



Insurance Solutions for Healthcare Providers

Facility Application

**Medical Professional Liability Insurance
Modified Claims-Made Policy**

To be completed by agent:

Agent Name: _____

License Number: _____

Agency Code: _____

Return Application To:

FPIC

1000 Riverside Ave,

Suite 800

Jacksonville, FL 32204

(904)354-5910

(800)741-3742

(904)358-6728 – fax

INSURANCE COVERAGE IS SUBJECT TO UNDERWRITING APPROVAL AND PAYMENT OF PREMIUM. NO COVERAGE EXISTS UNTIL THE INITIAL PREMIUM AND REQUIRED DOCUMENTS ARE RECEIVED AND A BINDER OR DECLARATIONS PAGE, TOGETHER WITH ANY APPLICABLE ENDORSEMENTS, HAS BEEN ISSUED TO THE NAMED INSURED.

Help us expedite the processing of your application by printing your responses in ink or type. Incomplete answers and/or missing attachments will delay our processing of the application.

- Answer every question or mark it “not applicable” (N/A);**
- Signature required on page 7 & 8 (if applicable);**
- Copy of corporate or association charter attached;**
- Copy of Accreditation report attached (if applicable);**
- Copy of Organizational Chart attached (showing legal entities of the facility);**
- Copy of Medical Staff list attached;**
- If the facility and/or the physician(s) have had claims, incidents or suits filed against them, please make certain a Claims Information Form is completed for each claim or suit in the past 15 years;**
- Proof of insurance attached on the facility, physician(s) and/or ancillary staff (i.e. physician assistants, nurse practitioners, nurse anesthetists, etc.);**

Facility Application

Requested Effective Date: ____/____/____

Requested Retroactive Date: ____/____/____

GENERAL INFORMATION

1. Name: _____

D/b/a: _____

2. Street address: _____

_____ City _____ State _____ Zip

3. Telephone Number: (____) ____ - ____

4. Fax Number: (____) ____ - ____

5. Billing address: _____

_____ City _____ State _____ Zip

6. Telephone Number: (____) ____ - ____

7. Fax Number: (____) ____ - ____

8. Contact name: _____

Please list all entity information on page 6

9. Facility type (please check):

Surgery Center: Outpatient – Ophthalmic: _____ number of annual surgeries
 Outpatient – all other: _____ number of annual surgeries

Laboratory: Medical \$ _____ annual revenue
 X-Ray/MRI \$ _____ annual revenue
 Dental \$ _____ annual revenue
 Ocular \$ _____ annual revenue
 Optical \$ _____ annual revenue
 Pathology \$ _____ annual revenue
 Pharmaceutical \$ _____ annual revenue

Clinic: Clinic _____ number of annual visits
 Other: _____ number of annual visits

10. Facility Descriptions (please check):

Corporation
 Partnership
 Joint Venture
 Limited Liability Corporation
 Professional Association
 Other: _____

11. Facility Designations (please check):

For Profit
 Not for Profit
 Governmental
 Osteopathic
 Other: _____

12. Facility Accreditations (please check): JCAHO CLIA State Accreditation

13. Years of operation: _____

14. Years under present ownership: _____

15. Are all owners/stockholders physicians? yes no

16. Are all owners/stockholders insured with FPIC? yes no

17. Please list current owners/stockholders (use separate sheet if necessary):

_____	_____	_____
Name	Title/Position	FPIC Policy Number*
_____	_____	_____
Name	Title/Position	FPIC Policy Number*
_____	_____	_____
Name	Title/Position	FPIC Policy Number*
_____	_____	_____
Name	Title/Position	FPIC Policy Number*
_____	_____	_____
Name	Title/Position	FPIC Policy Number*

*** If not insured with FPIC, please attach current declaration page**

18. Are there physicians utilizing the facility other than the owners and/or stockholders? yes* no

***If yes, please attach a list of all physicians with a copy of their current declaration page**

19. Is there an FPIC clinic policy associated with this facility? yes no

A. If yes, please provide:
Name: _____

Policy Number: _____

20. Are Anesthesia Services being provided? yes no

A. If yes, who provides: _____

B. Are the Anesthesia services contracted? yes* no

***If yes, please provide copy of contract**

C. Do CRNA's provide anesthesia services? yes no

➤ If yes, are they under the direct supervision of an anesthesiologist? yes no

➤ If yes, what is the Anesthesiologist v/s CRNA ratio? ____/____

21. Are Radiology Services being provided? yes no

A. If yes, who provides: _____

B. If yes, how many X-Ray/Imaging machines are owned and/or operated within the facility? _____

➤ Are they used for diagnosis? yes no

➤ Are they used for treatment? yes no

22. Staff Credentialing/Privileges:

A. Please list the number of physician(s) in each of the following categories:

_____ Active _____ Consulting _____ Emeritus
_____ Associate _____ Courtesy _____ Probationary

B. Please list the number of following ancillary staff members in each of the following categories:

_____ Certified Registered Nurse Midwives*
_____ Certified Registered Nurse Anesthetists*
_____ Physician Assistants*
_____ Nurse Practitioners*

