SPG SPECIALTY PROGRAM GROUP

Healthcare Free and Charitable Clinic 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

- Medical Personnel Roster (**format on Page 8**)
  - Complete if coverage is requested for any Personnel referenced on page 4 of the application

Attach copies of the following with this application:

- Current Audited Financial Statement
- Current Loss Run(s) (valued within 60 days on the insurer's format for the current year and a minimum of 5 additional years)
- Accreditation survey (Submit a copy of the most recent Accreditation Letter, Scoring Grid and Type 1 Recommendations and responses - **Page 2 of application**)

Free and Charitable Medical Clinic Application Guidelines for surplus lines coverage

PRODUCER INFORMATION

Agency Name

Mailing Address City/State/Zip

Producer Name Telephone Fax

APPLICANT INFORMATION

Named Insured County

Primary Location City/State/Zip

Address for Additional Locations: ☐ No Other Locations

CEO Risk Manager Website:

Email Address for Primary Contact:

Authorized representative for insurance matters: Telephone

How many years has the clinic been in operation? Years under present ownership?

Hours clinic open per week? ☐ Less than 20 hours ☐ 21-40 hours ☐ 41-60 hours ☐ More than 60 hours

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

FACILITY INFORMATION

Ownership and Control

☐ Governmental ☐ Individual ☐ Partnership ☐ Corporation ☐ Other (explain)

Tax Status

☐ For Profit ☐ Not for Profit ☐ Medicare Approved ☐ Charitable

The facility is (check all that apply):

☐ Accredited (By Whom?) ☐ Member of NAFC

☐ Other (specify)

Date of last survey Accreditation Period

INSURANCE COVERAGE REQUEST

☐ Check here if the clinic is buying coverage for the first time.

1. Desired Coverage Effective Date:
2. Professional Liability limits requested: ☐ $1,000,000/$3,000,000
   ☐ Other Limits: $ /$
3. If current coverage is a Claims Made policy, what it your Retroactive Date?
4. Would you like a quote for General Liability (limits will equal Professional Liability limits)? ☐ Yes ☐ No
5. Deductible Requested: ☐ None ☐ $2,500 ☐ $5,000 ☐ Other: $

INSURANCE HISTORY

Policy Year	Professional Liability Carrier	Limits of Insurance	Deductible	Policy Effective Date	Annual Premium
Expiring Policy					
One Year Prior					
Two Years Prior					
Three Years Prior					
Four Years Prior					

SERVICES

Indicate if the Applicant presently provides or operates, or plans to provide or operate any of the following:

☐ Abortion Clinic	☐ Geriatrics	☐ Outpatient Surgicenters	☐ Physical Rehabilitation
☐ Chemical Dependency	☐ Gynecology	☐ Pain Management	☐ Skilled Nursing
☐ Dental Services	☐ Obstetrics	☐ Pathology	☐ Transportation Services
☐ General Medicine	☐ Oncology	☐ Pediatrics	☐ Urgent Care
☐ General Surgery	☐ Other		

OUTPATIENT VISITS

	Current annual visits	***Projected*** annual visits
Alcohol/Drug Rehabilitation		
Behavioral/Mental Health		
Dental		
General Medicine		
Gynecology		
OB/Prenatal Medicine		
Pain Management		
Pediatric Medicine		
Physical Rehabilitation/Therapy		
Urgent Care		
Other exposures (specify)		

PERSONNEL

NOTE: No individual coverage is afforded to the following Professional Staff unless specifically requested.

Professional License/Status	Employed Staff Total Hours Per Month	IC/1099 Staff Total Hours Per Month	Volunteer Staff Total Hours Per Month	Include Any Staff from this Policy?	Do You Confirm Excluded Employees & ICs Have Own Policy?
1) Physician/Surgeon (MD/DO)*				☐ Y ☐ N	☐ Y ☐ N
2) Doctor - D.D.S./D.C./D.P.M./etc.*				☐ Y ☐ N	☐ Y ☐ N
3) Nurse Anesthetist (CRNA)				☐ Y ☐ N	☐ Y ☐ N
4) Nurse Practitioner (NP)				☐ Y ☐ N	☐ Y ☐ N
5) Physician Assistant (PA)				☐ Y ☐ N	☐ Y ☐ N
6) Nurse – RN/LPN/etc				☐ Y ☐ N	☐ Y ☐ N
7) Other (describe):					

