Curi

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MMIC Insurance, Inc. | UMIA Insurance, Inc.
Arkansas Mutual Insurance Company
MMIC Risk Retention Group, Inc.

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Hospital / Healthcare System Liability Renewal Questionnaire

Name of Applicant: _____ Policy Number: _____

(Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

A. General Information

1. Please use the Comments section to advise us of any changes to the contact information we have for you including the following:

☐ Address ☐ Phone/Fax Number ☐ Email Address ☐ Contact Person

2. Please use the Comments section to advise us of any desired changes to your insurance program including the following:

☐ Deductible ☐ Limits ☐ Umbrella Coverage ☐ Physician Coverage ☐ Other

For the following questions, please explain all "yes" answers in the Comments section.

3. Have there been any changes to the Applicant's operation within the past 12 months related to the following?

- Obtaining another operation/entity? ☐ Yes ☐ No
- Selling or discontinuing any operation/entity? ☐ Yes ☐ No
- Adding or reducing the number of employees? ☐ Yes ☐ No
- Adding or reducing the number of locations? ☐ Yes ☐ No
- Adding or reducing current services? ☐ Yes ☐ No
- Operating in new states? ☐ Yes ☐ No
- Entering into any joint ventures or limited partnerships? ☐ Yes ☐ No
- New construction or renovation projects? ☐ Yes ☐ No

4. Are future operational changes anticipated related to the items listed in question #3? ☐ Yes ☐ No

5. Have there been any changes to the Applicant's additional named insureds? ☐ Yes ☐ No

6. Does the Applicant provide management services to other entities for a fee? ☐ Yes ☐ No

7. Does the Applicant sell or rent any equipment to others? ☐ Yes ☐ No

8. Are all staff members required to maintain medical professional liability insurance? ☐ Yes ☐ No
Is this requirement stated in the staff bylaws? ☐ Yes ☐ No
If yes, what limits of liability are required? Each Incident: _____ Each Aggregate: _____
(Curi recommends the limits of liability be equal to or greater than your own limits of liability.)
Are Certificates of Insurance required annually? ☐ Yes ☐ No

9. Has the Applicant employed any new physicians in the past 12 months that are not currently listed on the schedule? If yes, please complete an individual application for each person. ☐ Yes ☐ No

10. Has the Applicant made reports to the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff in the last two years? ☐ Yes ☐ No

Please attach a listing of locations or a copy of your statement of values.

B. Obstetrics

Are obstetrical services provided? ☐ Yes ☐ No If yes, please answer the following questions based on annualized data:

Number of OB/GYN Deliveries: _____ Number of Births: _____
Deliveries by Family Practice Physicians: _____ Number of C-Sections: _____
Deliveries by Nurse Midwives: _____ Number of VBACs: _____
Other Deliveries: _____

C. Hospital Exposure Information

DIRECTIONS: Please provide the projected, current and previous 12 month exposure count for each classification.

Occupied Beds	Use the average number of occupied beds by dividing the total annual inpatient days by 365.
Licensed Beds	Total number of licensed beds.
Outpatient Visits	Count each appearance of an outpatient in a hospital unit, regardless of the number of procedures or treatments performed within each unit (AHA definition). Report visits to outpatient units, not occasions of service. Include visits made to a client's home when home healthcare is provided.
Receipts	Use annual gross revenues resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Freestanding Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed.

	Occupied Beds			
HOSPITAL INPATIENT	**Projected Next 12 Months**	**Current 12 Months**	**Previous 12 Months**	**Total Licensed Beds**
Acute Care Beds:				
Cribs and Bassinets:				
Psychiatric/Chemical Dependency/Rehab Beds:				
Extended Care Beds:				
Skilled Care Beds:				
Long Term Care Beds:				
Residential (Assisted) Care Beds:				
Independent Living Beds:				

HOSPITAL INPATIENT - OTHER	**Projected Next 12 Months**	**Current 12 Months**	**Previous 12 Months**
Total Number of Surgeries (inpatient only):			
Total Number of Births:			

HOSPITAL OUTPATIENT	**Projected Next 12 Months**	**Current 12 Months**	**Previous 12 Months**
Clinic Visits:			
Outpatient Surgery Visits:			
Emergency Room Visits:			
Home Healthcare Visits:			
All other hospital based visits:			

HOSPITAL - OTHER EXPOSURES	**Projected Next 12 Months**	**Current 12 Months**	**Previous 12 Months**
Durable Medical Equipment Receipts:			
Physical Fitness Center Receipts:			
Retail Pharmacy Receipts (for non-patients):			
Other (specify):			

FREESTANDING OPERATIONS	**Projected Next 12 Months**	**Current 12 Months**	**Previous 12 Months**
Urgent Care Center or Walk In Clinic Visits:			
SurgiCenter Visits:			
Birthing Center Number of Births:			
X-Ray/Imaging Center Receipts:			
Other (specify):			

