# HUDSON SPECIALTY INSURANCE COMPANY
# Medical Group 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
- 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 2 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 3 of application)**

- Actuarial Review for this year
- Trust Agreement

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

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

Employed Physicians, Dentists & Residents **(Page 4 of application)**

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

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
## Medical 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: ____________________

## 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 |
|---|---|---|
| | | |
| | | |

1. Within the next 12 month period, does your group plan to grow by acquisition of another group or entity? ☐ Yes ☐ No

   If "Yes", explain: ____________________

## OFFICE LOCATIONS

1. List any additional office location, or attach a separate list:

   Office location ____________________ City/State/Zip ____________________

   Telephone ____________________ County ____________________

   Office location ____________________ City/State/Zip ____________________

   Telephone ____________________ County ____________________

   Office location ____________________ City/State/Zip ____________________

   Telephone ____________________ County ____________________

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

   If "Yes", explain: ____________________

## INSURANCE COVERAGE REQUEST

1. Requested coverage 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 ☐ None *(*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 / *Excess Umbrella Liability (circle one) ☐ None *(*refer to application guidelines for required attachments)*

   Limits $__________________/$_____________________ Retroactive Date ____________________
6. Employee Benefits Administration Liability ☐ None

   Limits $__________________/$_____________________ Retroactive Date: ____________________

   Total number of employees _____________

## 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 ___________________

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 INFORMATION

1. 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) ________________________________

2. 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)
   - ☐ See each other's patients on a regular basis
   - ☐ Share overhead expenses
   - ☐ All physicians' names appear together on the office door
   - ☐ Other (describe) ________________________________________________

3. Indicate below the number of each type of professional employed or contracted by the entity:
   **NOTE: No coverage is afforded to Professional Employees unless specifically requested**

**Number of Professional Employees** **Number of Other Healthcare Employees**

| | Employees | Independent Contractors | | Employees | Independent Contractors |
|---|---|---|---|---|---|
| *Employed Physician/Dentist | | | Marriage, Family & Child Counselor | | |
| *Employed Resident | | | Nurse | | |
| Nurse Anesthetist | | | Optometrist | | |
| Nurse Midwife | | | Perfusionist | | |
| Nurse Practitioner | | | Physical Therapist | | |
| Physician Assistant | | | Athletic Trainer | | |
| Podiatrist | | | Chiropractor | | |
| Psychologist | | | EMT/Paramedic | | |
| Surgeons performing weight loss procedures, incl. bariatrics | | | Licensed Clinical Social Worker | | |
| | | | Independent Medical Staff (excl. employees) | | |

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

4. Departed Physicians
*List the full names of departed physicians for whom you are requesting coverage:
*(refer to application guidelines for required attachments)*

| Name | Specialty | Retroactive Date | Employment Start Date | End Date |
|---|---|---|---|---|
| | | | | |
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## SERVICES

Indicate if the Applicant presently provides or operates, or plans to provide or operate any of the following: ☐ **None of these**

☐ Abortion Clinic ☐ Dental Services ☐ Hospice ☐ Outpatient Surgicenters
☐ 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

## SURGERY

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

☐ 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 )

## UNDERWRITING INFORMATION

**If you answer "Yes" to any of the questions below, provide an explanation in the Comment section, or on a separate sheet of paper:**

| Question | Answer |
|---|---|
| 1. Has any company ever declined, cancelled, refused to renew, restricted, or surcharged your professional liability insurance? | ☐ Yes ☐ 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? | ☐ Yes ☐ 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 that has not yet been reported to the entity's current and/or prior insurance carrier? | ☐ Yes ☐ No |
| 4. Has your group ever been investigated or audited by a governmental or regulatory agency? | ☐ Yes ☐ 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? | ☐ Yes ☐ 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? | ☐ Yes ☐ No |
| 7. Are there an physician or allied healthcare professionals in your group who are not licensed or who have restricted licensure or privileges? | ☐ Yes ☐ No |
| 8. Are credentials for physicians and allied healthcare professionals checked and approved prior to joining the group? | ☐ Yes ☐ No |
| 9. Is there a probationary period? | ☐ Yes ☐ No |
| 10. Are new practitioners proctored? | ☐ Yes ☐ No |
| 11. Does any physician or allied healthcare professional have coverage independent of the group? | ☐ Yes ☐ No |
| 12. If "Yes" to number 11 above, are annual certificates of insurance required for proof of professional liability coverage and are specific limits required? Limits required: $ ______________________ | ☐ Yes ☐ No |
| 13. Are all physician and allied healthcare professional's privileges reviewed at least once every two years? | ☐ Yes ☐ No |
| 14. Are all foreign medical graduates certified by the Educational Council for Foreign Medical School Graduates or have they passed the FLEX? | ☐ Yes ☐ No |
| 15. 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.? | ☐ Yes ☐ No |
| 16. Does the entity have an ongoing quality assessment and/or improvement plan? | ☐ Yes ☐ No |
| 17. Does the entity have an ongoing risk management plan? | ☐ Yes ☐ No |
| If "Yes", how often is it updated? ____________________________________________ | |

## COMMENTS / EXPLANATIONS

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## 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:**

- ☐ HOMEOWNERS INSURANCE
- ☐ PERSONAL LINES PACKAGE INSURANCE
- ☐ PERSONAL INLAND MARINE INSURANCE
- ☐ PERSONAL AUTO INSURANCE
- ☐ WATERCRAFT INSURANCE
- ☐ COMMERCIAL INSURANCE
- ☐ PERSONAL UMBRELLA INSURANCE
- ☐ DWELLING INSURANCE
- ☐ AGRICULTURE INSURANCE
- ☐ 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.

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.