PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

1777 Sentry Parkway West, VEVA 14, Suite 300, Blue Bell, PA 19422
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com – Website: http://www.pajua.com

APPLICATION FOR NURSING HOME PROFESSIONAL LIABILITY INSURANCE

Limits of Liability: $500,000 Per Occurrence / $1,500,000 Per Annual Aggregate

POLICIES ARE ISSUED ON AN ANNUAL BASIS UNLESS OTHERWISE SPECIFIED AND APPROVED BY THE JUA
COVERAGE CANNOT BEGIN PRIOR TO APPLICATION AND PREMIUM RECEIPT BY THE JUA

JUA Coverage, if issued, will be on a CLAIMS-MADE Basis	Requested Effective Date:	
	Requested Retroactive Date:	

PART I – GENERAL INFORMATION

Applicant Name:

State License Number: Mcare License Number:

Address:

City: State: Zip: County:

Telephone: Fax: E-Mail Address:

PART II – BROKER INFORMATION (if this is being submitted by an insurance broker)

Broker: Contact Person:

Telephone: ( ) Fax: ( ) E-Mail Address:

Address:

Number and Street City State Zip

EIN or SSN (if broker is "new" to JUA): _____

PART III – COVERAGE INFORMATION

List ALL Prior Insurers for the last 10 years: (attach separate list if necessary)

Carrier or Self-Insurer	Policy Number	Coverage Dates (Month, Day & Year) Eff. Exp.	Coverage Type (Occurrence or Claims-Made)	Retroactive Date (if Claims-Made)	Tail Coverage Purchased?
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No
			☐ Occ ☐ CM		☐ Yes ☐ No

If any of the above policies are still in force, explain why coverage is requested from the JUA:

Explain any gaps in coverage in the past 8 years including any period directly preceding JUA coverage:

Explain why tail coverage was not purchased for any claims-made policy listed above:

Attach a copy of the facility's current Declarations and Policy History / Claim History Reports from each of the above carriers or self-insurers plus Mcare. Also see page 4 for a list of additional items to be submitted with the completed application.

You need to contact each of your current or prior carriers and request they send you these reports. They are required to provide these reports to you if you request them. The reports need to be no more than 3 months old as of the effective date of coverage. We need these reports even if the facility has had no claims.

Claims or Suits:

Have any claims been made or suits brought against the facility during the past 10 years as a result of professional services rendered? (Regardless of whether the claim was dismissed or a judgment rendered) □ Yes □ No If yes, attach a description of all claims made or suits brought including the date and status.

Has the facility ever operated for any period of time without insurance? □ Yes □ No
If yes, provide the dates the facility was uninsured: _____. Also provide a letter signed by the owner or administrator on the nursing home's letterhead listing all incidents, claims made and suits filed against the nursing home during the uninsured period. Include claimants' names, dates of alleged incidents, dates the claims were made, brief descriptions, current status and indemnity payment amounts, if any. If there were no claims or incidents, provide a signed letter stating such.

Medical Incidents:

Are you aware of any medical incidents which occurred during one of the claims-made policies *for which a claim has not yet been made*? □ Yes □ No If yes, attach a complete description of the incidents including the date and status.

Never Events:

Have any claims been made or suits brought against the facility for an incident where the patient's medical insurance or Medicare refused to pay because it was on their preventable serious adverse event or "never event" list? □ Yes □ No If yes, attach a description of the incident including the date and status.

