# HUDSON SPECIALTY INSURANCE COMPANY
## Healthcare Facility Application Guidelines

**Documents which form part of this application:**

- Fraud Statements(s)
  - Sign appropriate statement based on your State

- Supplemental Claim Information Form
  - Complete for every claim/suit paid at $50,000 or more reported within the past 6 years, and for every open claim/suit reserved at $50,000 regardless of when it was reported

- Nursing Home Supplement
  - Complete if applicant has a convalescent or nursing home as part of the facility

- Professional Employee Roster (**format on Page 15**)
  - Complete if coverage is requested for any Professional Employee referenced on page 4 of the application

**Attach copies of the following with this application:**

- Current Audited Financial Statement
- Risk Management Plan
- Current professional liability policy **(Page 4 of application)**
- Medical Staff Bylaws
- Current Loss Run(s) (valued within 60 days on the insurer's format for the current year and a minimum of 5 additional years)
- Agreements where other parties are indemnified
- JCAHO or other Accreditation survey (JCAHO - Submit a copy of the most recent JCAHO Accreditation Letter, Scoring Grid and Type 1 Recommendations and responses - **Page 3 of application**)

**Attach copies of the following with this application *as they apply to your coverage requests*:**

SIR (**Page 3 of application**)

- Actuarial Review for this year
- Trust Agreement

Excess Umbrella Liability (**Page 3 of application**)

- Schedule of owned autos
- Certificates of insurance verifying underlying coverage for Employers Liability and Auto Liability
- Currently valued auto loss runs

Employed Physicians, Dentists & Residents (**Page 5 of application**)

- Current Hudson Specialty Insurance Company application for each of these employees

Convalescent or Nursing Home (**Page 14 of Nursing Home Supplement)**

- Most recent state inspection report and facility responses
- Current state license

# HUDSON SPECIALTY INSURANCE COMPANY
## Healthcare Facility Application
**for surplus lines coverage**

**PRODUCER INFORMATION**

Agency Name _____

Mailing Address _____ City/State/Zip _____

Producer Name _____Telephone _____ Fax _____

**APPLICANT INFORMATION**

Named Insured _____ County _____

Primary Location _____ City/State/Zip _____

CEO _____ Risk Manager _____ Website: _____

Authorized representative for insurance matters: _____ Telephone _____

How many years has the facility been in operation? _____
How many years has the facility been under present ownership? _____

**LEGAL ENTITIES**

List all owned (50% or more) entities to be considered as a Named Insured, or attach a separate list:

| Name | Type/Purpose of Facility | Retroactive Date |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**FACILITY INFORMATION**

**Type** (check all that apply)

- ☐ Children's Hospital
- ☐ Clinic
- ☐ *Convalescent or Nursing Home
- ☐ General Acute Care Hospital
- ☐ Hospice
- ☐ Psychiatric Hospital
- ☐ Research Hospital
- ☐ Surgical Center
- ☐ Teaching Hospital

**Ownership and Control**

- ☐ Governmental
- ☐ Individual
- ☐ Partnership
- ☐ Corporation
- ☐ Other (explain)_____

**Tax Status**

- ☐ For Profit
- ☐ Not for Profit
- ☐ Medicare Approved
- ☐ Charitable

(**complete Nursing Home Supplement and refer to application guidelines for required attachments)*

The facility is (check all that apply):

- ☐ Accredited by AOA
- ☐ *Accredited by JCAHO
- ☐ Member of American Hospital Association
- ☐ Member of State Hospital Association
- ☐ Medicare Approved
- ☐ Other (specify) _____

(**refer to application guidelines for required attachments)*

Date of last survey _____ Accreditation Period _____

**INSURANCE COVERAGE REQUEST**

1. Requested Effective Date _____

2. Requested Limits

   Professional Liability $_____ /$_____ ☐ Claims Made Retroactive Date_____
   per claim aggregate

   General Liability $_____ /$_____ ☐ Claims Made Retroactive Date_____
   per claim aggregate ☐ Occurrence Coverage

