HOSPITALS AND HEALTH SYSTEMS
MEDICAL PROFESSIONAL LIABILITY
NEW BUSINESS APPLICATION

Curi

UMIA Insurance, Inc.

curi.com

Required Documents

In addition to this application, the following information is required:

1. Loss Runs covering the past ten (10) years, dated within sixty (60) days of the application submission date for all coverages being applied for.
2. Declarations Page from current medical professional and general liability insurance carrier(s). If Excess coverage is requested, please include the declarations for each of the underlying policies.
3. Roster of current Employed and Contracted Providers as specified in Section G3.
4. Organizational Ownership Chart reflecting all legal entities and DBAs.
5. Audited Consolidated Financial Statements for the past two (2) years.
6. Medical Staff Bylaws and Regulations.
7. Most recent State Survey, Licensure, and Accreditation Survey Reports.
8. Statement of Values or List of Locations with corresponding operations.

A. BROKER INFORMATION

Broker Office:	Producer:
Mailing Address:	
Producer Email Address:	Phone:

B. APPLICANT INFORMATION

The term "Applicant" used throughout this application shall mean all entities proposed for coverage.

Name of Policyholder:			
Mailing c/o or Attn, if applicable:			
Mailing Address:			
Physical Address:			
Tax ID:	NPI:	License #:	County:
Main Contact Name:		Phone:	Email:
Chief Executive Officer:		Phone:	Email:
Risk Management Contact:		Phone:	Email:
Claims Contact:		Phone:	Email:

Type of Facility (check all that apply):

☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Government Owned ☐ Critical Access

☐ Not for Profit ☐ For Profit ☐ Other (describe): _____

Provide a summary of operations:

List all accreditations and/or certifications:

Is the Applicant currently enrolled in a Patients' Compensation Fund or other state insurance fund? ☐ Yes ☐ No

If yes, please specify the fund name: _____

C. CURRENT COVERAGE

1. Professional Liability Carrier Information

Carrier: _____

Limits of Coverage: _____

Deductible/Retention: _____

Policy Period: _____ to _____

Policy Premium: _____

Claims-Made or Occurrence: _____

If claims-made, prior acts date is: _____

2. General Liability Carrier Information

Carrier: _____

Limits of Coverage: _____

Deductible/Retention: _____

Policy Period: _____ to _____

Policy Premium: _____

Claims-Made or Occurrence: _____

If claims-made, prior acts date is: _____

D. REQUESTED COVERAGE

1. Policy Period: _____ to _____ **2.** Prior Acts Date: _____

3. Primary Limits of Liability (limits are expressed as per claim/aggregate):

Medical Professional Liability Limit	☐ $1,000,000/$3,000,000	Other: _____
General Liability Limit	☐ $1,000,000/$3,000,000	Other: _____
Employee Benefits Liability Limit	☐ $1,000,000/$3,000,000	Other: _____

If Shared Excess Liability coverage is desired, please answer the following questions. If not, proceed to Section E.

4. Shared Excess Liability Limit: $ _____

5. Should physicians and healthcare providers be included in the Shared Excess Liability? ☐ Yes ☐ No

6. Select the following policies that should be included in the Shared Excess coverage and provide details for each.
In addition, please attach a current policy declarations page for each selected coverage.

Coverage Desired	Coverage Type	Carrier	Policy Number	Policy Period	Limits of Liability
☐	Auto Liability				
☐	Employers Liability				
☐	Helipad Liability				
☐	Non-Owned Aircraft Liability				
☐	Other Liability: _____				

If Excess Automobile Liability coverage is desired, please answer the following. If not, proceed to Section E.

