

<p style="text-align: center;"><b>HUDSON SPECIALTY INSURANCE COMPANY</b> <b>Emergency Medicine Group Application Guidelines</b></p>
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**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
  
- Professional Employee Roster (**format on Page 10**)
  - 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
- Written Risk Management Plan
- Current professional liability policy (**Page 3 of application**)
- Current Loss Run(s) (valued within 60 days on the insurer's format for the current year and a minimum of 5 additional years)
- Copies of all agreements where other parties are indemnified

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

**SIR (Page 2 of application)**

- Actuarial Review for this year
- Trust Agreement

**Departed Physician Coverage (Page 5 of application)**

- Attach evidence of current coverage for each physician (such evidence might consist of a policy endorsement or certificate of insurance)

**HUDSON SPECIALTY INSURANCE COMPANY**  
**Emergency Medicine Group Application**  
for surplus lines coverage

**PRODUCER INFORMATION**

Agency name \_\_\_\_\_  
Mailing address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Producer name \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

**APPLICANT INFORMATION**

Named Insured \_\_\_\_\_ County \_\_\_\_\_  
Primary address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
CEO \_\_\_\_\_ Risk Manager \_\_\_\_\_ Medical Director \_\_\_\_\_  
Authorized representative for insurance matters: \_\_\_\_\_ Telephone \_\_\_\_\_  
Website: \_\_\_\_\_  
Number of year under present ownership: \_\_\_\_\_

The entity is:

- Multi-Physician Shareholder Medical Corporation
- Medical Partnership with formal written agreement
- Staffing Agency/Locum Tenens Firm
- Other (IPA, PPO, Association, etc. specify) \_\_\_\_\_

Indicate extent of professional relationship between the physician members (check all that apply):

- Common letterhead
- Common billing statements (as opposed to utilizing the same billing service)
- Share profits
- Share professional employees (e.g., R.N., Technician)
- Share overhead expenses
- Other (describe) \_\_\_\_\_

**INSURANCE COVERAGE REQUEST**

1. Requested coverage effective date \_\_\_\_\_

2. Requested limits

Professional Liability: \$ \_\_\_\_\_ /\$ \_\_\_\_\_ Retroactive Date: \_\_\_\_\_  
(Claims Made Coverage) per claim aggregate

Deductible  None \$ \_\_\_\_\_ /\$ \_\_\_\_\_  
per claim aggregate

\*Self-insured retention (\*refer to application guidelines for required attachments)

None \$ \_\_\_\_\_ /\$ \_\_\_\_\_  
per claim aggregate

What coverage does the SIR contemplate?  Professional Liability

- a) Is there an Insurance Trust?  Yes  No
- b) Is there an Insurance Captive?  Yes  No
- c) What organization handles claims for the SIR? \_\_\_\_\_
- d) What legal firm is responsible for defending claims against the insured? \_\_\_\_\_

**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)

**1<sup>st</sup> Prior carrier** \_\_\_\_\_  Claims Made  Occurrence  
 Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_ Retroactive Date \_\_\_\_\_

**2<sup>nd</sup> Prior carrier** \_\_\_\_\_  Claims Made  Occurrence  
 Effective date \_\_\_\_\_ Expiration date \_\_\_\_\_ Retroactive Date \_\_\_\_\_

If you are currently insured on a claims made policy, are you obtaining Extended Reporting Period (Tail) Coverage from your current insurance carrier?  Yes  No

**Note: To prevent possible gaps in your Claims Made coverage, either Extended Reporting Period Coverage from your current insurer, or Prior Acts coverage from Hudson Specialty Insurance Company must be purchased. Prior Acts coverage is subject to underwriting approval and may not be available to all applicants.**

**PRACTICE LOCATIONS**

Please list the name and addresses of ALL locations for which insurance coverage is sought.

Location Name of Hospital/Clinic Street, City, State	Number of Annual ED Visits	Number of Annual Urgent Care Visits	Trauma Level	Location Retroactive Date

**PRACTICE INFORMATION**

1. Within the next 12 month period, does your group plan to add additional locations?  Yes  No

If “Yes”, explain: \_\_\_\_\_

2. What is your average door to doctor time? \_\_\_\_\_

3. What is your average length of stay in the ED for non admitted patients? \_\_\_\_\_

4. What is your average length of stay in the ED for admitted patients? \_\_\_\_\_

5. Are any of the group’s physicians medical directors of any EMS or other organization?  Yes  No  
If “yes”, please attach a list.

6. Please provide the ED and Urgent Care visit history for the past five years.

Fiscal Year	Total # of ER visits	Total # of Urgent Care visits
20____		
20____		
20____		
20____		
20____		

7. **Active Physicians**

List the full names of those for whom you are requesting coverage:

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

Name	Specialty	Retroactive Date	Board Certified	Board Name (ABEM, etc.)
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

8. Are the physicians employed or contracted by the Named Insured? \_\_\_\_\_

9. What is the turnover rate for physicians that work for you? \_\_\_\_\_ %

10. What percentage of physicians are ATLS, ACLS or PALS certified? \_\_\_\_\_ %

11. **Departed Physicians**

\*List the full names of departed physicians to be covered: (please use a separate sheet if more room is needed)

Name	Specialty	Retroactive Date	Employment	
			Start Date	End Date

12. Please indicate if the policies and procedures listed below exist in written form. If none exist please state the reason why or plans to rectify on a separate sheet.

