COLONY SPECIALTY
Member Argo Group

EXCESS CASUALTY
HOSPITAL SURVEY - MISSOURI

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 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 ☐ Yes ☐ No Open to the Public ☐ Yes ☐ No

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

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.

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