(if physician coverage is requested, complete Medical Personnel Roster)*

STAFF CREDENTIALING & PRIVILEGES

1. Are credentials for all Physicians and Allied Professionals checked and approved prior to granting staff privileges?	☐ Yes ☐ No
2. Are new staff members proctored?	☐ Yes ☐ No
3. Are there any Physicians or Allied Professionals who are not licensed or who have restricted licenses or privileges?	☐ Yes ☐ No
4. Are Physicians and Allied Professionals privileges reviewed at least once every other year?	☐ Yes ☐ No
5. Are all foreign medical graduates certified by the Educational Council for Foreign Medical Graduates (ECFMG) or have they passed the FLEX?	☐ Yes ☐ No
6. Are independent Physicians and Allied Professionals required to maintain professional liability insurance? What are the required limits?	☐ Yes ☐ No
7. Are certificates of insurance required as verification of insurance?	☐ Yes ☐ No

GENERAL INFORMATION

1. Are there medications stored on site? If Yes, how are the medications secured?:	☐ Yes ☐ No
2. Do physicians prescribe controlled substances for pain?	☐ Yes ☐ No
3. Does the applicant operate a mobile clinic?	☐ Yes ☐ No
4. Do all facility locations meet applicable National Fire Protection Agency (NFPA) building codes?	☐ Yes ☐ No

RISK MANAGEMENT

1. Is there an individual who is designated with the job title and role of hospital Risk Manager?	☐ Yes ☐ No
2. Is there a written, formalized Risk Management plan?	☐ Yes ☐ No
3. Is this plan regularly reviewed for effectiveness and/or any necessary changes? If "Yes", how often is the plan reviewed?	☐ Yes ☐ No
4. Is there an ongoing Quality Assessment or Improvement plan?	☐ Yes ☐ No

UNDERWRITING INFORMATION

1. Has the Applicant or other associated entity ever had it's license revoked, suspended or placed on probation by an governmental licensing agency? If "Yes", explain:	☐ Yes ☐ No
2. Has the Applicant ever been investigated by any third party for alleged fraud, erroneous billing or entered into a Compliance Integrity Agreement? If "Yes", explain:	☐ Yes ☐ No
3. Has the Applicant entered into any joint ventures or limited partnerships? If "Yes", explain: (% of ownership)	☐ Yes ☐ No
4. Is any part of the Applicant operated/leased by a management corporation? If "Yes", give the name of the corporation, details of the structure and provide a copy of the contract:	☐ Yes ☐ No
5. Does the applicant or any of its practitioners have a contract with or provide services to any correctional facilities which includes city or county jails, prisons, juvenile detention and youth correctional facilities?	☐ Yes ☐ No
6. Does the applicant or any of its practitioners provide services to professional athletes or celebrities?	☐ Yes ☐ No

5. Does the Applicant participate in any teaching programs or have affiliations with educational institutions? If "Yes", explain:	☐ Yes ☐ No
6. Does the Applicant anticipate any facility or service expansions within the next year?	☐ Yes ☐ No
7. Does the Applicant anticipate any sale of assets, mergers, acquisitions, consolidation or change in operations or services within the next twelve (12) months? If "Yes", explain:	☐ Yes ☐ No

Provide a detailed explanation for the following questions answered "Yes", on a separate sheet of paper:

8. Has any company ever declined, cancelled, refused to renew, restricted, or surcharged your professional liability insurance?	☐ Yes ☐ No
9. Have there been any complaints or suits brought against the applicant by a member of the medical staff?	☐ Yes ☐ No
10. Is the applicant aware of any conduct, circumstance, occurrence, incident, or accident that is likely to or reasonably could be expected to give rise to a claim that has not yet been reported to the current and/or prior insurance carrier?	☐ Yes ☐ No

COMMENTS/EXPLANATIONS

NOTICE

To All Prospective Insureds: 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

Notice to California Applicants: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia and Louisiana Applicants: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Oklahoma Applicants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Notice to Kansas Applicants: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Notice to Maine, Tennessee, Virginia and Washington Applications: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Hampshire Applicants: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

Notice to New York Applicants: 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Notice to New York Applicants (Fire insurance applications): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Notice to New York Applicants (Automobile): Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation."

Notice to Pennsylvania Applicants: 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 purposes 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.

Notice to Pennsylvania Applicants (Automobile): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information, shall, upon conviction, be subject to imprisonment for up to seven (7) years and the payment of a fine of up to $15,000.

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.

This application is for insurance to be placed on a surplus lines basis with Hudson Excess Insurance Company.

Signature

Date

Print Name/Title

Supplemental Claim Information Form

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

Medical Personnel Roster

(make copies of this page as needed)

	Last Name	First Name	Employment Status	Specialty	Hours Worked Per Month	Surgery Level	Retroactive 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.

Employment Status

E = Employee
C = Contractor
V = Volunteer