COLONY SPECIALTY
Member Argo Group

# EXCESS CASUALTY
# HOSPITAL SURVEY

1. Legal name and address of hospital: ______________________________________________

   ______________________________________________

2. List all affiliates and subsidiaries to which this insurance is to apply. Include a complete description of the operations of each affiliate/subsidiary and their relationship to the hospital.

   ______________________________________________
   ______________________________________________
   ______________________________________________
   ______________________________________________

3. Please state below the name of the insurance exactly as it appears on the policy:

   ______________________________________________
   ______________________________________________

4. Please list below or attach a list of entities to be included as Additional Named Insureds and their interests:

   ______________________________________________
   ______________________________________________

5. Is this hospital:
   a. Licensed as a hospital by the state? ☐ No ☐ Yes
   b. Accredited by the Joint Commission on Accreditation of Health Organizations? ☐ No ☐ Yes
   c. A member of the American Hospital Association? ☐ No ☐ Yes
   d. Approved by Medicare? ☐ No ☐ Yes

6. Does your hospital have a management contract to provide management services to other facilities? ☐ No ☐ Yes

7. Does another facility provide management facilities to your hospital? ☐ No ☐ Yes
   If "Yes," please provide name and address of other entity: ______________________________

   ______________________________________________

8. **If the answer to any item above is "no" or if accreditation, license, approval, or membership has ever been refused or canceled in the last ten years, please explain.______________________**

   ______________________________________________

9. Does the hospital participate in any teaching programs? ☐ No ☐ Yes
   If "Yes," please list the type of program(s): ______________________________
   a. Is the hospital sponsored? ☐ No ☐ Yes
   If "Yes," please give the name of the sponsoring institution: ______________________________

   ______________________________________________

10. Date of the most recent JCAHO accreditation: ______________________________
    a. Does the hospital have a Risk Management Program? ☐ No ☐ Yes
    b. Does the hospital have a Quality Assurance Program? ☐ No ☐ Yes
    If "Yes," please attach a synopsis of these programs. Please provide the names and telephone number of the person responsible for these programs:
    Risk Manager______________________Telephone______________
    Quality Assurance__________________Telephone______________

c. Does the hospital settle or coordinate the settlement of Professional Liability claims? ☐ No ☐ Yes
If "Yes," please provide the name of the person responsible for claims handling:
1. Full-time Risk Manager ____________________
2. Person responsible for reporting claims ____________________
3. Who sets claim reserves ____________________
4. Defense firm ____________________
5. Adjusting service ____________________

## Coverage Desired

11. Excess/Umbrella Professional Liability coverage applied for:
$______________/per claim, $______________/aggregate
12. Excess of total underlying limits of
$______________/per claim, $______________/aggregate

13. Coverage: ____________________
Effective: ______________ Expiration: ______________

14. Is underlying coverage provided on an occurrence basis or on a claims-made basis? ☐ No ☐ Yes
____________________
If claims made, what is the retroactive date: of underlying coverage? ______________
Of excess coverage? ______________

## Facilities and Services

15. Type of institution (X if appropriate)

_____ Hospital - General
_____ Hospital - Children
_____ Hospital - Psychiatric
_____ Hospital - Rehabilitation
_____ Hospital - Teaching/research
_____ Convalescent or Nursing Home
_____ Clinic (describe service) ____________________

Operations: _____ For Profit _____ Non-Profit _____ Governmental

16. Types of services provided (X if appropriate)

_____ Abortion
_____ CCU
_____ Dialysis
_____ Emergency Care
_____ Home Health Care
_____ Radiology
_____ Nursery
_____ OB/Gyn
_____ Open Heart
_____ Pathology
_____ Pharmacy
_____ Physical Therapy
_____ Neonatal
_____ Surgery
_____ ICU
_____ Psychiatric
_____ Inhalation Therapy
_____ Radiation Therapy
_____ Long-term Care
_____ Substance Abuse