3. Deductible ☐ None

   Professional Liability $_____ /$_____ General Liability $_____ /$_____
   per claim aggregate per claim aggregate

4. *Self Insured Retention $_____ /$_____ *(*refer to application guidelines for required attachments)*
   per claim aggregate

   a) What coverage does the SIR contemplate? ☐ Professional Liability ☐ GL ☐ Other _____
   b) Is there an Insurance Trust? ☐ Yes ☐ No
   c) Is there an Insurance Captive? ☐ Yes ☐ No
   d) What organization handles claims for the SIR? _____
   e) What legal firm is responsible for defending claims against the insured? _____
   _____

5. ☐ Straight Excess Liability ☐ *Excess Umbrella Liability *(*refer to application guidelines for required attachments)*
   Limits $_____/$_____ Retroactive Date _____

6. ☐ Employee Benefits Administration Liability
   Total number of employees _____ Retroactive Date: _____

**INSURANCE HISTORY**

Complete the following professional liability insurance history:

***Current Carrier** _____ ☐ Claims Made ☐ Occurrence
Effective Date _____ Expiration Date_____ Retroactive Date _____
Limits $_____/$_____ ☐ Deductible/SIR $ _____
Expiring premium(s) $ _____
(**attach copy of current policy - see application guidelines)*

**1st Prior Carrier** _____ ☐ Claims Made ☐ Occurrence
Effective Date _____ Expiration Date_____ Retroactive Date _____

**2nd Prior Carrier** _____ ☐ Claims Made ☐ Occurrence
Effective Date _____ Expiration Date_____ Retroactive Date _____

**CENSUS STATISTICS**

**BEDS**

Occupancy: The daily average number of occupied beds shall be the sum of the annual occupancy divided by 365. Acute Care Beds are defined as: All beds licensed by the state, including but not limited to, all beds designated for burn, coronary, intensive care, medical, surgical, pediatrics, or other acute care patients.

| | **No. Licensed Beds** | | | **Average Annual Occupied Beds** | | |
|---|---|---|---|---|---|---|
| | Current Year | 1st Prior | 2nd Prior | Current Year | 1st Prior | 2nd Prior |
| Acute Care | | | | | | |
| Cribs & Bassinets | | | | | | |
| Psychiatric | | | | | | |
| Rehabilitation | | | | | | |
| **Nursing Home Beds** | | | | | | |
| Skilled Care | | | | | | |
| Intermediate Care | | | | | | |
| Residential Care | | | | | | |

**OUTPATIENT VISITS**

| | ***Current*** annual visits | ***Projected*** annual visits |
|---|---|---|
| Emergency Medicine | | |
| Mental Health | | |
| Alcohol/Drug Rehabilitation | | |
| Physical Rehabilitation/Therapy | | |
| Home Health Care | | |
| Nursing Home Visits | | |
| Other Outpatient Visits (multiple procedures on the same patient on the same date constitute one visit) | | |
| Inpatient Surgeries (excluding Bariatric) | | |
| Outpatient Surgeries | | |
| Total Deliveries (including C-sections) | | |
| Bariatric Surgeries | | |
| Other exposures (specify) _____ _____ | | |

**PERSONNEL**

**NOTE: No individual coverage is afforded to the following Professional Employees unless specifically requested**

**Number of Professional Employees**

| | Employees | Independent Contractors | Other | |
|---|---|---|---|---|
| *Employed Physician/Dentist | | | Independent Medical Staff (excluding employees) | |
| *Employed Resident | | | | |
| Nurse Anesthetist | | | | |
| Nurse Midwife | | | | |
| Nurse Practitioner | | | | |
| Physician Assistant | | | | |
| Podiatrist | | | | |
| Psychologist | | | | |

*(* if coverage is requested, refer to application guidelines for required attachments)*

