Nebraska Residual Malpractice Insurance Authority

Requested Effective Date _____

Instructions:

- Please print or type all responses and answer all questions as instructed.
- If any questions do not apply, print N/A in the space.
- If more space is needed, continue in the Comments section of this application, or attach a separate paper.
- Coverage will not be considered until this application is completed and all required documents are provided.

Required Documents:

In addition to this application, the following information is required:

☐ Separate application for each hospital location if multiple locations exist
☐ Individual applications for each employed physician, surgeon, dentist and oral surgeon
☐ Declarations page from current insurance carrier, including retroactive date if claims-made coverage
☐ List of all subsidiaries and other entities to be covered, including a copy of the latest ERM-14 and org. chart
☐ List of all physicians, surgeons, interns and residents, including name, specialty and privileges

- Include medical professional liability insurance information for all employed and contracted individuals, including name of insurance company, retroactive date, policy period and limits of liability

☐ Location schedule for general liability exposures
☐ Loss runs, dated within 60 days of submission, covering the past ten years including the current year via disk, CD or email

- Include within loss runs a breakdown of total incurred losses (paid and outstanding for indemnity and expense) and complete details of allegations on all losses paid or outstanding in excess of $100,000

☐ Current accrediting agency (JCAHO, AOA, CARF, etc.) report with recommendations and the Applicant's response to any contingencies
☐ Current audited financial statements
☐ Risk management and quality improvement plan

A. AGENT INFORMATION				
Agent Name:	Agency Name:	Address:		
City:	State:	Zip:	Telephone Number:	Fax Number:

B. APPLICANT INFORMATION (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)			
Hospital or Healthcare System Name:			
Street Address (City, State, Zip, County):			
Telephone:	Fax:	Email Address:	Policy # (if renewal):
Tax I.D. Number	License Number:	AHA Number:	Website Address:
Legal structure (check all that apply: ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ For Profit ☐ Not for Profit ☐ Government ☐ Other (Specify): _____			

C. FACILITY ADMINISTRATIVE TEAM			
Name	Title	Phone Number	Email Address

D. SUBSIDIARIES

List Below all Subsidiaries	Type and Legal Structure	Retro Date

Type of entities: general hospital, teaching hospital, psychiatric hospital, children's hospital, convalescent or nursing home, clinic, critical access, hospital, governmental, operated for profit, not for profit, corporation, partnership, charitable, surgery center, home health care, urgicenter

Is coverage desired for all subsidiaries? *If no, please explain in the Comments section* ☐ Yes ☐ No

E. GENERAL INFORMATION

1. Is the Applicant accredited by the Joint Commission on Accreditation of Healthcare Org.: ☐ Yes ☐ No
   If yes, what is the date of the last survey: _____
   Please specify the type of accreditation: ☐ Full ☐ Conditional
   If the accreditation is conditional, have all recommendations been complied with: ☐ Yes ☐ No
2. Has the Applicant entered into joint ventures or limited partnerships: ☐ Yes ☐ No
   If yes, please explain in the Comments section.
3. Does the Applicant provide management services to other entities for a fee: ☐ Yes ☐ No
   If yes, please provide entity name(s) managed by the Applicant and describe the services provided in the Comments section.
4. Does the Applicant provide management services to other entities for a fee? ☐ Yes ☐ No
   If yes, please provide entity name(s) managed by the Applicant and describe the services provided in the Comments section.
5. Do you own or operate an HMO, PPO, IPA or other managed care service? ☐ Yes ☐ No
   If yes, please explain in Comments section including number of members and whether a separate legal entity is used.
6. Is the Applicant currently enrolled in a Patient's Compensation Fund (PCF) ☐ Yes ☐ No
   If yes, answer the following question and indicate the fund name: _____
   Has the Applicant at all times subsequent to the retroactive date, been continually qualified/covered by the state fund? ☐ Yes ☐ No *If no, use Comments section to provide exact dates of gaps in coverage and explanation.*
   ☐ Nebraska Excess Liability Fund ☐ Other (specify): _____

F. CURRENT LIABILITY COVERAGE

Professional Liability Carrier:	General Liability Carrier:
Limit of Coverage:	Limit of Coverage:
Deductible/Retention:	Deductible/Retention:
Policy Period:	Policy Period:
Coverage is: ☐ Claims-Made ☐ Occurrence	Coverage is: ☐ Claims-Made ☐ Occurrence
If claims made, what is the retroactive date:	If claims made, what is the retroactive date:

Has any insurer canceled or declined to issue any of the coverages being applied for under this application: ☐ Yes ☐ No
If yes, please provide details in the Comments section.

