Off-site Surgical Center     Children's Hospital
- Mental/ Psychiatric     Day Care     Alcohol - Drug Rehab     Off-site Urgent Care Ctr.

B.  Accredited by J.C.A.H.O. Date of Last Accreditation: \_\_\_\_\_  
 (If checked please attach a copy of last J.C.A.H.O. Report)

C. Number of years this facility has been: \_\_\_\_\_ Operating: \_\_\_\_\_

Owned by Present Owners: \_\_\_\_\_ Managed by Present Management: \_\_\_\_\_

4. Please check those services that your facility provides.

- |  |   |
|--|---|
| <input type="checkbox"/> Abortions                         | <input type="checkbox"/> Echocardiogram               |
| <input type="checkbox"/> AIDS Unit                         | <input type="checkbox"/> MRI                          |
| <input type="checkbox"/> Ambulance                         | <input type="checkbox"/> Radiation Oncology Unit      |
| <input type="checkbox"/> Blood Bank                        | <input type="checkbox"/> Emergency Department         |
| <input type="checkbox"/> Burn Unit                         | <input type="checkbox"/> Pre-Post Interventional Unit |
| <input type="checkbox"/> CCU                               | <input type="checkbox"/> Progressive Care Unit        |
| <input type="checkbox"/> Day Care                          | <input type="checkbox"/> Hyperbaric Treatment         |
| <input type="checkbox"/> Dept. of Corrections              | <input type="checkbox"/> Cardiac Catheterization Lab  |
| <input type="checkbox"/> Outpatient Surgery Ctr.           | <input type="checkbox"/> Addiction Treatment Program  |
| <input type="checkbox"/> Radiation Therapy                 | <input type="checkbox"/> EKG/Stress Testing Unit      |
| <input type="checkbox"/> Pulmonary Rehabilitative Services | <input type="checkbox"/> Nuclear Medicine             |
| <input type="checkbox"/> Maternity Unit/Postpartum Unit    | <input type="checkbox"/> Cardiovascular Lab           |
| <input type="checkbox"/> Women's Center                    | <input type="checkbox"/> Ultrasound                   |
| <input type="checkbox"/> Endoscopy Unit                    | <input type="checkbox"/> Social Work Services         |
| <input type="checkbox"/> Assisted Reproductive Tech. Lab   | <input type="checkbox"/> Intervention Radiology       |
| <input type="checkbox"/> Pastoral Care Services            | <input type="checkbox"/> Perianesthesia Unit          |
| <input type="checkbox"/> Diagnostic Center                 | <input type="checkbox"/> Surgical Intensive Care Unit |
| <input type="checkbox"/> LDRP                              | <input type="checkbox"/> Transitional Care Facility   |
| <input type="checkbox"/> Sleep Disorder Lab                | <input type="checkbox"/> Diabetes Care Program        |
| <input type="checkbox"/> Home Health Care                  | <input type="checkbox"/> Blood Flow Lab               |
| <input type="checkbox"/> Computerized Tomography           | <input type="checkbox"/> Pharmaceutical Services      |
| <input type="checkbox"/> Telemetry                         | <input type="checkbox"/> Dialysis                     |
| <input type="checkbox"/> Intensive Care Unit               | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Neonatal Intensive Care           | <input type="checkbox"/> Other _____                  |
| <input type="checkbox"/> Obstetrical                       |   |
| <input type="checkbox"/> Surgery, Off-site                 |   |
| <input type="checkbox"/> Trauma Center                     |   |
| <input type="checkbox"/> X-ray                             |   |
| <input type="checkbox"/> Surgical Services                 |   |
| <input type="checkbox"/> Child Development Center          |   |
| <input type="checkbox"/> Rehabilitative Services           |   |
| <input type="checkbox"/> Cardiac Rehabilitative Services   |   |
| <input type="checkbox"/> Nursery                           |   |
| <input type="checkbox"/> EEG                               |   |
| <input type="checkbox"/> Oncology Unit                     |   |

- a. Will any new services be provided in the next 12 months?  Yes  No
- b. Will any new services be discontinued in the next 12 months?  Yes  No
- c. Have any services been discontinued in the last 24 months?  Yes  No

d. If you answered yes to any of the above please provide details:  Yes  No

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5. Type(s) of Patient Care:

- |   |  |
|---|--|
| <input type="checkbox"/> Alcoholic              | <input type="checkbox"/> Anesthesiology          |
| <input type="checkbox"/> Custody/ High Security | <input type="checkbox"/> Dental                  |
| <input type="checkbox"/> Dietary                | <input type="checkbox"/> Drug Addiction          |
| <input type="checkbox"/> General                | <input type="checkbox"/> Geriatrics              |
| <input type="checkbox"/> Hyperbaric Treatment   | <input type="checkbox"/> Immunology              |
| <input type="checkbox"/> Intensive Care Unit    | <input type="checkbox"/> Maternal / Child        |
| <input type="checkbox"/> Medical                | <input type="checkbox"/> Morgue                  |
| <input type="checkbox"/> Occupational Therapy   | <input type="checkbox"/> Open Heart Surgery      |
| <input type="checkbox"/> Pediatrics             | <input type="checkbox"/> Physical Therapy        |
| <input type="checkbox"/> Progressive Care Unit  | <input type="checkbox"/> Psychiatric             |
| <input type="checkbox"/> Recreational Therapy   | <input type="checkbox"/> Research / Experimental |
| <input type="checkbox"/> Respiratory Therapy    | <input type="checkbox"/> Self Care               |
| <input type="checkbox"/> Speech Pathology       | <input type="checkbox"/> Surgery                 |
| <input type="checkbox"/> Surgical ICU           | <input type="checkbox"/> Transplants             |
| <input type="checkbox"/> Trauma                 | <input type="checkbox"/> Tuberculosis            |

6. a. Does hospital have any teaching affiliations?  Yes  No  
b. Is hospital a teaching and/ or research center?  Yes  No  
c. Does the hospital have any revenue affiliations?  Yes  No  
(e.g. Joint ventures, PPO's, HMO's, etc.?)  
d. If you answered yes to any of the above, provide details:

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7. Are products sold to others *for use off* applicant's premises?  Yes  No  
If yes, indicate type of products and annual receipts: \_\_\_\_\_

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8. Do you lease or rent any equipment to others?  Yes  No  
If yes, indicate type of equipment and annual receipts: \_\_\_\_\_

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9. Do you lease or rent any clinical equipment from others?  Yes  No  
If yes, type of equipment. \_\_\_\_\_

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10. Do you own or operate a Day Care Center?  Yes  No

If yes: Center is open to:  Employees' Children Only  General Public  Both

- a. Location: \_\_\_\_\_  
b. Hours of operation: \_\_\_\_\_  
c. Number of children (licensed): \_\_\_\_\_

d. Are hospital and/ or day care center vehicles used to transport children  Yes  No

11. Will there be any sponsored fund raising events this year for which you will need coverage?  Yes  No

If yes, please describe:

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**PROFESSIONAL/GENERAL LIABILITY**

Current HPL/ CGL insurance carrier: \_\_\_\_\_

Policy Period From: \_\_\_\_\_ To: \_\_\_\_\_

Has any previous carrier ever declined, cancelled, or refused to renew your professional or general liability coverages?  Yes  No

If yes, please explain: \_\_\_\_\_

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1. Do you request Prior Acts coverage?  Yes  No

2. Current Retroactive Date: \_\_\_\_\_

3. Limits of Liability: \$ \_\_\_\_\_ Each Medical Incident  
Aggregate

4. Deductible or SIR: \$ \_\_\_\_\_ Each Medical Incident  
Aggregate

5. Desired Deductible options:

|          |          |
|----------|----------|
| \$ _____ | \$ _____ |
| \$ _____ | \$ _____ |



## 7. Outpatient Data

| Type Visit                        | 12 – Months | 24 - Months |
|-----------------------------------|-------------|-------------|
| Hospice                           |             |             |
| Alcohol/Drug Abuse                |             |             |
| Emergency Room                    |             |             |
| Off-site Emergency Room           |             |             |
| On-site Home Health               |             |             |
| Physical Rehabilitation           |             |             |
| Psychiatric                       |             |             |
| Surgical outpatient               |             |             |
| Other                             |             |             |
| Total Number of Outpatient Visits |             |             |

## 8. Credentialing

1. Are credentials of doctors approved by the medical staff and/or hospital review board before privileges are granted?  Yes  No