7. Current automobile liability premium: $ _____

8. Current number of owned and leased company vehicles by type:

Private Passenger: _____ Light Service: _____ Medium Service: _____ Heavy Service: _____

Ambulance: _____ Passenger Vans: _____ Other (describe): _____

9. Indicate the number of employees driving:

a. Company vehicles: _____ b. Personal vehicles on behalf of the Applicant: _____

10. How often are Motor Vehicle Records reviewed for staff who drive company or personal vehicles? _____

11. If the Applicant provides transportation services, please answer the following:

a. Are transportation services provided to the public? ☐ Yes ☐ No

b. Are passengers carried for a fee? ☐ Yes ☐ No

c. Describe the transportation services offered by the Applicant:

_____

E. GENERAL OPERATIONS

1. Specify the number of years the Applicant has been:

Operating: _____ Owned by present owners: _____

2. List each state the Applicant provides services, along with a description of services rendered, and the estimated percentage (%) of overall services provided by the Applicant.

State	Description of Services Rendered	% of Services
		%
		%
		%
		%
		%

If answering yes to any of the following questions, please explain in the Comments section.

3. Does the Applicant provide management services to other entities? ☐ Yes ☐ No

4. Within the past five (5) years, has the Applicant acquired, sold or discontinued any operations? ☐ Yes ☐ No

5. Within the next twelve (12) months, does the Applicant plan to:

a. Obtain another operation/entity? ☐ Yes ☐ No

b. Add or reduce the number of locations? ☐ Yes ☐ No

c. Add or reduce current services? ☐ Yes ☐ No

d. Operate in states other than those already listed? ☐ Yes ☐ No

6. Owned Entities and DBA's: Complete the chart below for all subsidiaries, DBA's, and entities the Applicant owns or has ownership interest in. If the Applicant owns or operates a long-term care facility (skilled nursing, assisted living, or independent living) that is separate from the hospital, an additional application will be required.

Entity Name or DBA	FEIN	NPI	Prior Acts Date	Ownership Interest (%)	Policy Limits
				%	☐ Shared ☐ Separate
				%	☐ Shared ☐ Separate
				%	☐ Shared ☐ Separate
				%	☐ Shared ☐ Separate
				%	☐ Shared ☐ Separate

Attach a separate schedule if additional space is needed. If any entities do not require coverage, please explain in the Comments section.

7. Considering all entities listed, please answer the following and explain any 'yes' answers in the Comments section.

a. Have any licenses been suspended, revoked or placed under probation? ☐ Yes ☐ No

b. Has insurance coverage ever been denied, revoked, limited or surrendered? ☐ Yes ☐ No

c. Have any of the entities been subject to disciplinary investigative proceedings or been reprimanded by a government licensure board or professional association? ☐ Yes ☐ No

d. Has any insurer canceled or declined to issue any coverages applied for under this application? **Missouri applicants do not need to answer this question.* ☐ Yes ☐ No

8. Do the Applicant's bylaws require all contracted personnel to carry medical professional liability insurance? ☐ Yes ☐ No

If yes, are certificates of insurance obtained to verify coverage? ☐ Yes ☐ No

If yes, what limits are required? $_____occurrence/$_____aggregate

9. Surveys

a. When was the Applicant's last accreditation survey? _____

b. Who performed the inspection? _____

c. Total number of deficiencies identified: _____

d. Did the survey result in the Applicant being placed on Immediate Jeopardy? ☐ Yes ☐ No

e. How many patient/family complaints or grievances were filed in the past year? _____

f. How many grievances/complaints were substantiated? _____

F. HOSPITAL EXPOSURES

1. Complete this section using the definitions provided below.

Occupied Beds	Provide the projected, current, and previous 12-month (365 day) exposure count for each classification. If the Occupied Bed count is unavailable, provide either the total inpatient days or the average daily census.
Outpatient Visits	Count each appearance of an outpatient in a hospital unit, regardless of the number of procedures or treatments performed within each unit.
Revenue	Use annual gross revenues resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Acute Beds	All beds licensed by the state, including but not limited to all beds designated for burn, coronary, intensive care, medical surgical, pediatric or other acute care patients receiving medical care.
Extended Care	Intermediate care - the provision of health-related care and services, on a regular basis to individuals who do not require the degree of care or treatment that a skilled care nursing unit is designed to provide.
Personal Care	Provides housing, meals and help with activities of daily living.
Skilled Care	All beds licensed or approved as such by the state and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous or extended basis.