MISCELLANEOUS		Total Number
Total Number of Employees:		
Adult or Child Care Center Number of Individuals:		
HMO/PPO/IPA or other Managed Care Services Number of Members:		
Vacant Land Number of Acres:		
Pay Parking Areas Receipts:		
Gross Revenues:	Most Current 12 Months:	Projected 12 Months:

D. PHYSICIANS/SURGEONS AND OTHER MEDICAL PROFESSIONALS

1. Please indicate the number of physicians/surgeons in each of the following categories.

PHYSICIANS/SURGEONS	Employed	Contracted	Privileges
Physicians/Surgeons:			
Residents:			
Interns:			
Locum Tenens:			

2. Please indicate the number of other medical professionals in each of the following categories. Compute full-time equivalents (FTE) for all part-time employees using 40 hours per week as one full-time equivalent.

OTHER MEDICAL PROFESSIONALS	Employed FTE	Contracted FTE	OTHER MEDICAL PROFESSIONALS	Employed FTE	Contracted FTE
Chiropractors:			Oral Surgeons:		
Dentists:			Paramedics:		
Emergency Medical Technicians:			Paramedics-Ambulance Svc:		
Laboratory or X-Ray Technicians:			Physical Therapists:		
Licensed Practical Nurses (LPN):			Podiatrists:		
Nurse Anesthetists:			Physicians Assistants:		
Nurse Midwives (certified):			Psychologists:		
Nurse Practitioners:			Registered Nurses (RN):		
Optometrists:			Social Workers:		

E. HEALTHCARE UMBRELLA LIABILITY COVERAGE

1. Is Excess/Umbrella coverage desired? If yes, please complete this section. ☐ Yes ☐ No

2. For Nebraska and Wisconsin hospitals only, is coverage desired for: ☐ General Liability ☐ Professional Liability ☐ Both

3. Requested Limit of Liability: $

NOTE: All underlying carriers need to have an AM Best Rating of "A-" or better. The following minimum limits apply to underlying coverage:
- Auto minimum limits of $1,000,000 CSL
- Employers liability minimum limits of $500,000/$500,000/$500,000
- Non-owned aircraft limits of $5,000,000/helipad limits of $1,000,000

4. Please complete **Underlying Insurance** information.

Coverage Type	Carrier	Policy Number	Policy Period	Limits of Liability	Annual Premium
Auto Liability:					
Employers Liability:					
Helipad Liability:					
Non-Owned Aircraft Liability:					
Other:					
Other:					

*All Wisconsin Applicants must complete the Wisconsin UM/UIM Supplement.

5. Please list all vehicles below:

Type		# Owned	# Non-Owned	# Leased	Property Hauled	0-50 Miles	50-200 Miles	Over 200 Miles
Private Passenger								
Trucks	Light							
	Medium							
	Heavy							
	Ex Heavy							
Trucks/ Tractors	Heavy							
	Ex Heavy							
Buses								

For question 6 through 15, please explain all "yes" answers in the Comments section.

6. Are explosives, caustics, flammables or other dangerous cargo hauled? ☐ Yes ☐ No
7. Are passengers carried for a fee? ☐ Yes ☐ No
8. Are any units not insured by underlying policies? ☐ Yes ☐ No
9. Are any vehicles leased or rented to others? ☐ Yes ☐ No
10. Are hired and non-owned coverages provided? ☐ Yes ☐ No
11. Is auto symbol 1 (any auto) used on the underlying coverage? ☐ Yes ☐ No

Aircraft & Watercraft Liability:

12. Does the Applicant own, lease or operate any aircraft? ☐ Yes ☐ No
13. Does the Applicant own or lease watercraft? ☐ Yes ☐ No

If yes, provide # owned, length and horsepower:

Employers Liability:

14. Is the Applicant self-insured in any state? ☐ Yes ☐ No
15. Is the Applicant subject to any of the following: ☐ Jones Act ☐ FELA ☐ STOP GAP ☐ OTHER:

Loss History:

16. Does the loss history provided with underlying coverages include umbrella loss history? ☐ Yes ☐ No

If no, please provide detailed loss history for all umbrella losses in the Comments section or by attachment.

Exposure Analysis:

17. Indicate if any of the following exposures apply to your business.

☐ Aircraft Liability	☐ Care, Custody, Control	☐ Garagekeepers Liability	☐ Professional Liability (E&O)
☐ Aircraft Passenger Liability	☐ Employee Benefit Liability	☐ Liquor Liability	☐ Vendors Liability
☐ Additional Interests	☐ Foreign Liability/Travel	☐ Pollution Liability	☐ Watercraft Liability

F. HOSPITAL ADMINISTRATIVE TEAM

Named	Title	Phone Number	Email Address
	CEO		
	CFO		
	Risk Management		
	CNO		
	QA/QI		

G. COMMENTS

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an insurance company or another 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 and subjects the person to criminal and civil penalties.

I hereby certify the foregoing information is true and correct.

Applicant Signature	Title	Date