G. REQUESTED LIABILITY COVERAGE

Retroactive Date:

Professional Liability Limit: ☐ $1,000,000/$3,000,000 ☐ Other (specify):

Deductible: ☐ None ☐ $25,000/$125,000 ☐ $50,000/$250,000 ☐ Other (specify):

Note: Limits and deductibles are expressed as each claim/aggregate. Professional and general liability deductible amounts should be the same.

H. HOSPITAL EXPOSURE INFORMATION

DIRECTIONS: Please provide the projected, current and previous 12 month exposure count for each classification.

Occupied Beds	Use the average nvumber of occupied beds by dividing the total annual inpatient days by 365
Licensed Beds	Total number of licensed beds
Outpatient Visits	Count each appearance of an outpatient in a hospital unit, regardless of the number of procedures or treatments performed within each unit (AHA definition). Report visits to outpatient units, not occasions of service. Include visits made to a client's home when home healthcare is provided.
Revenue	Use total annual revenue resulting from services performed. The number must represent an annual figure based upon fiscal year, calender year or policy period.
Freestanding Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed.

	Occupied Beds	

HOSPITAL INPATIENT	Projected Next 12 Months	Current 12 Months	Previous 12 Months	Total Licensed Beds
Acute Care Beds:				
Crib and Bassinets:				
Psychiatric/Chemical Dependency/Rehab Beds:				
Extended Care Beds:				
Skilled Care Beds:				
Personal Care Beds:				

HOSPITAL INPATIENT – OTHER	Projected Next 12 Months	Current 12 Months	Previous 12 Months
Total Number of Surgeries (inpatient only):			
Total Number of Births:			

HOSPITAL OUTPATIENT	Projected Next 12 Months	Current 12 Months	Previous 12 Months
Clinic Visits:			
Outpatient Surgery Visits:			
Emergency Room Visits:			
Home Healthcare Visits:			
All Other Hospital Based Visits:			

HOSPITAL – OTHER EXPOSURES	Projected Next 12 Months	Current 12 Months	Previous 12 Months
Durable Medical Equipment Revenue:			
Physical Fitness Center Revenue:			
Retail Pharmacy Revenue (for non-patients):			
Other (specify):			

FREESTANDING OPERATIONS	Projected Next 12 Months	Current 12 Months	Previous 12 Months
Urgent Care Center or Walk-In Clinic Visits:			
SurgiCenter Visits:			
Birthing Center Number of Births:			
X-Ray/Imaging Center Visits:			
Other (specify):			

MISCELLANEOUS	Total Number
Total Number of Employees:	
Adult or Child Care Center Number of Individuals:	
Vacant Land Number of Acres:	
Pay Parking Areas Revenue:	

Total Annual Revenue:	Most Current 12 Months:	Previous 12 Months:

I. PHYSICIANS/SURGEONS AND OTHER MEDICAL PROFESSIONALS

1. Please indicate the number of physicians/surgeons in each of the following categories.

PHYSICIANS/SURGEONS	Employed	Contracted	Privileges
Physician/Surgeons:			
Residents:			
Interns:			
Locum Tenens:			

2. Please indicate the number of other medical professionals in each of the following categories. Compute full-time equivalents (FTE) for all part-time employees using 40 hours per week as one full-time equivalent.

OTHER MEDICAL PROFESSIONALS	Employed FTE	Contracted FTE	OTHER MEDICAL Professionals	Employed FTE	Contracted FTE
Chiropractors:			Oral Surgeons:		
Dentists:			Paramedics:		
Emergency Medical Technicians:			Paramedics-Ambulance Svc:		

Laboratory or X-Ray Technicians:			Physical Therapists:		
Licensed Practical Nurses (LPN):			Podiatrists:		
Nurse Anesthetists:			Physicians Assistants:		
Nurse Midwives (certified):			Psychologists:		
Nurse Practitioners:			Registered Nurses (RN):		
Optometrists:			Social Workers:		

J. STAFF PRIVILEGES

1. Are credentials for full-time staff members checked and approved prior to granting staff privileges: ☐ Yes ☐ No
If yes, who approves credentials: _____

2. How are the applicants' degree(s) and experience verified: _____

3. Are privileges probationary for at least six months for all new staff members: ☐ Yes ☐ No

4. Are there any staff members who are not licensed or who have restricted licenses or privileges: ☐ Yes ☐ No
If yes, please explain in the Comments section.