17. Special Services:

| | | | | | |
|---|---|---|---|---|---|
| a. | Ambulance: | Number of Vehicles | _____ | Number of Emergency Runs | _____ |
| b. | Blood Banks: | Number of Donors | _____ | Purchased from Others | _____ |
| c. | Day Care: | Number of Children | _____ | Number of Days per Week | _____ |
| | | On Hospital Premises | _____ | Open to the Public | _____ |

## Beds and Utilization

| Hospital Beds | # of Licensed Beds | Average # of Occupied Beds |
|---|---|---|
| Acute Care | ______________ | ______________ |
| Cribs and Bassinets | ______________ | ______________ |
| Psychiatric | ______________ | ______________ |
| Alcohol or Drug Abuse | ______________ | ______________ |
| Other Rehabilitation | ______________ | ______________ |
| Extended Care | ______________ | ______________ |
| Hospice | ______________ | ______________ |
| Other ______________ | ______________ | ______________ |

| Outpatient Visits | # of Outpatient Visits |
|---|---|
| Emergency Room | |
| Outpatient Surgery | |
| Alcohol or Drug Abuse | |
| Rehabilitation/Therapy | |
| Psychiatric | |
| Home Health Care | |
| All Other | |

| **Employees** | | **Physician** | **Resident/Intern** | **Total F/T Employees** |
|---|---|---|---|---|
| **Class A** | | | | |
| Anesthesiology | | | | |
| Emergency Medicine | | | | |
| Cardiovascular Surgery | | | | |
| General Surgery | | | | |
| Gynecology | | | | |
| Neonatology | | | | |
| Neurosurgery | | | | |
| Obstetrical | | | | |
| Orthopedics | | | | |
| Otolaryngology/ENT | | | | |
| Pediatric Surgery | | | | |
| Plastic Surgery | | | | |
| Podiatry | | | | |
| Urology | | | | |
| | **Total** | | | |
| **Class B** | | | | |
| Burn Treatment | | | | |
| Cardiology | | | | |
| Gastroenterology | | | | |
| General Medicine/ Family Practice | | | | |
| Intensive Care | | | | |
| Ophthalmology | | | | |
| Pain Management | | | | |
| Pathology | | | | |
| Pediatrics | | | | |
| Psychiatry | | | | |
| Radiology | | | | |
| | **Total** | | | |
| **Class C** | | | | |
| Allergy | | | | |
| Dentistry | | | | |
| Dermatology | | | | |
| Endocrinology | | | | |
| Geriatrics | | | | |
| Internal Medicine | | | | |
| Hematology/Oncology | | | | |
| Infectious Diseases | | | | |
| Nephrology | | | | |
| Nuclear Medicine | | | | |
| Physical Med./Physiatry | | | | |
| Pulmonary Disease | | | | |
| Rheumatology | | | | |
| | **Total** | | | |

| Other Specialists | Number |
| --- | --- |
| Nurse Practitioner | ________ |
| R.N. | ________ |
| CRNA | ________ |
| Midwife | ________ |
| Perfusionists | ________ |

## Anesthesia

18. Is staffing by:_____ Residents _____ Employed Physicians _____ CRNA's _____ Contracted Physicians

19. Is the Physicians Board certified or eligible? ☐ No ☐ Yes
    If under contract, to whom is staffing contracted?______________________________

20. Are contracted physicians required to carry Professional Liability Insurance? ☐ No ☐ Yes
    If "Yes," what limits are required? $______________________________

21. Does the hospital obtain:
    a. Certificate of Insurance ☐ No ☐ Yes
    b. Hold Harmless Agreement ☐ No ☐ Yes

22. What are the staffing requirements - Please describe minimum qualifications for administration of general anesthesia?______________________________