PART IV – EXPOSURE INFORMATION

1. Type of Home (see Definitions below). Check one box: □ Convalescent □ Skilled Nursing
   Definitions:
   Convalescent Facilities
   Convalescent Facilities are free-standing facilities which provide skilled nursing care and treatment for patients requiring continuous health care, but do not provide any hospital services (such as surgery); and 50% or more of their patients are under 65.
   Skilled Nursing Facilities
   Skilled Nursing Facilities are free-standing facilities which provide the same service as a Convalescent Facility, except that more of their patients are over 65.
2. The actual number of occupied beds for the last 12 months. _____
3. The projected number of occupied beds for the next 12 months. _____
4. Does the applicant have unrestricted General Liability insurance (e.g. no patient injury, products liability or other significant exclusions)? □ Yes □ No
   If yes, provide evidence of insurance so indicating.
   If no, provide the annual gross receipts for nursing services for:
   The last 12 months _____
   Projected for the next 12 months _____

PART V – OWNERSHIP AND MANAGEMENT

1. Years facility has been in operation _____
2. Years owned by present owners _____
3. Years managed by present management _____
4. Years experience present owners have in nursing homes _____
5. Years experience present management has in nursing homes _____
6. Nursing Home Administrator:
   a. Full name _____
   b. License number _____
   c. Years experience as an Administrator _____ Years at this facility _____
   d. □ Employed or □ Contracted Number of hours per week at this facility _____
   e. Serving □ this facility only or □ other facilities as well?

7. Director of Nursing (DON):
    a. Full name _____
    b. License number _____
    c. Years experience as a DON _____ Years at this facility _____
    d. ☐ Employed or ☐ Contracted Number of hours per week at this facility _____
    e. Serving ☐ this facility only or ☐ other facilities as well?
8. Medical Director:
    a. Full name _____
    b. License number _____
    c. Years experience as a Medical Director _____ Years at this facility _____
    d. ☐ Employed or ☐ Contracted Number of hours per week at this facility _____
    e. Serving ☐ this facility only or ☐ other facilities as well?
    f. Serves as attending physician for any residents? ☐ Yes ☐ No
    If yes, how many? _____

PART VI - STAFFING

1. Nurse staffing

	1st shift	2nd shift	3rd shift
RN			
LPN			
Nurse Aides			

2. Are nursing personnel provided on each floor of the facility? ☐ Yes ☐ No
3. Total number of direct nursing care hours per resident per 24 hour period _____
4. What is the staff turnover rate for the last 12 months? _____%
5. Do you utilize contracted or temporary personnel? ☐ Yes ☐ No
   If yes, what percentage of your nurse staffing is contracted or temporary? _____%
6. Is there an employee orientation program? ☐ Yes ☐ No
7. Is inservice training conducted? ☐ Yes ☐ No What is the frequency? _____
8. Who is authorized to administer drugs and medications? _____

PART VII - RESIDENTS

1. Age range of residents

	Under 50	50 - 64	65 and over
Number			

2. Is an initial nursing assessment performed for each new resident upon admission? ☐ Yes ☐ No
   Are there regular updates? ☐ Yes ☐ No How often? _____
3. Is there an individual discharge plan for each resident? ☐ Yes ☐ No
4. Does each resident have a written physician's order for each medication received? ☐ Yes ☐ No
5. Does each resident have his or her own attending physician? ☐ Yes ☐ No
   If no, who fills that role? _____
6. Do you obtain evidence of medical professional liability insurance in force at the state-mandated limits for all attending physicians? ☐ Yes ☐ No

PART VIII – RISK MANAGEMENT

1. Is there an established risk management program? ☐ Yes ☐ No
2. Is there an assigned risk manager? ☐ Yes ☐ No
   If no, how is this role filled? _____
3. Is there a risk management committee? ☐ Yes ☐ No
4. Is there an incident reporting and analysis system in place? ☐ Yes ☐ No
5. Is there a resident satisfaction survey system? ☐ Yes ☐ No
6. Is there a resident complaint resolution program? ☐ Yes ☐ No