5. Are staff privileges reviewed each year: ☐ Yes ☐ No
If no, how often: _____

6. Is the clinical work of all staff members during reappointment and the privileges process evaluated by department chairpersons: ☐ Yes ☐ No

7. Are all staff members required to maintain medical professional liability insurance: ☐ Yes ☐ No
Is this requirement stated in the staff bylaws: ☐ Yes ☐ No
If yes, what limits of liability are required: Each incident: _____ *Aggregate:* _____
Are Certificates of Insurance required annually: ☐ Yes ☐ No

8. Is history of previous employment verified: ☐ Yes ☐ No

9. Have the privileges/credentials of any employed or contracted physician/surgeon ever been restricted or suspended: ☐ Yes ☐ No
If yes, please provide details in the Comments section.

10. Has the Applicant made reports to the National Practitioner Data Bank of suspension, peer review action or professional liability payment involving any member of the medical or dental staff in the last two years? ☐ Yes ☐ No
If yes, please provide details in the Comment section.

K. RISK MANAGEMENT

1. Is there a written, formalized risk management program: ☐ Yes ☐ No

2. Does the governing body periodically review the program for effectiveness and approve necessary changes: ☐ Yes ☐ No

3. Is there a designated risk manager: ☐ Yes ☐ No
If no, use the Comments to explain how these functions are monitored.

4. Is the risk manager accountable and responsible solely for risk management: ☐ Yes ☐ No
If no, describe other responsibilities:

5. Is the risk manager responsible for reviewing incident reports: ☐ Yes ☐ No

L. ANESTHESIA

1.Are anesthesia services provided? If no, please proceed to the next section. ☐ Yes ☐ No
If yes, please answer the following questions.

2. Do certified registered nurse anesthetists (CRNAs) provide anesthesia services: ☐ Yes ☐ No

3. Specify how the anesthesiology department is staffed: ☐ Yes ☐ No

4. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually: ☐ Yes ☐ No
If yes, what limits of liability are required?

M. BARIATRIC SURGERY

1. Are bariatric surgery services provided? If no, please proceed to the next section. ☐ Yes ☐ No
If yes, please answer the following questions.

2. How long has the Applicant been performing bariatric procedures: _____

3. Specify the number of procedures performed annually: _____

4. Does the Applicant have a bariatric services coordinator: ☐ Yes ☐ No

5. Does the Applicant have a call coverage team consisting of surgeons who are trained in or familiar with bariatrics? ☐ Yes ☐ No

6. Does the Applicant have an ICU with speciality services such as Pulmonology, Cardiology, Nephrology or Infectious Diseases with staff trained to handle bariatric patients? ☐ Yes ☐ No

7. Are surgical, ER, radiology and floor staff aware of and trained to respond to the types of bariatric surgery being performed, and are they educated regarding associated complications and issues related to bariatric surgery? ☐ Yes ☐ No

8. Are anesthesia and recovery room staff trained to work with bariatric surgery patients: ☐ Yes ☐ No

9. Does the Applicant have special equipment (operating tables, x-ray tables, retractors, Stabling equipment, surgical instruments, hospital beds, commodes, wheelcahirs, etc.) to accommodate larger patients? ☐ Yes ☐ No

10. Does the Applicant advertise bariatric services: ☐ Yes ☐ No
If yes, please provide copies of materials and website addresses utilized for advertising.

11. Does each patient undergo a complete evaluation before being accepted and scheduled for surgey: ☐ Yes ☐ No

12. What is the age range of patients undergoing bariatric surgery:_____

13. Does the Applicant perform bariatric surgery on adolescents? ☐ Yes ☐ No
*If yes, indicate the number of adolescent procedures done in the past 12 months:*_____
Please submit your criteria for evaluating adolescents.

14. Do procedures for informed consent include a quiz type format, which allows a patient to answer specific questions regarding the procedure they are to undergo and risks that are being undertaken in their own handwriting? ☐ Yes ☐ No

15. Are you willing to refuse a procedure to any patient who fails the quiz or is not able to reflect an accurate understanding of the informed consent in his or her own handwriting? ☐ Yes ☐ No

16. On average, what percentage of procedures have complications: %

17. What percentage of procedures are laparoscopic: %

18. Please providee the following data regarding any major complications, adverse outcomes or deaths with any of your cases for the last three years:

Outcome	Total	% of Total	Outcome	Total	% of Total
Inpatient Mortality			Revisions		
30 Day Mortality			Transfers to Other Facilities		
90 Day Mortality			Number of Re-admissions in past 12 months		

19. Check those organizations whose guidelines you follow:
☐ American College of Surgeons ☐ Society of American Gastrointestinal Endoscopic Surgeons
☐ American Society of Bariatric Surgery ☐ American Society of Bariatric Surgeons
☐ Other (specify):

20. Are the credentialing guidelines of the Society of American Gastrointestinal Endoscropic Surgeons and The American Society of Bariatric Surgery being followed? ☐ Yes ☐ No
If no, please explain in the Comments section.