**SERVICES**

Indicate if the Applicant presently provides or operates, or plans to provide or operate any of the following:

| | | | |
|---|---|---|---|
| ☐ Abortion Clinic | ☐ Dental Services | ☐ Hospice | ☐ Outpatient Surgicenters (complete **Surgery**, page 6) |
| ☐ *Ambulance Services | ☐ Dialysis | ☐ Intensive Care Unit | ☐ Pain Management |
| ☐ Birthing Suites | ☐ Emergency Room | ☐ Long-Term Care | ☐ Pathology |
| ☐ *Blood Bank | ☐ *Fitness Center | ☐ Neonatal ICU | ☐ Pediatrics |
| ☐ Burn Units | ☐ General Medicine | ☐ Nursery | ☐ Rehabilitation |
| ☐ Cardiac Catheterization Ctr | ☐ General Surgery | ☐ OB/GYN | ☐ Research/Experimental Surgery |
| ☐ Chemical Dependency | ☐ Geriatrics | ☐ Oncology | ☐ Skilled Nursing |
| ☐ Coronary Care Unit | ☐ HMO | ☐ Open Heart Surgery | ☐ Transplants |
| ☐ *Day Care | ☐ Home Health Care | ☐ Organ Transplants | ☐ Transportation Services (other than ambulance) |
| ☐ Other _____ | | | ☐ Trauma Centers |

*Complete the following information for SERVICES selected above:

Ambulance Services

Number of runs per year _____ Number of vehicles _____

EMT(s)/Paramedic(s) ☐ Yes ☐ No

If "Yes", number of: _____ Employed by facility ☐ Yes ☐ No

Fitness Center

☐ On premises ☐ General public

☐ Patient only ☐ Swimming pool

Blood Bank

Are you accredited by: ☐ AABB ☐ CAP

☐ Hospital patient use only ☐ Used by outside patients

Day Care

Number of children per day _____ Maximum caregiver to child ratio _____

Number of days per week _____ ☐ On-hospital premises ☐ Open to the public

**EMERGENCY DEPARTMENT**

| | |
|---|---|
| 1. What is the JCAHO designation of the Emergency Department? ☐ N/A<br>☐ Level I (tertiary) ☐ Level II (comprehensive) ☐ Level III (basic) ☐ Level IV (standby) ☐ Level V | |
| 2. Is the Emergency Department staffed by:<br>____ Employed Physicians _____Contract Group _____ Staff Physicians | |
| 3. If under contract, provide name of group: _____<br>Required Professional Liability Limits: $_____/$_____ | |
| 4. Are all ER physicians required to be Board Certified or eligible in Emergency Medicine? | ☐ Yes ☐ No |
| 5. Are the ER physicians required to respond to cardiac/respiratory arrests or other medical Emergencies occurring in the institution? | ☐ Yes ☐ No |
| 6. Is the Emergency Room equipped with the following: | |
| a. Emergency resuscitation care equipped with defibrillator | ☐ Yes ☐ No |
| b. Electrocardiograph machine | ☐ Yes ☐ No |
| c. Staffed radiology room(s) | ☐ Yes ☐ No |
| d. Dedicated triage area and staff | ☐ Yes ☐ No |
| e. Dedicated trauma room(s) and staff | ☐ Yes ☐ No |
| f. Dedicated laboratory personnel | ☐ Yes ☐ No |
| 7. Do any of the Emergency Department staff routinely work more than a eight (8) hour duty shift?<br>If "Yes", explain: _____ | ☐ Yes ☐ No |

**SURGERY**

1. Are any of the following performed at your facility and/or outpatient surgicenters? (circle location(s)) ☐ None

| | |
|---|---|
| ☐ Cosmetic Surgery ( Hospital / Outpatient Center ) | ☐ Laser Assisted Surgery/LASIK ( Hospital / Outpatient Center ) |
| ☐ Experimental Surgery ( Hospital / Outpatient Center ) | ☐ Sex change operations ( Hospital / Outpatient Center ) |
| ☐ Neurosurgery ( Hospital / Outpatient Center ) | ☐ Weight reduction surgery/Bariatrics ( Hospital / Outpatient Center ) |

**PATHOLOGY**

| |
|---|
| 1. Is the Pathology Department staffed by:<br>____ Employed Physicians _____Contract Group _____ Staff Physicians |
| 2. If under contract, provide name of group: _____<br>Required Professional Liability limits: $_____/$_____ |