2. Is there a probationary period of at least six months *for* all staff doctors?  
 Yes  No

3. Do medical staff and/or hospital review boards periodically review staff doctors performances?  
 Yes  No

4. Do hospital by-laws require staff doctors to carry medical malpractice insurance?  
 Yes  No

If yes, what limits required? \$ \_\_\_\_\_ per claim / \$ \_\_\_\_\_ aggregate

5. Are all privileges granted to staff doctors detailed in writing?  
 Yes  No

6. Has license of any staff physician ever been restricted or suspended?  
 Yes  No

7. Does a committee review qualifications *of* non-physician professionals?  
 Yes  No

Continuous coverage when they leave the hospitals medical staff?  
 Yes  No

**Personnel:**

1. Professional Employees:

Indicate total (full-time equivalents for part time) employees:

| <b>Type</b>            | <b>Total</b> | <b>Specialty</b> |
|------------------------|--------------|------------------|
| RNs                    |              |                  |
| Nurse \ Midwives       |              |                  |
| CRNAs                  |              |                  |
| LPNs                   |              |                  |
| Nursing Students       |              |                  |
| Radiology Techs        |              |                  |
| Physicians Assistants  |              |                  |
| Medical Students       |              |                  |
| Midwives               |              |                  |
| Pharmacists            |              |                  |
| Nurse Practitioners    |              |                  |
| Paramedics             |              |                  |
| Perfusionists          |              |                  |
| Respiratory Therapists |              |                  |
| Employed Physicians    |              |                  |
| Employed Surgeons      |              |                  |
| Interns                |              |                  |
| Externs                |              |                  |
| Residents              |              |                  |
| Dentist                |              |                  |
| Lab Technicians        |              |                  |
| Volunteers             |              |                  |
| DPM                    |              |                  |
| DC                     |              |                  |
| Others                 |              |                  |
|                        |              |                  |
| <b>TOTAL EMPLOYEES</b> |              |                  |

**Criteria for qualification of employed physicians and surgeons:**

1. History of previous employment investigated?

Yes  No

2. References checked?

Yes  No

3. How many employed physicians are board certified or board eligible? \_\_\_\_\_

**Anesthesia:**

1. Is anesthesia provided by:

- Hospital Employees
- Contract Group (name): \_\_\_\_\_
- Staff (fee for services)

If contract group, are Certificates of Insurance required?

- Yes  No

If yes, what limits of insurance are required? \$ \_\_\_\_\_ Per claim/\$ \_\_\_\_\_ Aggregate

2. Number of Anesthesiologists: Full-time: \_\_\_\_\_ Part-time: \_\_\_\_\_

3. Number of those who are Board Certified: \_\_\_\_\_

4. Are CRNAs supervised at all times by an Anesthesiologist?

- Yes  No

5. Is anesthesia equipment equipped with oxygen analyzers?

- Yes  No

6. Is anesthesia equipment equipped with disconnecting alarms?

- Yes  No

7. If you answered no to any of the above, provide details:

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**Pharmacy:**

1. Does the pharmacy provide medicine to non-patients?

- Yes  No

If yes, annual receipts for non-patient medications are: \$ \_\_\_\_\_

2. Does the facility utilize the Unit-dose system of dispensing medicine?

- Yes  No

3. Is a registered pharmacist directing the operations of the pharmacy?

- Yes  No

**Radiology:**

1. Is the radiology department staffed by:

- Hospital Employees
- Contract Group (name): \_\_\_\_\_
- Staff

2. If contract group, are certificates of insurance required?

- Yes  No

If yes, what are the minimum limits required? \$ \_\_\_\_\_ per / \$ \_\_\_\_\_ aggregate

3. Are radiologists board-certified?

- Yes  No

4. Are X-ray technicians licensed?

- Yes  No

5. Are X-ray technicians certified?

- Yes  No

**Surgery**

1. Indicate the number of surgical procedures performed in the last year:

- Total: \_\_\_\_\_
- Inpatient: \_\_\_\_\_
- Outpatient: \_\_\_\_\_

2. Are sponge, needle and instrument counts performed in the course of a surgical procedure?

- Yes  No

If yes, at what intervals of the operations? \_\_\_\_\_

3. Are any of the following performed at your facility?

- Experimental Surgery
- Neurosurgery
- Sex Change Operations
- Weight Reduction Surgery
- Bariatric Surgery - Procedures

**Obstetrics/Nursery:**

1. How many caesarian sections? \_\_\_\_\_

• Perform VBACS                      Yes  No                       Annual Number \_\_\_\_\_

2. Is electronic fetal monitoring performed on all patients in active labor?  
 Yes  No

3. Does a written procedure exist for transferring all high-risk mothers and/or babies whom the hospital is not qualified to treat?  
 Yes  No