Triage Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Screening Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transfer (COBRA/EMTALA) Policy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Protocols	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient Satisfaction Survey	<input type="checkbox"/> Yes <input type="checkbox"/> No
Average score _____	
Claims Management	
Incident Reporting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Report & Track Claims	<input type="checkbox"/> Yes <input type="checkbox"/> No
Credentialing Protocols	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Records	
Dictated	<input type="checkbox"/> Yes <input type="checkbox"/> No
If dictated, what is the turnaround time?	_____
Hand written	<input type="checkbox"/> Yes <input type="checkbox"/> No
If hand written, are preformatted charts used?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic	<input type="checkbox"/> Yes <input type="checkbox"/> No
If electronic, which system is used?	_____
Mechanism to handle Test Discrepancies	
Radiology	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lab	<input type="checkbox"/> Yes <input type="checkbox"/> No
EKG	<input type="checkbox"/> Yes <input type="checkbox"/> No

## UNDERWRITING INFORMATION

If you answer “Yes” to questions 1 -8 below, provide an explanation in the Comment section, or on a separate sheet of paper:

1. Has any company ever declined, cancelled, refused to renew, restricted, or surcharged your professional liability insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has your group or any health care professional rendering services on its behalf ever been notified of its involvement in a malpractice claim, suit, or incident, either directly or indirectly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is your group or any health care professional rendering services on its behalf aware of any conduct, circumstances, occurrences, incidents, or accidents that are likely to or reasonably could be expected to give rise to a claim <u>that has not yet been reported</u> to the entity’s current and/or prior insurance carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has your group ever been investigated or audited by a governmental or regulatory agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any physician, patient, or insurance plan filed a complaint of any kind against your group with a medical society, foundation or state/federal agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does your group or any of your practitioners have any written contracts or agreements with a Medical Practice Foundation, Management Services Organization, or similar entity to provide services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are there physicians or allied healthcare professionals in your group who are not licensed or who have restricted licensure or privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have any of your physicians been involved in an impaired physician program for substance or mental or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are credentials for physicians and allied healthcare professionals checked and approved prior to joining the group?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is there a probationary period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Are new practitioners proctored?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Does any physician or allied healthcare professional have coverage independent of the group?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. If “Yes” to the above question, are annual certificates of insurance required for proof of professional liability coverage and are specific limits required? Limits required: \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Are all physician and allied healthcare professional’s privileges reviewed at least once every two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are all foreign medical graduates certified by the Educational Council for Foreign Medical School Graduates or have they passed the FLEX?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Does the entity own, operate, or control any specialized, medically related unit, such as a pharmacy, laboratory, physical therapy center, free-standing surgery center, office based surgical suite, etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Does the entity have an ongoing quality assessment and/or improvement plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Does the entity have an ongoing risk management plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “Yes”, how often is it updated?	

**COMMENTS / EXPLANATIONS**

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**AUTHORIZATION**

**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 in full

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

# HUDSON SPECIALTY INSURANCE COMPANY

## **A. GENERAL FRAUD STATEMENT**

(Not applicable in Colorado, Ohio, Oklahoma and Utah)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and (NY: substantial) civil penalties.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name/Title

## **B. FRAUD STATEMENT(S)**

### **UTAH FRAUD STATEMENT**

(Workers' Compensation)

**For your protection, Utah law requires the following to be included in this application:**

Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

### **OKLAHOMA FRAUD STATEMENT**

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

### **OHIO FRAUD STATEMENT**

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

### **COLORADO APPLICATION SUPPLEMENT**

**This Notice is a part of your application for:**

- |                          |                                  |                          |                             |
|--------------------------|----------------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | HOMEOWNERS INSURANCE             | <input type="checkbox"/> | COMMERCIAL INSURANCE        |
| <input type="checkbox"/> | PERSONAL LINES PACKAGE INSURANCE | <input type="checkbox"/> | PERSONAL UMBRELLA INSURANCE |
| <input type="checkbox"/> | PERSONAL INLAND MARINE INSURANCE | <input type="checkbox"/> | DWELLING INSURANCE          |
| <input type="checkbox"/> | PERSONAL AUTO INSURANCE          | <input type="checkbox"/> | AGRICULTURE INSURANCE       |
| <input type="checkbox"/> | WATERCRAFT INSURANCE             | <input type="checkbox"/> | MOBILE HOME INSURANCE       |

### **FRAUD WARNING**

**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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name/Title

**HUDSON SPECIALTY INSURANCE COMPANY**  
**Supplemental Claim Information Form**  
(make copies of this page as needed)

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**  
**Professional Employee Roster**  
 (make copies of this page as needed)

	Last Name	First Name	M.I.	Specialty	Surgery Level	Retro 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.

**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.

**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.