**ANESTHESIA**

| | |
|---|---|
| 1. Is the Anesthesiology Department staffed by:<br>_____ Employed Physicians _____Contract Group _____ Staff Physicians | |
| 2. If under contract, provide name of group: _____<br>Required Professional Liability limits: $_____/$_____ | |
| 3. Are all anesthesiologists required to be Board Certified or eligible in Anesthesiology? | ☐ Yes ☐ No |
| 4. Do CRNA's provide anesthesia services? | ☐ Yes ☐ No |
| 5. CRNA employment by: ☐ Applicant ☐ Anesthesiologist ☐ Surgeon<br>☐ Independent Contractor | |
| 6. Is the anesthesia care performed by CRNA's supervised and reviewed by the anesthesiologists? If "No", explain: _____ | ☐ Yes ☐ No |

**RADIOLOGY**

| | | |
|---|---|---|
| 1. | Is the Radiology Department staffed by:<br>____ Employed Physicians _____Contract Group _____ Staff Physicians | |
| 2. | If under contract, provide name of group: _____<br>Required Professional Liability limits: $_____/$_____ | |
| 3. | Are all radiologists required to be Board Certified in Radiology and/or Nuclear Medicine? | ☐ Yes ☐ No |
| 4. | State the number of X-ray machines owned and/or operated: _____ | |
| 5. | How many are used for: Diagnosis: _____ Treatment: _____ Both: _____ | |

**OBSTETRICS**

| | | |
|---|---|---|
| 1. | How many: Labor rooms _____ Delivery rooms _____ Birthing Suites _____ | |
| 2. | Is the delivery room suite separate from the surgical suite? | ☐ Yes ☐ No |
| 3. | What is the C-section rate for the previous 12-month period ? _____ | |
| 4. | Are you in current compliance with all ACOG standards, including those that pertain to C-sections? | ☐ Yes ☐ No |
| 5. | Is an Obstetrician available in-house twenty-four (24) hours per day for the obstetrics suite?<br>If No, what is the maximum time allowed for arrival at the facility? _____ | ☐ Yes ☐ No |
| 6. | Is an Anesthesiologist or CRNA available in-house twenty-four (24) hours per day?<br>If No, what is the maximum time for arrival at the facility? _____ | ☐ Yes ☐ No |
| 7. | If the Applicant has a neonatal intensive care unit (NICU), what is the total number of neonates admitted in the last 12 months? _____ | |
| 8. | Is the Applicant a regional referral center for newborns requiring intensive care? How many were transferred from other facilities? _____ | ☐ Yes ☐ No |
| 9. | Is a full-time attending neonatologist on-site in the NICU twenty-four (24) hours per day? | ☐ Yes ☐ No |

**STAFF CREDENTIALING & PRIVILEGES**

| | | |
|---|---|---|
| 1. | Are credentials for all Physicians and Allied Professionals checked and approved prior to granting staff privileges? | ☐ Yes ☐ No |
| 2. | Are privileges probationary?<br>What is the amount of probationary time? _____ | ☐ Yes ☐ No |
| 3. | Are new staff members proctored? | ☐ Yes ☐ No |
| 4. | Are there any Physicians or Allied Professionals who are not licensed or who have restricted licenses or privileges? | ☐ Yes ☐ No |
| 5. | Are Physicians and Allied Professionals privileges reviewed at least once every other year? | ☐ Yes ☐ No |
| 6. | Are all foreign medical graduates certified by the Educational Council for Foreign Medical Graduates (ECFMG) or have they passed the FLEX? | ☐ Yes ☐ No |
| 7. | Are independent Physicians and Allied Professionals required to maintain professional liability insurance?<br>What are the required limits? _____ | ☐ Yes ☐ No |
| 8. | Are certificates of insurance required as verification of insurance? | ☐ Yes ☐ No |