PART IX – ADDITIONAL PROFESSIONAL INFORMATION

1. Does the facility maintain or is a member of any website, blog or other internet, electronic or social media network? ☐ Yes ☐ No If yes, provide names of sites: _____
   _____
2. Has any enforcement action ever been taken against the facility (ban on admissions, license revoked, provisional license, civil money penalty, etc.)? ☐ Yes ☐ No If yes, provide date, description of action taken and name of governmental agency assessing the enforcement action. Attach a separate page if necessary. Also attach copies of any correspondence regarding the enforcement action.
   _____
   _____
3. Has adverse action ever been taken against the facility's Medicare or Medicaid certification? ☐ Yes ☐ No If yes, provide date, description of action taken and name of governmental agency assessing the action. Attach a separate page if necessary. Also attach copies of any correspondence regarding the adverse action. _____
   _____

ADDITIONAL ITEMS TO BE SUBMITTED WITH THE APPLICATION:

1. A copy of the current policy's Declarations page.
2. A copy of the current Certificate of Licensure.
3. Evidence of unrestricted General Liability insurance (e.g. no patient injury, products liability or other significant exclusions).
4. Financial information including a profit & loss statement and balance sheet.
5. A copy of the Resident Census form CMS 672.
6. A copy of the Statement of Deficiencies form CMS 2567L with Plan of Correction for the most recent survey. This should not be a draft copy.
7. An organizational chart displaying the various ownership interests.
8. Company prepared loss runs or claims history reports from all carriers for the last 10 years, even if there were no claims.
9. Mcare loss run.

APPLICATION CERTIFICATION

I certify that I will not accept insurance from the JUA if I am able to obtain insurance through ordinary methods at rates not in excess of those applicable to similarly situated health care providers.

I do hereby warrant the truth of any statements and answers on this application or any materials that accompany this application and that I have not withheld any information which is calculated to influence the judgment of the JUA in considering this application.

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.

IMPORTANT: This application **must** be signed by the Chief Executive Officer or Administrator.

SIGNATURE (all pages must be signed) TITLE DATE

GENERAL INFORMATION

We write **only** *professional liability* (the *general liability is not covered*), nor do we write any excess coverage (coverage that is over the Mcare).

It is critical that the type of claim be indicated on loss history reports (professional liability separated from general liability; institutional professional separated from physicians professional).

We require a **separate application for all employed physicians to be covered.**

We require a separate application for each licensed facility.

We provide coverage only for the licensed health care provider (not any holding company or other parent company). No additional insureds will be added. The name of the insured will be as shown on the license.

ORDERING MCARE LOSS RUNS/CLAIM HISTORIES

For facilities requesting their own information, requests are to be on the facility's letterhead and include position title with signature of person submitting request. Include the claim history date range or "all history" for a full report. Also include the name, email and/or address where the claim history is to be sent.

For individual health care providers, the request must be signed by the individual and include the individual's name and PA license number. Indicate the claim history date range or "all history" for a full report. Indicate the name of the person or entity authorized to receive the claim history and the email and/or address where the claim history is to be sent.

Requests are to be sent to Mcare by U.S. Mail, fax or email:

Mailing Address (for USPS first class mail):

Mcare
Claims Administration Division
P.O. Box 12030
Harrisburg, PA 17108-2030

Fax: (717) 787-0651 Email: RA-IN-CLAIMCOVERAGEINFO@pa.gov

If you have any questions regarding Mcare loss runs/claim histories call Mcare at (717) 783-3770 or email RA-IN-CLAIMCOVERAGEINFO@pa.gov.

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Supplemental Claims Information Form

Complete one form for each claim. Make additional copies of this form as needed.

Nursing Home's Name: _____

License Number: _____

Claimant's Name: _____
(First) (Middle) (Last)

Incident Date: _____
(Month, Day and Year)

Date Reported: _____
(Month, Day and Year)

Location Where Incident or Alleged Injury Occurred: _____

Carrier Name: _____

Policy Number: _____ Effective Date: _____

Status (check all that apply):

☐ Open ☐ Closed Date Closed: _____

☐ Settlement ☐ Judgment ☐ Dismissed

Amount of Indemnity Payment (if any): $_____

Description of Claim:

_____

_____

_____

_____

_____

_____

_____

_____