## Certified Registered Nurse Anesthetist (CRNA's)

23. Do CRNA's provide anesthesia service? ☐ No ☐ Yes
    If "Yes," please describe the relationship between hospital and CRNA's below:
    a. Are they employed by hospital ☐ No ☐ Yes
    b. Employed by Anesthesiologist ☐ No ☐ Yes
    c. Employed by Surgeon ☐ No ☐ Yes
    d. Independent ☐ No ☐ Yes

24. Is proof of insurance required by the hospital? ☐ No ☐ Yes
If "Yes," what are the limits? $______________________________

25. Do CRNA's work under the direct supervision of an anesthesiologist? ☐ No ☐ Yes
If "No," who is responsible for the supervision of the CRNA? ______________________________

## Emergency Room

26. Please indicate how your Emergency Department is classified according to JCAHO standards:
    _____ Level I (Tertiary)
    _____ Level II (Comprehensive)
    _____ Level III (Basic)
    _____ Non (Standard)
    _____ Other

27. Is staffing by: _____ Residents _____ Employed Physicians _____ Contracted Physicians

28. Is the Physicians Board certified or eligible? ☐ No ☐ Yes
    If under contract, to whom is staffing contracted? ______________________________

29. Are contract physicians required to carry Professional Liability Insurance? ☐ No ☐ Yes
    If "Yes," what are the limits required? $______________________________

30. Does the hospital obtain:
    a. Certificate of Insurance ☐ No ☐ Yes
    b. Hold Harmless Agreement ☐ No ☐ Yes
    c. Support Facilities: 24-hour X-ray availability ☐ No ☐ Yes
       24-hour Surgery ☐ No ☐ Yes
       24-hour Laboratories ☐ No ☐ Yes

## Radiology

31. Is staffing by: ______ Residents ______ Employed Physician ______ Contracted Physician

32. Is the Physicians Board certified or eligible? ☐ No ☐ Yes
    If under contract, to whom is staffing contracted? ______________________________

33. Are contract physicians required to carry Professional Liability Insurance? ☐ No ☐ Yes
    If "Yes," what are the limits of liability required? $______________________________

34. Does the hospital obtain:
    a. Certificate of Insurance ☐ No ☐ Yes
    b. Hold Harmless Agreement ☐ No ☐ Yes

## Obstetrics

35. Is the institution a regional referral center for newborns requiring intensive care? ☐ No ☐ Yes
36. Number of Labor Rooms: ______
37. Number of Delivery Rooms: ______
38. Does the hospital have a separate birthing center? ☐ No ☐ Yes
39. Is Delivery Room suite separate from surgical suite? ☐ No ☐ Yes
40. Can Cesarean sections be performed within 30 minutes at all times? ☐ No ☐ Yes
41. Is anesthesiologist or CRNA available in-house 24-hours a day of obstetrical suite? ☐ No ☐ Yes
42. Is obstetrician available in-house 24-hours a day for obstetrical suite? ☐ No ☐ Yes

**If the institution has neonatal intensive care unit (NICU), please answer the following:**

43. Total number of neonates admitted to NICU in the last 12 months: ______________________
44. Number of neonates admitted to NICU who were transferred from other facilities: __________
45. Is full-time attending neonatologist on site in NICU 24-hours a day? ☐ No ☐ Yes
    If the institution does not have NICU, what is the total number of neonates transferred from institution to other facilities in past 12 months: ____

## Staffing Privileges

46. Are credentials for new staff members checked and approved prior to granting staffing privileges? ☐ No ☐ Yes
    By whom: ______________________________

47. How are the applicants' degree(s) and experience verified? ______________________________
    ______________________________

48. Are privileges probationary for at least 6 months for all new staffers? ☐ No ☐ Yes
49. Do you have any staff members who are not licensed or who have restricted licenses or privileges? ☐ No ☐ Yes
    **If "Yes," please explain on a separate sheet of paper.**

