PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

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APPLICATION FOR PRIMARY HEALTH CENTER 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:

Address:

City: State: Zip: County:

Telephone: ( ) Fax: ( ) Mcare License Number:

E-Mail Address: Web Site:

Is the above address the only location? ☐ Yes ☐ No If no, attach a separate page listing all other locations including name, address, city, county and state for each location.

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 8 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.

You need to contact each of your current or prior carriers and request they send you the policy history/claim history 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.

Applicant's Signature (all pages must be signed): ______________________________
(Name) (date)

Claims or Suits:

Have any claims been made or suits brought against the facility during the past 8 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 on the facility's letterhead and signed by an authorized representative of the facility listing all incidents, claims made and suits filed against the facility 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. Services Provided (check all that apply). Complete a separate copy for each location to be insured.

☐ Primary Care Medicine
☐ Pediatrics/Well Child Care
☐ EPSDT Program
☐ Family Planning
☐ Nutritional Counseling
☐ Chronic Illness Monitoring
☐ Routine Physical Examinations
☐ Hearing and Vision Screening
☐ Home Health Care
☐ Immunizations and Vaccinations
☐ Substance Abuse Treatment
☐ Emergency or Urgent Care
☐ Laboratory Services (describe)
☐ Radiology/Imaging
☐ Women's Health
☐ Wound Care Center
☐ Allergy Shots
☐ Outpatient/Minor Surgery
☐ Mental Health / Mental Rehabilitation
☐ Podiatry
☐ Oncology & Hematology
☐ Internal Medicine
☐ Other Specialists (describe below)
☐ Complementary and Alternative Medicine

☐ Other not listed above (describe – attach separate sheet if necessary): ____________________________

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2. Does the facility provide Telemedicine / Remote Services? ☐ Yes ☐ No If yes, please describe.
Do any of the services involve out-of-state exposures? ☐ Yes ☐ No If yes, please describe.
Attach a separate sheet if necessary. ____

3. Exposure Data. Complete a separate copy for each location to be insured.

Visits means the total number of visits to the institution (regardless of the number of visits to particular departments within such institution) by outpatients (patients not receiving bed and board services), during the policy period.

Number of Visits:	Estimated last 12 months	Projected for next 12 months
Emergency		
Mental Health/Mental Rehabilitation		
Outpatient Surgical		
Home Health Care		
Other (describe):		

Applicant's Signature (all pages must be signed): ____
(Name) (date)

4. Have any services been discontinued in the *last* 12 months? ☐ Yes ☐ No
   If yes, explain: ____
5. Are there plans to discontinue any services in the *next* 12 months? ☐ Yes ☐ No
   If yes, explain: ____
6. Are there any new services planned or being considered for the *next* 12 months? ☐ Yes ☐ No
   If yes, explain: ____

PART V – OWNERSHIP AND MANAGEMENT

1. Years facility has been in operation __________
2. Years owned by current owners __________
3. Years experience owners have in primary health centers __________
4. Years managed by current management __________
5. Years experience management has in primary health centers __________

PART VI – MEDICAL STAFF

1. For each type of health care provider/health care professional listed below, provide the numbers that are employed, contracted and/or volunteers. If none, enter zero (0).

Type of Provider	Employed	Contracted	Volunteer
Physicians (MD or DO)			
Podiatrists (DPM)			
Certified Nurse Midwives (CNM)			
Physician Assistants (PA-C)			
Nurse Practitioners (CRNP)			
Registered Nurses (RN)			
Licensed Practical Nurses (LPN)			
Radiology/Imaging Technicians			
Laboratory Technicians			
Psychologists			
Social Workers			
Physical Therapists			
Occupational Therapists			
Medical Assistants			
Other – describe:			
Other – describe:			

2. Does the facility obtain evidence of individual medical professional liability insurance in force at the state-mandated limits for all physicians, podiatrists and certified nurse midwives that provide health care professional services at the facility, whether employed, contracted or volunteer? ☐ Yes ☐ No
3. How often is the evidence of insurance verified? ☐ Annually ☐ Other (describe) __________________
4. Are the insurance requirements stated in the bylaws? ☐ Yes ☐ No

PART VII – RISK MANAGEMENT

1. Is there an established risk management program? ☐ Yes ☐ No
2. Is there a risk management committee? ☐ Yes ☐ No
3. Is there an assigned risk manager? ☐ Yes ☐ No
   If no, how is this role filled? ____

Applicant's Signature (all pages must be signed): ____
(Name) (date)

4. Does the risk manager have other responsibilities? ☐ Yes ☐ No
   If yes, describe: ____
5. Is there an incident/event reporting and analysis system in place? ☐ Yes ☐ No
6. Is there a patient satisfaction survey system? ☐ Yes ☐ No
7. Is there a patient complaint resolution program? ☐ Yes ☐ No