**RISK MANAGEMENT**

| | | |
|---|---|---|
| 1. | Is there an individual who is designated with the job title and role of hospital Risk Manager? | ☐ Yes ☐ No |
| 2. | Is there a written, formalized Risk Management plan? | ☐ Yes ☐ No |
| 3. | Is this plan regularly reviewed for effectiveness and/or any necessary changes?<br>If "Yes", how often is the plan reviewed? _____ | ☐ Yes ☐ No |
| 4. | Is there an ongoing Quality Assessment or Improvement plan? | ☐ Yes ☐ No |

**CONTRACTUAL AGREEMENTS**

| | | |
|---|---|---|
| 1. | Identify any remaining contracted professional services performed at the hospital not previously identified: ☐ None<br>☐ Home Health ☐ Occupational Therapy ☐ Physical Therapy<br>☐ Laboratory ☐ Pharmacy ☐ Respiratory Therapy<br>☐ Other: _____ | |
| 2. | Does the hospital require contractors to provide professional liability insurance verification?<br>If "Yes", what limits are required by your current by-laws? _____ | ☐ Yes ☐ No |
| 3. | Are all contracts reviewed by legal counsel prior to execution? | ☐ Yes ☐ No |
| 4. | Does the applicant indemnify (hold harmless) any other party for liability?<br>If "Yes", submit a copy of the agreement *(per application guidelines)* | ☐ Yes ☐ No |
| 5. | Does the applicant rent or lease equipment to or from others? | ☐ Yes ☐ No |
| 6. | Does the applicant contract outside entities for the removal and/or disposal of the following wastes?<br>☐ Low Level Radioactive ☐ Other Radioactive<br>☐ Hazardous or Toxic ☐ Medical or Infectious | ☐ Yes ☐ No |
| 7. | If "Yes" to any of the above, is evidence of insurance required?<br>What are the minimum limits required? _____ | ☐ Yes ☐ No |
| 8. | Does the applicant have any on-site dumps, landfills, or other disposal areas? | ☐ Yes ☐ No |

**GENERAL INFORMATION**

| | | |
|---|---|---|
| 1. | Does the applicant engage in any of the following:<br>a. Formal clinical research under the auspices of an institutional review board?<br>b. Administration of non-FDA approved pharmaceuticals (experimental drugs)?<br>c. Biomedical device research and development?<br>d. Animal research?<br>e. Medical and/or surgical experimentation that is not approved by an institutional review board?<br>If "Yes" to any of the above, provide details: _____<br>_____ | ☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No<br>☐ Yes ☐ No |
| 2. | Has the Applicant or other associated entity ever had it's license revoked, suspended or placed on probation by an governmental licensing agency? If "Yes", explain: _____<br>_____ | ☐ Yes ☐ No |
| 3. | Has the Applicant ever been investigated by any third party for alleged fraud, erroneous billing or entered into a Compliance Integrity Agreement? If "Yes", explain: _____<br>_____ | ☐ Yes ☐ No |
| 4. | Has the Applicant entered into any joint ventures or limited partnerships? If "Yes", explain: (% of ownership)_____ | ☐ Yes ☐ No |

| | | |
|---|---|---|
| 5. | Is any part of the Applicant operated/leased by a management corporation? If "Yes", give the name of the corporation, details of the structure and provide a copy of the contract: _____ _____ | ☐ Yes ☐ No |
| 6. | Does the Applicant participate in any teaching programs or have affiliations with educational institutions? If "Yes", explain: _____ | ☐ Yes ☐ No |
| 7. | Does the Applicant anticipate any facility or service expansions within the next year? _____ | ☐ Yes ☐ No |
| 8. | Does the Applicant anticipate any sale of assets, mergers, acquisitions, consolidation or change in operations or services within the next twelve (12) months? If "Yes", explain: _____ _____ | ☐ Yes ☐ No |

*Provide a detailed explanation for the following questions answered "Yes", on a separate sheet of paper:*

| | | |
|---|---|---|
| 9. | Has any company ever declined, cancelled, refused to renew, restricted, or surcharged your professional liability insurance? | ☐ Yes ☐ No |
| 10. | Have there been any complaints or suits brought against the applicant by a member of the medical staff? | ☐ Yes ☐ No |
| 11. | Is the applicant aware of any conduct, circumstance, occurrence, incident, or accident that is likely to or reasonably could be expected to give rise to a claim that has not yet been reported to the current and/or prior insurance carrier? | ☐ Yes ☐ No |