	Occupied Beds			
INPATIENT BEDS	**Projected 12 Months**	**Current 12 Months**	**Previous 12 Months**	**Total Licensed Beds**
Extended Care				
Personal Care				
Skilled Care				
Acute				
Behavioral Health and Psychiatric				
Chemical Dependency				
Cribs and Bassinets				
Intensive Care				
Neonatal				
Other (describe):				

SURGERIES	**Projected 12 Months**	**Current 12 Months**	**Previous 12 Months**
Inpatient			
Outpatient			

OUTPATIENT VISITS	**Projected 12 Months**	**Current 12 Months**	**Previous 12 Months**
Emergency Room			
Home Health			
Physical and Occupational Therapy			
Behavioral Health			
Substance Abuse			
Urgicenter			
Dialysis Center			
Clinic			
Other Outpatient (describe):			

DELIVERIES (Births)	**Projected 12 Months**	**Current 12 Months**	**Previous 12 Months**
Total Deliveries			

2. Considering all DELIVERIES in the current twelve (12) month period, please provide the estimated percentage (%) of deliveries performed by each **provider type** and **delivery method** below.

Provider Type	Deliveries
OB/GYN Physicians	%
Family or General Practice Physicians	%
Nurse Midwives	%
Physician Assistants & Nurse Practitioners	%
Other (describe):	%
Total	**100%**

Delivery Method	Deliveries
Vaginal	%
C-section	%
VBAC	%
Total	**100%**

REVENUE	Projected 12 Months	Current 12 Months	Previous 12 Months
Applicant's Total Revenue	$	$	$
Retail Pharmacy (for non-patients):	$	$	$
X-Ray and Other Imaging	$	$	$
Durable Medical Equipment	$	$	$
Fitness Center – Public Use	$	$	$
GENERAL LIABILITY	**Projected 12 Months**	**Current 12 Months**	**Previous 12 Months**
Apartment Units (total number of units for all buildings)			
Daycare Enrollees – Adult			
Daycare Enrollees – Child			
Dwelling Units (total number of units for all dwellings)			
Parking (gross revenue)	$	$	$
Storage (square footage)			
Vacant Land (total acreage)			

G. MEDICAL STAFF

1. Provide the total number of employees, including non-medical staff: _____
2. Specify the number of employed and contracted medical professionals working on behalf of the Applicant.

Type	Employed	Contracted	Type	Employed	Contracted
Physicians			Heart/Lung Perfusionists		
Residents			Psychotherapists		
Interns & Externs			Clinical Social Workers		
Nurse Practitioners			Podiatrists		
Physician Assistants			Chiropractors		
CRNA's			Dentists		
Nurse Midwives			Oral Surgeons		

3. **PLEASE ATTACH A ROSTER OF ALL CURRENT <u>EMPLOYED</u> AND <u>CONTRACTED</u> PROVIDERS** listed above and include the following information. States with Patient Compensation Funds may require additional information.
   - Full Name (First, Middle Initial, Last) and Designation
   - Date of Birth
   - Social Security Number
   - NPI Number
   - Medical Specialty (include: No Surgery, Minor Surgery or Major Surgery)
   - Prior Acts Date (if claims-made)
   - State Medical License Number(s)
   - Employment Status (employed or contracted)
   - Hours worked for any part-time providers
   - Specify if coverage is desired. If not, specify current carrier.
4. Does the Applicant have continuing risk in connection with departed providers? ☐ Yes ☐ No
   If yes, provide a roster with provider names, specialties, prior acts dates and termination dates.
5. Should coverage for any providers be limited to those services provided on behalf of the Applicant? ☐ Yes ☐ No
   If yes, please explain: _____

6. Specify all other medical professionals working for the Applicant. Compute full-time equivalents (FTE) for all part-time providers by using 40 hours per week as one full-time equivalent.

Type	Employed FTE	Contracted FTE	Type	Employed FTE	Contracted FTE
Anesthesia Assistants			Pharmacists		
Emergency Medical Technicians			Physical Therapists		
Laboratory or X-Ray Technicians			Speech Therapists		
Licensed Practical Nurses (LPN)			Psychologists		
Occupational Therapists			Registered Nurses (RN)		
Optometrists			Other:		
Paramedics			Other:		

H. HIRING AND SCREENING

If answering no to any of the following questions, please explain in the Comments section.