4. Are labor-inducing drugs always administered by an obstetrician?  
 Yes  No

5. How many annual abortions? \_\_\_\_\_

6. Indicate OB level (I - V): \_\_\_\_\_

**Emergency Room:**

1. Is emergency room staffed by?

- Hospital Employees
- Contract Group (name): \_\_\_\_\_
- Staff

2. If contract group, are certificates of insurance required?  
 Yes  No

If yes, what are the minimum limits required? \$\_\_\_\_\_ per / \$\_\_\_\_\_ aggregate

3. Is the emergency room staffed by a physician on a 24-hour basis?  
 Yes  No

If no, provide details: \_\_\_\_\_  
\_\_\_\_\_

4. What level is the Emergency Room? \_\_\_\_\_

5. Is the emergency room equipped with the following?

- Blood
- Cardiopulmonary resuscitation facilities
- Intravenous fluids
- Life-Saving Drugs

6. Staffing Standards: What is the minimum qualification required *of* the senior medical professional at all times (i.e., Physicians, Staff Physician, Resident, RN)?

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7. Support facilities:

- 24-hour X-ray availability                       24-hour surgery  
 24-hour laboratories                               24-hour anesthesia

8. Does this facility regularly handle:

- Street Trauma     Yes     No  
Indigent Cases     Yes     No

9. Does the hospital have a heliport?

- Yes     No

If yes, Landings per year? \_\_\_\_\_

If yes, do you obtain certificates of insurance from users of the heliport/helipad?

- Yes     No

If yes, what limits of insurance are required by the hospital? \_\_\_\_\_

10. Does the hospital own ambulances or other emergency-use vehicles?

- Yes     No

If yes, what is the number of EMT's utilized? \_\_\_\_\_

11. Indicate level of emergency services: \_\_\_\_\_

12. Does the hospital require all E.D. patients to see a physician before discharge?

- Yes     No

**Risk Management:**

1. Is there a written, formalized Risk Management Program?

- Yes     No

2. Is the program periodically reviewed for effectiveness and the necessary changes implemented?

- Yes     No

3. Who coordinates your risk management program?

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Length of Employee \ Experience: \_\_\_\_\_

\_\_\_\_\_

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

Yes  No

5. To whom does the risk manager report?

Name: \_\_\_\_\_ Title \ Phone Number: \_\_\_\_\_

6. Is the risk manager responsible for reviewing incident reports?

Yes  No

How Often? \_\_\_\_\_

7. Are the following findings incorporated in the risk management program?:

| Area of Concern                         | Yes | No |
|---|-----|----|
| Generic or Critical indicator Screening |     |    |
| Incident Reporting                      |     |    |
| Infection Control Committee             |     |    |
| Full-time Patient Representative        |     |    |
| Peer Review Organization                |     |    |
| Quality Assurance Coordinator           |     |    |
| Safety Committee                        |     |    |
| Tissue Review Committee                 |     |    |
| Other                                   |     |    |

8. Does the hospital utilize the following risk management systems?

| Area of Concern                         | Yes | No |
|---|-----|----|
| Generic or Critical Indicator Screening |     |    |
| Incident Reporting                      |     |    |
| Infection Control Committee             |     |    |
| Full-time Patient Representative        |     |    |
| Peer Review Organization                |     |    |
| Tissue Review Committee                 |     |    |
| Other                                   |     |    |

**SUPPLEMENTAL INFORMATION NEEDED**

1. Hospital organizational chart.
2. A copy of the most recent JCAHO and or State Accreditation Report
3. Updated loss experience for the past 10 years to include all carriers involved.
4. A copy of the latest actuarial funding report for self-insured programs.
4. A copy of the latest annual CPA audited financial statements.
6. Completed exposure data form provided by Yellowstone Insurance Exchange, RRG

Signature of CEO or Authorized Hospital Personnel:

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

***Signing this application does not bind Yellowstone Insurance Exchange, RRG to complete the insurance. All information requested in this application is considered material and important. If a company agrees to be bound under the terms of this application, your policy is void if you hide any important information from us, or attempt to defraud or lie to us about any matter contained in this application. If accepted the application will form the basis for policy issuance and will be included as part of the policy.***

**Please attach your Emergency Management/Preparedness Plan including any separate plan that addresses chemical and bioterrorism.**

The person completing this form should sign below:

Name & Title: \_\_\_\_\_

Date: \_\_\_\_\_