**PHYSICAL PREMISES**

1. List all buildings applicant owns, controls, or occupies or attach a separate list.

| **Address** | **Use** | **Construction** (Brick, Fire Restrictive etc.) | **Year Built** | **# Of Stories** | **Total Sq. Ft.** | **Complete Sprinkler System** |
|---|---|---|---|---|---|---|
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |
| | | | | | | ☐ Yes ☐ No |

2. Does the Applicant own, rent, or charter any aircraft or helicopters? ☐ Yes ☐ No

3. Does the Applicant have or maintain a heliport/helipad? ☐ Yes ☐ No

   If "Yes", where is the pad located (e.g., parking lot, top of building etc.)_____
   Is the area identified with warning signs and/or fencing? ☐ Yes ☐ No
   Is the area equipped with proper lighting for night or foul weather landings? ☐ Yes ☐ No
   How many annual landings do you have? _____

4. Does the Applicant own ambulances or other emergency vehicles? (see **Services** page 5) ☐ Yes ☐ No

5. Do all facility locations meet applicable National Fire Protection Agency (NFPA) building codes? ☐ Yes ☐ No

**THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.**

**For FL, KY, MN, NJ, OH and PA residents only: Any person who knowingly and with intent to defraud any insurance company or other person who 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. For NY residents only: And shall also be subject to a civil penalty not to exceed five thousand ($5,000) dollars and the stated value of the claim for each such violation.**

***This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company.***

_____ _____

**Signature** **Date**

_____

**Print Name/Title**

# HUDSON SPECIALTY INSURANCE COMPANY

## FRAUD WARNINGS

**To All Prospective Insureds:** 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

**To Prospective Insureds in:**

**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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

**New York:** 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

| Applicant's Signature | Print Name | Date |
|---|---|---|

# HUDSON SPECIALTY INSURANCE COMPANY
## Supplemental Claim Information Form

1. Full name of applicant: _____

2. Full name of claimant: _____

3. Indicate whether: Claim_____ Suit_____ Incident_____

4. Date of incident: _____ 5. Date claim was reported: _____

6. Additional defendants: _____

7. If closed:
   Total loss paid including deductible: $_____ Defense costs: _____

   Indicate whether: Court judgment_____, or Out of court settlement _____

   Date closed: _____

8. If pending:
   Claimant's settlement demand: $_____

   Defendant's offer for settlement: $_____

   Insurer's loss reserve: $_____

   Deductible amount: $_____

   Is claim in suit? Yes_____ No_____
   If "Yes", amount asked in summons: $_____

9. Insurance carrier:_____

10. Description: (Provide enough information to allow evaluation. Use reverse side or additional sheet if required.)

A. Alleged acts, error or omission upon which Claimant bases claim:

_____

_____

B. Description of case and events:

_____

_____

C. Description of the type and extent of injury or damage allegedly sustained:

_____

_____

_____ _____
Signature of applicant Date

# HUDSON SPECIALTY INSURANCE COMPANY
## Nursing Home Supplement

Name of Facility _____

**Operation/Degree of Care**

☐ Skilled Nursing Facility – offers nursing services on a 24 hour basis
☐ Intermediate Care Facility – offers medical, nursing, social and rehabilitative services
☐ Personal Care Facility – non-continuous nursing care with supervised living
☐ Other _____

**Ownership**

☐ 100 percent corporately owned
☐ Partnership or Joint Venture. Indicate parties and percentage of ownership _____

_____

☐ Individually owned
☐ Other – explain _____

*Has license ever been revoked? ☐ Yes ☐ No If "Yes", explain: _____

_____

_____

*(refer to application guidelines for required attachments)