1. Are privileges probationary for all new medical staff? ☐ Yes ☐ No
   If yes, for what duration are privileges probationary? _____
2. Is previous employment history verified for all medical staff? ☐ Yes ☐ No
3. Are all medical providers required to maintain medical professional liability insurance? ☐ Yes ☐ No
   a. If yes, indicate the required limits: $_____per occurrence/$_____aggregate
   b. How often are Certificates of Insurance required? _____
4. Are both state and nationwide criminal background checks, including sexual offenses, performed for all medical staff? ☐ Yes ☐ No
5. Does the Applicant have an active peer review process for all professional providers? ☐ Yes ☐ No
   If yes, please answer the following questions:
   a. Are peer reviews performed by providers with similar qualifications? ☐ Yes ☐ No
   b. Does the Applicant utilize external peer reviews? ☐ Yes ☐ No
   c. What triggers an external peer review? _____
   d. Are reviewers asked to recuse themselves when there is a conflict of interest? ☐ Yes ☐ No
6. Are both quantitative data (e.g. patient outcomes, complication rates) and qualitative assessments (e.g. peer feedback, patient satisfaction) used when renewing privileges? ☐ Yes ☐ No

When answering the following questions, consider the past two (2) years. If answering yes, please explain in the Comments section. A separate application for the provider(s) may be required.

7. Has any medical staff's license been restricted, suspended, surrendered or revoked? ☐ Yes ☐ No
8. Has any medical staff been accused of sexual misconduct, including unfounded accusations? ☐ Yes ☐ No
9. Has any medical staff been hired who has a criminal record? ☐ Yes ☐ No
10. Has the Applicant made a report to the National Practitioner Data Bank on any provider(s)? ☐ Yes ☐ No

I. MEDICAL SERVICES

1. Does the Applicant own or operate any of the following? Please check all that apply and provide a brief description in the Comments section. A supplemental questionnaire may be required.

   ☐ Stand Alone Surgery Center ☐ Crisis Center ☐ Medi-Spa

   ☐ Skilled, Assisted, or Independent Senior Living Facility ☐ Psychiatric or Behavioral Health Unit

   ☐ Separate Facility or Housing for Behavioral Health, Substance Abuse, or Developmental Disabilities

2. Does the Applicant provide telemedicine services? ☐ Yes ☐ No
   a. If yes, provide a description of services offered in the Comments section.
   b. When providing services for patients living out of state, are the providers appropriately licensed in the patient's state of residence? ☐ Yes ☐ No

3. Does the Applicant or its medical staff provide services to correctional facilities? ☐ Yes ☐ No
   If yes, provide the location(s) and estimated visits for the most recent twelve (12) months in the Comments section.
4. Does the Applicant provide clinical training for students that attend a medical school or other healthcare related school? If yes, please explain in the Comments section. ☐ Yes ☐ No
5. Complete columns a, b, or c for each of the Applicant's departments or services listed below.

Department or Service	a. Staffed by employees	b. If contracted, provide group name	c. Services not offered
Anesthesia	☐		☐
Emergency Room	☐		☐
Radiology	☐		☐
Obstetrics/Gynecology	☐		☐
Laboratory	☐		☐
Nursing	☐		☐
Pharmacy	☐		☐
Physical & Occupational Therapy	☐		☐
Home Health Care	☐		☐
Grounds Maintenance	☐		☐
Valet	☐		☐
Ambulance	☐		☐
Non-Emergent Transport	☐		☐
Other contracted services (describe):			

Please answer the department-specific questions below. If the Applicant does not provide the services described, please check N/A and proceed to the next question.