*** If not insured with FPIC, please attach current declaration page**

- C. Are all physicians board certified? yes no
- D. Are credentials checked/approved prior to granting staff privileges? yes no
- E. Do privileges have a 6-month provisional for new staff members? yes no
- F. Does any staff physician(s) have restricted privileges and/or licenses?
 yes* no
**If yes, please explain in writing*
- G. Do department supervisors evaluate the work of their assigned staff? yes no
- H. Are periodic medical audits completed on staff members? yes no

Insurance Information

23. Requested Limits (please check):

- \$100,000/\$300,000
- \$250,000/\$750,000
- \$500,000/\$1,500,000
- \$1,000,000/\$3,000,000
- \$2,000,000/\$4,000,000
- \$3,000,000/\$5,000,000
- \$4,000,000/\$6,000,000
- \$5,000,000/\$7,000,000

24. If the expiring policy is on a “claims-made” basis, an Extended Reporting Period (“tail”) endorsement is generally available as an option of your expiring “claims-made” policy.

- A. Are you exercising the option? yes no
- B. If no, do you want FPIC to afford coverage for prior acts? yes no

25. Insurance history for previous 15 years:

Name of Company	Policy Number	Retro Date / /	Effective Dates
Name of Company	Policy Number	Retro Date / /	Effective Dates
Name of Company	Policy Number	Retro Date / /	Effective Dates

26. Has the professional liability insurance ever been refused, declined, non-renewed, canceled, or accepted on special terms?

- yes* no

**If yes, please explain in “Remarks” section*

27. Has the facility ever had a malpractice claim or suit, either directly or indirectly?

- yes* no

**If yes, please complete the Supplementary Claim Information Form*

28. Are you currently aware of any situation that could lead to a claim against the facility?

- yes* no

**If yes, please complete the Supplementary Claim Information Form*

Remarks:

Supplemental Waiver and Release

I hereby acknowledge that the foregoing information constitutes my application for insurance with First Professionals Insurance Company (FPIC). All statements are my own representations and are true, to the best of my knowledge. I have not knowingly withheld any information that is calculated to influence the judgment of FPIC in considering this application for liability insurance. If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by FPIC and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by FPIC. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state of hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Recovery network, individuals and FPIC. I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to act performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I understand that, if I am insured by FPIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with FPIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FPIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FPIC

Fraud Statement Section 817.234 (1)(b), Florida Statutes (if applicable)

This section requires insurers to include a specified fraud statement on applications as well as claims forms. The requirement is effective March 1, 1996; however, the Department has begun notifying companies in form filings that they must include it or re-file it next year. The statute requires the statement to contain in substance the following language: Any person who knowingly and with intent to injure, defraud, or deceive any insurer or files a statement or claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

This application form duly completed, together with any supplementary information, must be signed in ink by the applicant. A signature on the form does not bind the applicant or FPIC to complete insurance.

_____/_____/_____
Date

Authorized Signature

Title/Position

(A photostat copy of this authorization shall be considered as effective and as valid as the original)

Supplementary Claims Information Form

(If there has been more than one claim, please use a separate form for each.)

Complete information is necessary to avoid complications under your insurance policy issued upon reliance of this application:

1) Patient's name: _____

2) Address: _____
_____ City State Zip

3) Name of attending physician: _____

4) Date reported to insurance company: ____/____/____

5) Date of incident: ____/____/____

6) Allegations:

7) What is the present condition of the patient: _____

8) Did you in any way alter, embellish, delete, change, and/or destroy any records, pertaining to this claim? yes no

9) Insurance company at time of claim? _____

10) Name/address of representing attorney? _____

11) Present status of claim (check applicable answer):

- | | |
|---|--|
| <input type="checkbox"/> Suit threatened, no action taken | <input type="checkbox"/> Out of court settlement in the amount of \$ _____ |
| <input type="checkbox"/> Dropped by claimant | Date claim paid (mm/dd/yy): ____/____/____ |
| <input type="checkbox"/> Awaiting court action | <input type="checkbox"/> Court settlement in the amount of \$ _____ |
| <input type="checkbox"/> Awaiting mediation | Date claim paid (mm/dd/yy): ____/____/____ |
| <input type="checkbox"/> Reserve Amount \$ _____ | <input type="checkbox"/> Summary judgment in your favor |
| <input type="checkbox"/> Court trial in your favor | |

The above is a true and correct statement. By signing this form, I hereby authorize my prior insurance company to release any claim information requested by FPIC.

Date

Signature of Applicant

(A photostatic copy of this authorization shall be considered as effective and as valid as the original)