By separate attachment, provide a detailed description of your bariatric guidelines, policies and procedures. Include within the attachment the patient pre-screening/selection process, your post-surgery follow-up procedures and the medical professionals involved in the process, including types and responsibilities.

N. EMERGENCY ROOM

1. Are emergency room services provided? If no, please proceed to the next section. ☐ Yes ☐ No
If yes, please answer the following questions.

2. What level of service is provided based upon the American College of Surgeons' definition?
☐ Level I – 24 hour in-house emergency room physician and physician specialists
☐ Level II – 24 hour in-house emergency room physician with physician specialists within 30 minutes
☐ Level III – 24 hour on-call physician available within 30 minutes
☐ Level IV – Assessment, lifesaving first aid and appropriate referral

3. Specify how the emergency room physicians are staffed: ☐ Hospital Employees ☐ Contract Group

4. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually: ☐ Yes ☐ No
If yes, what limits of liability are required? Each incident: _____ Aggregate: _____

5. Is the Applicant a designated trauma center or advertised as one: ☐ Yes ☐ No

6. Specify the number of emergency room physicians: _____

7. Do you staff with non-board certified emergency room physicians: ☐ Yes ☐ No

8. Specify the number of nurse practitioners and physicians assistants: _____

9. Is the emergency room staffed by a physician on a 24-hour basis: ☐ Yes ☐ No

O. OBSTETRICS

1. Are obstetrical services provided? If no, please proceed to the next section. ☐ Yes ☐ No
If yes, please answer the following questions.

2. Specify the number of obstetricians on staff: _____

3. Specify the following information on an annual basis: _____

Total Number of births:	Number of OB/GYN deliveries:
Number of multiple births:	Number of family practice physician deliveries:
Number of c-sections:	Number of midwife deliveries:
Number of VBACs:	Number of all other healthcare professional deliveries: *If any, please describe in Comments section.*

4. If VBACs are performed, is c-section immediately available with MD qualified to peform c-sections in house during labor? ☐ Yes ☐ No

5. Is the Applicant a regional referral center for high-risk pregnancies or newborns: ☐ Yes ☐ No

P. PHARMACY

1. Are pharmacy services provided? If no, please proceed to the next section. ☐ Yes ☐ No
If yes, please answer the following questions.

2. Specify how the pharmacy is staffed: ☐ Hospital Employees ☐ Contract Group

3. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually: ☐ Yes ☐ No
If yes, what limits of liability are required: Each incident: _____ Aggregate: _____

4. Does the pharmacy dispense medicine to non-patients: ☐ Yes ☐ No

5. Does the facility use the bar coding system for dispensing medicine: ☐ Yes ☐ No

6. Is the pharmacy staffed 24-hours a day: ☐ Yes ☐ No
If not, how are medications accessed when the pharmacy is closed? _____

Q. RADIOLOGY

1. Are radiology services provided? If no, please proceed to the next section. ☐ Yes ☐ No
If yes, please answer the following questions.

2. Specify how radiology is staffed: ☐ Hospital Employees ☐ Contract Group ☐ Staff Physicians

3. If a contract group is used, specify the name of the group: _____
Are Certificates of Insurance required from this group annually: ☐ Yes ☐ No
If yes, what limits of liability are required: Each incident: _____ Aggregate: _____

4. Does the Applicant or contract group (if used) use teleradiology: ☐ Yes ☐ No

5. Are any radiologists (including radiologists of the contract group) located out of state: ☐ Yes ☐ No
If yes, specify states: _____

6. Are any radiologists (including radiologists of the contract group) providing services to patients out of state?
If yes, specify states: _____ ☐ Yes ☐ No

7. Are all radiographs over-read by the radiologist: ☐ Yes ☐ No
If no, please explain.

R. SURGERY

1. Are surgery services provided? If no, please proceed to the next section. ☐ Yes ☐ No
If yes, please answer the following questions.