J. EMERGENCY DEPARTMENT ☐ N/A

1. If the Applicant is a designated trauma center, please select the level of services provided, as defined by the American College of Surgeons:

☐ Level I	Comprehensive: Total care for every aspect of injury, from prevention through rehabilitation. 24-hour coverage with general surgeons and specialists.
☐ Level II	Definitive: Initiates definitive care for all injured patients. 24-hour coverage similar to Level I but may not have the breadth of specialist availability.
☐ Level III	Emergency resuscitation: Prompt assessment, resuscitation, surgery, intensive care, and stabilization. Has transfer agreements with Level I or II centers for patients requiring more comprehensive care.
☐ Level IV	Advanced trauma life support: Initial evaluation, stabilization, diagnostic and transfers to a higher-level trauma center.
☐ Level V	Initial evaluation and stabilization: Transfer agreements for transferring patients to a higher-level trauma center.
☐ Applicant is not a designated trauma center.	

2. Provide the number of emergency department physicians: _____
3. Provide the number of nurse practitioners and physician assistants: _____
4. Are emergency department physicians required to be board-certified? ☐ Yes ☐ No
5. Are all licensed support staff ACLS/PALS certified? ☐ Yes ☐ No
6. Is there a written policy that requires a phone call to the patient within 24 hours after discharge? ☐ Yes ☐ No
7. Provide the number of Emergency Department return visits within 72 hours for the past twelve (12) months: _____

K. OBSTETRICS ☐ N/A

1. Select the level of services provided, as defined by the AAP and the ACOG.

☐ Level I	Provides full obstetrical services, including the ability to perform a c-section within 30 minutes, for patients not considered to be at high risk of complications during labor or delivery.
☐ Level II	Manages high risk deliveries and caring for neonates who are small or moderately ill. There may or may not be a special care nursery.
☐ Level III	Provides comprehensive services to all patients. Frequently functions as a regional referral center for high-risk pregnancies and very small or seriously ill neonates. Will have a separate neonatal intensive care unit and may provide stabilization and transport services for neonates from the referring hospital.

2. Provide the number of obstetricians on staff: _____
3. If VBAC's are performed, can a c-section be performed in 30 minutes or less from decision to incision? ☐ Yes ☐ No
4. Is the Applicant a regional referral center for high-risk pregnancies or newborns? ☐ Yes ☐ No
5. Are all obstetrical physicians board-certified or board qualified in Obstetrics? ☐ Yes ☐ No
6. Do midwives perform high-risk deliveries? ☐ Yes ☐ No
7. Is electric fetal monitoring performed on all patients in active labor? ☐ Yes ☐ No
8. Are all obstetrical staff (including RN's) required to maintain NICHD fetal monitoring certification? ☐ Yes ☐ No
9. Are water births performed? ☐ Yes ☐ No
10. Do any deliveries occur outside of the hospital? ☐ Yes ☐ No
    If yes, include the location(s) and distance to the nearest hospital:
    _____
11. Considering the past twelve (12) months, how many:
    a. Infants were born with an Apgar of six (6) or less, at five (5) minutes: _____
    b. C-sections were performed that exceeded 30-minute decision to incision criteria: _____
    c. C-sections were performed by Family or General Practice Physicians: _____
    d. Vaginal Birth After C-Section (VBAC's) were performed by Family or General Practice Physicians: _____

L. SURGERY ☐ N/A

1. Can residents perform surgery without an attending physician present? ☐ Yes ☐ No
2. Provide the number of Unintended Retained Foreign Bodies in the past two (2) years: _____
3. Is a third-party used for instrument sterilization? ☐ Yes ☐ No
4. When instruments are sterilized on site, please indicate the sterilization method(s) used:
   ☐ Steam ☐ Gas ☐ Routine Flash ☐ Chemical Soak ☐ Other (describe): _____

Consider the past twelve (12) months for the following questions.

5. What percentage of surgical patients experienced a major post-operative complication? _____%
6. Provide the risk adjusted: mortality rate: _____% morbidity rate: _____%
7. Provide the number of reported incidents or events:
   Wrong site surgery: _____ Wrong patient: _____ Wrong procedure: _____

M. RADIOLOGY AND PHARMACY ☐ N/A

1. Are any radiologists providing services to patients out of state via teleradiology? ☐ Yes ☐ No
   If yes, specify which states: _____
2. Does a radiologist perform final reads on all radiographic tests? ☐ Yes ☐ No
   If no, please explain: _____
3. Is the pharmacy staffed 24-hours per day? ☐ Yes ☐ No
   If no, how are medications accessed when the pharmacy is closed? _____

4. What is the Applicant's process for addressing discrepancies and prescription violations related to controlled substances?