50. Do department heads evaluate the work of their staff members? ☐ No ☐ Yes
    If yes, are the evaluations done in writing? ☐ No ☐ Yes
51. Are all staff privileges reviewed each year? ☐ No ☐ Yes
52. Do you require all foreign school graduates to be certified by the Educational Council for Foreign Medical School Graduates? ☐ No ☐ Yes

### Staff Member Malpractice Insurance

53. Are all staff members required to maintain malpractice insurance? ☐ No ☐ Yes
54. Is this requirement stated in the staff bylaws? ☐ No ☐ Yes
55. What evidence of compliance is required? ______________________________
    **If "No," please explain on a separate sheet of paper.**

**Physical Plant (Attach inspection report if available)**

56. Number of stories ___________
57. Sprinklers ___________
58. Automatic Fire Alarm ___________
59. Connected to Fire Dept. ___________
60. Hourly watchmen ___________
61. Age of buildings ___________
62. Construction of buildings ___________________________________________________________________
63. Distance to the Fire Dept. ___________ Paid ___________ Volunteer ____________

**Automobile Exposures**

64. State the number and type of vehicles owned or leased by the institution
    a. Private passenger ___________
    b. Trucks, Pick-ups ___________
    c. Ambulances ___________
    d. Buses, Vans (seating capacity) ___________
    e. Other ____________________ ___________

**Primary Insurance**

65. List all primary insurances over which the applied - excess/umbrella coverage is to apply

| Type of Coverage | Limits (Incl. Agg.) | Carrier | Policy Period | Premium |
|---|---|---|---|---|
| CGL | | | | $ |
| Prod/Comp Ops | | | | $ |
| Automotive | | | | $ |
| Employers Liab. | | | | $ |
| Aviation | | | | $ |
| Helipad | | | | $ |
| Excess | | | | $ |
| Other | | | | $ |

66. List which primary coverage costs and expenses are included in the above limits:
_____________________________________________________________________________________

67. Is primary coverage provided on ☐ an occurrence or ☐ claims made basis?

## Attachment Section

1. Please attach loss history for 10 years, including current year and include breakdown of total incurred losses, paid losses, outstanding losses separated by year for Hospital Professional Liability and General Bodily Injury. Additionally, please provide full details of any claim paid or outstanding during the period excess of $100,000 (paid) and $25,000 (outstanding).

2. Survey information

3. Please include copies of the following:
    a. Your most recent annual report
    b. A copy of the most recent JCAHO report and response to any contingencies
    c. Financial Statement
    d. Current balance of the Self-Insured Trust Fund [1]
    e. Trust Agreement
    f. Recent actuarial study supporting the funding of the Self-Insured Trust [1]

    [1] These items apply if the applicant has set up a Self-Insured Trust Fund

The hospital hereby makes application for insurance against General Liability and Professional Liability as set forth in this application. It is understood and agreed that the application constitutes agreement and representation made to the company for procuring such insurance and that the information is true and correct.

**GENERAL FRAUD STATEMENT**

**(Not applicable in the states mentioned below where a specific warning applies.)**

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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

**Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, West Virginia**

Any person who knowingly and willfully 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 fines and confinement in prison.

**Colorado**

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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

**Florida**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kentucky**

Any person who knowingly and with intent to defraud any insurance company or other 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.

**New Jersey**

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**New York**

Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor

vehicles or an insurance company, 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 value of the subject motor vehicle or stated claim for each violation.

**Ohio**
Any person who, with intent to defraud or knowing that he 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.

**Oklahoma**
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.

**Pennsylvania**
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.

**Maine, Tennessee, Virginia, Washington**
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Signatures**
I declare to the best of my knowledge that all statements herein are true and no material facts have been suppressed or misstated. I am also aware that my operation may be inspected by the Insurance Company.

__________________________________________________________________

Applicant’s Signature/Title | Date

__________________________________________________________________

Agent’s or Broker’s Name (Please print) | Telephone Number | Agents Signature

__________________________________________________________________

License No. | Date