PART VIII – 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 networks: ______________________________
   ____
2. Is the facility currently accredited by: ☐ The Joint Commission ☐ CARF
   ☐ Other (describe): ______________________ ☐ None / No accreditation
   Is the accreditation: ☐ Full/Unconditional ☐ Preliminary ☐ Provisional ☐ Conditional
3. Does the facility use Electronic Health Records (EHR) / Electronic Medical Records (EMR)?
   ☐ Yes ☐ No If Yes, please answer all of the following questions a. through h. If No, skip to 4 below.
   a. What is the name of the EHR/EMR system? ______________________
   b. Is the EHR/EMR system certified? ☐ Yes ☐ No
   c. Name of certifying body: ______________________
   d. How long has the system been in use? ______________
   e. Is all or part of the system in use? ☐ All ☐ Part
   f. What type of training has been provided? ______________________________
   g. How is data protected? ____________________________________
   h. Is there a process in place to receive regular or available system updates? ☐ Yes ☐ No
4. Does the facility have unrestricted General Liability insurance (e.g. no patient injury, products liability or other significant exclusions)? ☐ Yes ☐ No
   If yes, provide evidence of insurance (such as a Certificate of Insurance or copy of GL declarations page).
   If no, explain: ____
   ____
   ____
5. Has any enforcement action ever been taken against the facility (limitation/ban on admissions/services, license revoked or suspended, refusal to renew license, 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.
   ____
   ____
   ____
6. 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.
   ____
   ____
   ____

Applicant's Signature (all pages must be signed): ____
(Name) (date)

ADDITIONAL ITEMS TO BE SUBMITTED WITH THE APPLICATION:

1. A copy of the current policy's Professional Liability Declarations page.
2. A copy of the current Certificate of Compliance (license).
3. Copies of the Articles of Incorporation and any Articles of Amendment.
4. Evidence of unrestricted General Liability insurance (e.g. no patient injury, products liability or other significant exclusions).
5. Current audited financial information including a profit & loss statement and balance sheet.
6. An organizational chart displaying the various ownership interests.
7. Company prepared loss runs or claims history reports from all carriers for the last 8 years, even if there were no claims.
8. Mcare loss run (see General Information Supplement for ordering instructions).
9. JUA Supplemental Claims Information forms for any claims not listed on the carriers' or Mcare's loss runs.

ORDERING MCARE CLAIM HISTORY/LOSS RUNS

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 Fund
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 claim histories/loss runs call Mcare at (717) 783-3770 or email RA-IN-CLAIMCOVERAGEINFO@pa.gov.

APPLICATION CERTIFICATION

I certify that I am authorized to act on behalf of the Insured.

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.

Applicant's Signature (all pages must be signed): ______________________________

(Name) (date)

GENERAL INFORMATION

We write **only** *professional liability* coverage (*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 each physician, podiatrist and certified nurse midwife 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.

DEFINITIONS

Hospitals are facilities treating all general or special medical and surgical cases, including sanitariums with surgical operating room facilities.

Mental Health and Mental Rehabilitation are facilities that provide non-surgical medical intervention for:

- short term crisis stabilization for mental health and substance abuse; and
- long-term mental health rehabilitation.

This includes facilities that assist individuals to develop or improve task and role-related skills, and social and environmental supports needed to perform as successfully and independently as possible at home, family, school, work, socialization, recreations and other community living roles and environments).

Extended Care: All beds located within a hospital, licensed by the state and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous and extended basis.

Outpatient Surgical Facilities are facilities that provide surgical procedures on an outpatient (same day) basis. Beds are used primarily for recovery purposes, and overnight stays, if any, are the exception.

Health Institutions are facilities that provide non-surgical medical treatment other than as described above under Mental Health / Mental Rehabilitation.

Home Health Care Services are organizations which provide nursing, physical therapy, housekeeping and related services to patients at their residences.

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 are free-standing facilities which provide the same service as a Convalescent Facility, except that more of their patients are over 65.

Personal Care Facilities are free-standing facilities which provide health-related personal care, residential and social care with some routine health care, but not continuous skilled nursing care. Residents are primarily or exclusively over 65. Personal care facilities are not eligible for coverage.

Sanitariums or Health Institutions – not hospitals or mental psychopathic institutions are facilities with regular bed and board accommodations, and with laboratory or medical departments, but not risks with surgical operating room facilities even though designated as sanitariums or health institutions.

Primary Health Center means a community-based non-profit corporation meeting standards prescribed by the Department of Health, which provides preventive, diagnostic, therapeutic, and basic emergency health care by licensed practitioners who are employees of the corporation or under contract to the corporation.

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

Supplemental Claims Information Form

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

Facility 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:

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