N. RISK MANAGEMENT

1. Does the Applicant have a dedicated Risk Manager? ☐ Yes ☐ No
   If yes, who does the Risk Manager report to? _____
2. Is there a physician on site 24/7 to respond to medical emergencies? ☐ Yes ☐ No
   If no, how soon can the on-call physician arrive? _____
3. Do you perform employee culture surveys? ☐ Yes ☐ No
   If yes, when was the most recent survey conducted? _____
   What was the Applicant's overall score? _____
4. Considering the past twelve (12) months, provide the number of:
   Incident reports: _____ Serious or sentinel events: _____ Inpatient falls: _____
   Near miss events, including precursor events that reached but did not impact patient's outcome: _____
   Complaints or grievances related to: Informed consent: _____ Delay in diagnosis: _____
   Fall rate with injury (percentage): _____%

O. CLAIM INFORMATION

In answering these questions, consider all coverage being applied for:

1. Have any claims or suits ever been made against the Applicant, the Applicant's owners, employees or contractors, including any person for whose acts or omissions the Applicant is legally responsible for? ☐ Yes ☐ No
   If yes, have all claims and suits been disclosed to us? ☐ Yes ☐ No ☐ N/A
2. Is the Applicant aware of any potential claims including alleged injury, incidents or circumstances that might reasonably lead to a claim or suit being brought against the Applicant, the Applicant's owners, employees or contractors (including any person for whose acts or omissions the Applicant is legally responsible for) even if the claim or suit would be without merit? This includes any request for medical records related to an adverse outcome. ☐ Yes ☐ No
   If yes, have they all been reported to your current or prior professional liability carrier? ☐ Yes ☐ No ☐ N/A
3. Is the Applicant aware of any claims, suits or potential claims that have not been reported to the Applicant's current or prior professional liability carrier? ☐ Yes ☐ No

P. COMMENTS

Please explain all "yes" answers in the Comments section. Please include section and question number.

COMMENTS SECTION CONTINUED

Please be advised that providing materially false or misleading information with the intent to deceive during the application process may result in the rescission of your insurance policy. It is essential to ensure all information submitted is accurate and complete. Additionally, the Applicant has a duty to inform us of any changes in conditions or circumstances following the submission of this application to ensure coverage remains valid and effective.

APPLICATION: All application information is considered important. Signing this application does not bind insurance. We must review and formally approve or reject the application.

FRAUD WARNING/STATEMENT: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Any person who includes any false or misleading information on an application for an insurance policy may be guilty of a crime and subject to penalties that include imprisonment, fines and denial of insurance benefits. Refer to the State Fraud Warning Notices document for your state specific fraud warning notice, if applicable.

CLAIMS-MADE AND REPORTED DISCLOSURE: If any portion of the policy is issued on a claims-made and reported basis, such portions will apply only to claims first made against the Applicant during the policy period arising out of the performance of professional services occurring on or after the prior acts date shown on the policy. Claims must be reported to us during the policy period or under an extended reporting period endorsement.

PRIVACY STATEMENT: We may communicate the results of the application to the Applicant's authorized representative. To review detailed information on how we collect and use the Applicant's personal information, visit the company website at curi.com.

APPLICANT ACKNOWLEDGEMENT: The Applicant certifies this information is complete and accurate. Applicant acknowledges a continuing duty to supplement any information that may materially affect this application. Applicant acknowledges the applicable state fraud warning notice as shown on the State Fraud Warning Notices document, if applicable.

PRIOR ACTS ACKNOWLEDGEMENT: All claims or potential claims have been reported to the Applicant's current or prior carrier. The Applicant understands the company will not provide coverage for any claim, suit or potential claim known on the effective date.

Applicant Signature	Title	Date