2. Specify the number of surgeries performed in the previous 12 months for the following categories:

Abdominal:	Cardiac:	Cardiovascular:	Colon & Rectal:
Dermatology:	Endocrinology:	Foot & Ankle:	Gastroenterology:
General:	Geriatrics:	Gynecology:	Hand:
Head & Neck:	Lap Choles:	Laryngology:	Neonatal:
Nephrology:	Neurosurgery:	Obstetrics/Gynecology:	Ophthalmology:
Orthopedic Surgery:	Otorhinolaryngology:	Plastic:	Thoracic:
Transplant:	Traumatic:	Urological:	Vascular:

S. OTHER SERVICES

1. Does the Applicant sell or rent any equipment to others: ☐ Yes ☐ No
If yes, please provide a description: _____

2. Does the Applicant participate in any teaching programs: ☐ Yes ☐ No
If yes, check each that apply and specify the number of students and faculty:

	Number of Students	Number of Faculty
☐ Medical		
☐ Nursing		
☐ Radiology		
☐ Laboratory		
☐ Pharmacy		
☐ Other		

☐ Other		

3. Does the Applicant operate a blood bank: ☐ Yes ☐ No

If yes, indicate which services are provided: ☐ Procuring of blood ☐ Testing of blood ☐ Distributing blood

Does the Applicant test for the West Nile Virus, HIV, and Hepatitis C: ☐ Yes ☐ No

T. PREMISES AND OPERATIONS

1. List all premises owned, rented, leased, occupied or used by you. Attach a separate sheet, if necessary.

Address	Use	Year Built	Constr. Type Number*	Fire Class	# of Stories	Sprinkler System Y/N	Total Area

*Construction Type Number: 1 = Frame, 2 = Joisted Money, 3 = Non-Combustible, 4 = Masonry Non-Combustible, 5 = Fire Resistive/Modified Fire Resistive

2. Does each location meet applicable NFPA building codes: ☐ Yes ☐ No

3. Does the Applicant have a written emergency evacation plan: ☐ Yes ☐ No
If yes, please attach a copy of the plan.

4. If an inpatient care facility location is older than 15 years old, when was the last qualified inspection of electric, heating and plumbing: _____

5. List any planned major fund raising activities or sporting events which will be sponsored by the Applicant during the next year:

6. Does the Applicant have a heliport/helipad: ☐ Yes ☐ No
If yes, please provide a description: _____
Does the Applicant have a writtent maintenance plan for the pad or port: ☐ Yes ☐ No
If yes, please attach a copy.

7. Does the Applicant own or operate fixed-wing air ambulance: ☐ Yes ☐ No

8. Are there any construction projects planned for the next year? ☐ Yes ☐ No
If yes, please provide a description of the project(s) in the Comments section, including the estimated cost and duration of the project.

U. CONTRACTUAL AGREEMENTS

1. Specify any contracted professional services performed:

☐ Laboratory ☐ Physical/Occupational Therapy ☐ Social Work

☐ Pathology ☐ Housekeeping ☐ Biomedical

☐ Home Health Care ☐ Laundry

2. Does the Applicant require these contractors to provide evidence of insurance: ☐ Yes ☐ No
If yes, what limits of liability are required: Each incident: _____ Aggregate: _____

3. Are there any service contracts in effect: ☐ Yes ☐ No
If yes, please describe services: _____
Does the Applicant indemnify (hold harmless)the owner for liability: ☐ Yes ☐ No

4. Does the Applicant have an attorney review all contracts before signing: ☐ Yes ☐ No

V. Comments

FRAUD WARNING/STATEMENT: Any person who knowingly and with intent to defraud an 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 civil penalties.

APPLICANT AUTHORIZES ACCESS TO AND RELEASE OF INFORMATION: The Applicant authorizes access by and release to Nebraska Residual Malpractice Insurance Authority of any and all information pertaining to underwriting the undersigned Applicant and relating to medical claims or any other matter in the possession, custody, or control of any of the following: State Board of Medical Examiners or Medical Practice or any other medical association or medical organization; any county medical society or medical organization; any insurance carrier that previously has insured or been requested to insure the undersigned Applicant with respect to medical professional liability and/or premises liability coverage; and any other peer review committee or organization reviewing conduct on behalf of any hospital, health maintenance organization or third party, private or public reimburser, including State Departments of Welfare.

APPLICANT ACKNOWLEDGEMENT: The Applicant hereby certifies the foregoing information is true and correct and that any and all claims or potential claims have been reported to the current carrier.

Applicant Signature	Title	Date