How long has this facility been in operation? _____

Is the facility certified for Medicaid reimbursement? ☐ Yes ☐ No

**Physical Protection of Premises**

1. a) Is the building fully sprinklered? ☐ Yes ☐ No If "No", what percentage of the building is sprinklered? _____ Indicate those areas that are not sprinklered _____

   b) Was building originally constructed for use as a nursing or retirement home? ☐ Yes ☐ No

   If "No", explain _____

   _____

   c) How often is the fire alarm and automatic sprinkler system tested? _____

2. Are all hallways and stairways equipped with firmly secured handrails? ☐ Yes ☐ No

3. Do all stairways used by patients contain anti-slip treads? ☐ Yes ☐ No

4. Is the facility in compliance with the Life Safety Codes or Regulations as indicated by the local fire department? ☐ Yes ☐ No Indicate date of last survey by local fire officials _____

5. Does the Nursing Home have door alarms to monitor patients leaving the building unattended after hours? ☐ Yes ☐ No

6. Does the facility have a written policy concerning the use of smoking materials in the building? ☐ Yes ☐ No
   Indicate the facility's policy on a separate sheet.

# HUDSON SPECIALTY INSURANCE COMPANY
## Nursing Home Supplement - Continued

### Services/Activities

1. Are all bedridden patients on ground floor? ☐ Yes ☐ No If not, indicate floor level for these patients _____

2. a. Indicate the following Medical and Professional Services contracted from outside the facility:
   ☐ Dental ☐ Inhalation Therapy ☐ Other (explain): _____
   ☐ Dialysis ☐ Physical Therapy
   ☐ Grooming/Beauty ☐ X-Ray

   b. Are Certificates of Insurance requested from these contractual services? ☐ Yes ☐ No
   If "Yes", what limits of liability are required $ _____

3. Does the Nursing Home own or operate any of the following services:
   Home Health Care Services ☐ Yes ☐ No
   Durable Medical Equipment Service ☐ Yes ☐ No
   Adult Day Care ☐ Yes ☐ No
   Pharmacy ☐ Yes ☐ No
   Wellness/Fitness Center Program ☐ Yes ☐ No

4. Does the facility sponsor any recreational events or picnics involving residents, their families or members of the community? ☐ Yes ☐ No If "Yes", indicate activities: _____
   _____
   _____
   _____

### Miscellaneous

1. Indicate number of employees in each category:
   _____ LPNs _____ Pharmacist _____ Therapists _____ Other: _____
   _____ Nurses Aides _____ RNs _____ Volunteers

   Ratio of patients to nurses: _____ to _____

2. If a Skilled Nursing Facility:
   a. Is a physician appointed to act as the medical director of the facility? ☐ Yes ☐ No
   b. Do you have privileges procedures in place for attending physicians? ☐ Yes ☐ No

3. Do you have an arrangement for transportation and care (i.e. local hospital) of patients needing additional medical services? ☐ Yes ☐ No

4. Is access to records granted to other individuals or institutions only on the signing of a release form? ☐ Yes ☐ No

**Completed by:**

_____

Name Title Date Phone number

# HUDSON SPECIALTY INSURANCE COMPANY
## Professional Employee Roster
(make copies of this page as needed)

| | Last Name | First Name | M.I. | Specialty | Surgery Level | Retroactive Date |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| 11 | | | | | | |
| 12 | | | | | | |
| 13 | | | | | | |
| 14 | | | | | | |
| 15 | | | | | | |

**Part-Time Employees**
Indicate average number of hours worked on a weekly basis

**Surgery Level(s)**

No Surgery **(NS)**
Includes normal office procedures as commonly found in a family practice. Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered "No Surgery". This includes administration of local or topical anesthesia and circumcision. No invasive procedures or special procedures room activities are done.

Minor Surgery **(MS)**
Includes all listed in definition of "No Surgery", as well as assisting in major surgery, D&C, and vasectomies. Invasive procedures are done, but the procedures do not open or enter a major body cavity.

Major Surgery **(S)**
Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, any other operation, which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life, removal of tumors, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections, and any other operation done using general anesthesia, and the administration of anesthesia other than local or topical.