

**ED GROUP APPLICATION
FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE**

Please note you are applying for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: 1) arise from incidents or events that happen while the policy is in force and that involve your work at an approved emergency department facility, and 2) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a certificate insert, together with any endorsements that may apply, has been issued.

Please attach a copy of your letterhead and any advertising material that your group may use.

1. GROUP INFORMATION

A. Group Name: _____

Group Address: _____

City _____ State _____ Zip Code _____ Phone _____

B. Key Contact: _____ Title: _____

C. Email: _____ Group Website: _____

D. Name of Medical Director: _____ Phone _____

E. Type of Group Sole Proprietorship ___ Partnership ___ Professional Corp. ___ Other (explain) ___

F. Group Tax ID Name: _____ Group Tax ID Number: _____

G. Contract Holder(s)/Owner(s) _____

H. Total Number in Group: _____ Physicians _____ PAs _____ NPs _____ RNs _____ Other (explain) _____

If you use health care extenders at your facility, please attach a copy of your protocols.

I. Are your group physicians: Employees ___ Independent Contractors ___ Mix of Both ___

If any contractors, please provide a copy of the contractor's agreement.

J. Does the hospital allow physicians to practice without evidence of medical malpractice insurance?

yes ___ no ___

K. How many of your physicians work for you on a part-time basis? _____

L. What is your turnover rate for physicians that work for you? _____%

[# of physicians who left or were terminated during most recent 12 month period ÷ total of physician employees + contractors during most recent 12 month period]

Minimum number of hours of CME required per year: _____

J. Physicians Compliance & Training of:

Nurses	___	___	___	___
Ancillary/Extenders	___	___	___	___
CQI Program	___	___	___	___

K. Are Patient Satisfaction Surveys utilized? ___ ___ ___ ___

Please attach a sample copy.

Average score? Facility #A: _____ Facility #B: _____ Facility #C: _____

L. Claims Management Activities

Incident Reporting	___	___	___	___
Record & Track Claims	___	___	___	___
Credentialing Protocols	___	___	___	___

M. Are Medical Records:

Dictated	___	___
Electronic	___	___
Handwritten	___	___

N. If handwritten, are pre-formatted charts used? ___ ___

O. Are PDAs used? ___ ___

P. Are Scribes used? ___ ___

Q. Mechanism to handle Test Discrepancies:

Provide copy of written procedures.

Radiology	___	___
Lab	___	___
EKG	___	___
Safety Mechanisms	___	___
Security Mechanisms	___	___
Compliance with COBRA	___	___

Facility #A Facility #B Facility #C

R. What is your average door to doctor time? _____

S. What is your average length of stay in the ED for non-admitted patients? _____

T. What is your average length of stay in the ED for admitted patients? _____

8. PHYSICIAN ROSTER

Please list all active and terminated physicians and health care extenders on attachment B.

Total # listed: _____

9. REMARKS

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information and/or material misrepresentation will cause immediate rescission of the Emergency Medical Group's insurance coverage.

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning the Emergency Medical Group's professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter and insurance agent to furnish any information concerning the Emergency Medical Group that the company may request.

No Known Claims Statement: The undersigned warrants that as of (date) all known claims or suits for incidents which occurred between the retroactive dates as per the attached location schedule and the date this statement is signed, and all acts, incidents and/or circumstances, of which (Named Insured), its agents, employees or physician contractors are aware, and which might reasonable be expected to result in a claim under the Prior Acts coverage afforded by this policy, were disclosed in writing to _____ Insurance Company prior to the binding of such coverages.

Further, the undersigned acknowledge and agree that any claims resulting from acts committed prior to the binding of coverage, and which (Named Insured), its agents, employees or physician contractors were aware, are specifically excluded from coverage under this policy. This warranty is material to the acceptance of coverage by Emergency Physicians Insurance Company Risk Retention Group and is made a part of the insurance policy.

ACKNOWLEDGED AND AGREED:

SIGNATURE: _____

DATE: _____

PRINTED NAME: _____

TITLE: _____

APPLICATION CHECKLIST

- ___ Letterhead attached?
- ___ Printed advertising material attached?
- ___ App completed, dated & signed?
- ___ If more than 3 facility contracts, are the rest of the facility names listed on a separate sheet?
- ___ Copy of current insurance declarations page attached?
- ___ Copy of currently valued loss runs (not more than 90 days old) for the past 6 years from all prior and current carriers attached?
- ___ All physicians and health care extenders to be covered listed on Physician Roster?
- ___ Each physician to be covered has completed the Physician Underwriting Profile Sheet? All are attached?

Thank you



Professional Liability/Medical Malpractice
Preferred • Standard • Non-Standard

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