

Clinic Purchasing Group

RENEWAL APPLICATION

For Claims Made Professional Liability Insurance



IMPORTANT INFORMATION

The coverage of any policy is limited generally to liability only for those claims that are first made against an Insured and reported to NORCAL while the policy is in force. The coverage provided under the optional Health Care General Liability Insurance, if purchased, is limited to bodily injury, property damage, fire damage, personal injury or advertising injury that occurred during the policy period. The coverage provided under the optional Non-Owned Auto and Hired Auto Liability Insurance, if purchased, is limited to bodily injury, property damage or fire damage that occurred during the policy period.

The coverage of any policy is limited to the liability of the Named Insured and any Insured. The Named Insured and all Insureds share a single limit of liability. Coverage for an Insured is provided only while he or she is acting within the course and scope of his or her duties for the Named Insured.

No coverage exists until written verification of coverage by NORCAL Mutual Insurance Company is issued in the clinic's/ organization's name.

The application asks that you provide information regarding affiliations, practice associations, etc. This information is requested to provide us with an understanding of the clinic's/organization's practice but does not mean that a policy, if issued, would cover such entities and persons.

APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- If you wish to explain any of your answers, please use the Remarks section on page 10. If you need more space, please attach additional pages.
- If a table in the application does not have a sufficient number of rows to provide the requested information, please attach a separate page with the required information.
- Please ensure that you sign and date the application on page 11.
- In addition to a completed application and the information requested within it, please provide the following items:
 - List of Locations see Section III
 - List of Providers, see Section IV
 - Deeming and Scoping Documents, if clinic is FTCA deemed.
 - A Copy of the latest OSHPD report, number of visits section only, if clinic is FTCA deemed.
 - Please make a copy of the completed application and supporting documentation for your records.

SECTION I**GENERAL INFORMATION**

Clinic/Organization Name

Tax ID Number

Clinic's Email Address:

Clinic's Website

Primary Address

*(City)**(State)**(Zip Code)*Telephone # *(Including Area Code)*Fax # *(Including Area Code)*

Mailing Address

*(Location where all mailings except invoices will be sent)**(City)**(State)**(Zip Code)*Telephone # *(Including Area Code)*Fax # *(Including Area Code)*

Billing Address

*(Location where all mailings except invoices will be sent)**(City)**(State)**(Zip Code)*Telephone # *(Including Area Code)*Fax # *(Including Area Code)***Authorized Representative**

The Authorized Representative is the person responsible for providing consent decisions on behalf of the Named Insured and the person who will act on behalf of the Named Insured or other Insureds for all other purposes relating to the policy. One person may be designated for both purposes or a separate person may be designated for each purpose.

Please provide the name and title of the person authorized to provide consent decisions on behalf of the Named Insured:

Name

Title

Email Address:

Telephone Number

Please provide the name and title of the person authorized to act on behalf of the Named Insured and all other Insureds for all other (non-consent) purposes relating to the policy.

Name

Title

Email Address:

Telephone Number

SECTION II**COVERAGE INFORMATION****Health Care General Liability Insurance – Occurrence****Non-Owned Auto and Hired Auto Liability Insurance – Occurrence**

1. If the clinic/organization has not already purchased General Liability from NORCAL, do you wish to add this coverage?

Yes No

2. Do you own any vehicles? Yes No

SECTION III

COVERAGE/INSURANCE INFORMATION

1. Please complete the following by identifying all locations for clinic/organization.

* If the clinic/organization owns the location, please identify the square footage of the entire building. If the clinic/organization does not own the location, please identify the square footage that the clinic/organization occupies. If the clinic location is not licensed please explain in the remarks section.

Location <i>(Name and address)</i>	Type of Location and Percentage of Location's Service	Square Footage of Building or Area Occupied	Location Licensed Yes/No
		<input type="checkbox"/> Primary Care Clinic_____% <input type="checkbox"/> Extended Care Facility_____% <input type="checkbox"/> Halfway House_____% <input type="checkbox"/> Long term Inpatient Mental Health_____% <input type="checkbox"/> Nursing Home_____% <input type="checkbox"/> Residential Treatment Center_____% <input type="checkbox"/> Other (specify)_____ %	
		<input type="checkbox"/> Primary Care Clinic_____% <input type="checkbox"/> Extended Care Facility_____% <input type="checkbox"/> Halfway House_____% <input type="checkbox"/> Long term Inpatient Mental Health_____% <input type="checkbox"/> Nursing Home_____% <input type="checkbox"/> Residential Treatment Center_____% <input type="checkbox"/> Other (specify)_____ %	
		<input type="checkbox"/> Primary Care Clinic_____% <input type="checkbox"/> Extended Care Facility_____% <input type="checkbox"/> Halfway House_____% <input type="checkbox"/> Long term Inpatient Mental Health_____% <input type="checkbox"/> Nursing Home_____% <input type="checkbox"/> Residential Treatment Center_____% <input type="checkbox"/> Other (specify)_____ %	
		<input type="checkbox"/> Primary Care Clinic_____% <input type="checkbox"/> Extended Care Facility_____% <input type="checkbox"/> Halfway House_____% <input type="checkbox"/> Long term Inpatient Mental Health_____% <input type="checkbox"/> Nursing Home_____% <input type="checkbox"/> Residential Treatment Center_____% <input type="checkbox"/> Other (specify)_____ %	
		<input type="checkbox"/> Primary Care Clinic_____% <input type="checkbox"/> Extended Care Facility_____% <input type="checkbox"/> Halfway House_____% <input type="checkbox"/> Long term Inpatient Mental Health_____% <input type="checkbox"/> Nursing Home_____% <input type="checkbox"/> Residential Treatment Center_____% <input type="checkbox"/> Other (specify)_____ %	

1. Please identify the following administrative personnel:

Title/Name

Chief Executive Officer:

Medical Director:

President:

Administrator:

Executive Director:

Other:

2. Please attach a roster of all medical professionals who provide services on behalf of the clinic/organization. Physicians, dentists, physicians assistants, nurse practitioners, nurse midwives, perfusionists are the only provider types that will be included in the endorsed Roster of Insureds.

The roster must include the following items for each individual:

- Name and designation
- Type of provider (for example, physician, nurse practitioner or registered nurse)
- If a Physician, Dentist, Physician's Assistant, Nurse Practitioner, Nurse Midwife or Perfusionist, include the individual's license number
- Whether the individual is a partner/shareholder, employee, independent contractor, leased worker or volunteer
- Date of employment, if an employee

SECTION V

PROCEDURES, SERVICES AND OCCUPIED BEDS

1. Please complete the following table by providing the estimated number of procedures and surgeries to be performed or services to be provided on behalf of the clinic/organization for the current (and complete) calendar year, regardless of where they are performed or provided. If the clinic/organization has deemed status under the Federal Tort Claims Act (FTCA), or if the clinic is an Indian clinic, please estimate the number of procedures or services that are not covered by the FTCA or provided to Non-Indian patients.

* Asterisk(s) indicate excluded specialty procedures. All providers performing these procedures (specialty providers) must be endorsed onto the policy for coverage to be extended. If specialty provider is not already endorsed, a specialty provider application must be completed.

Procedure/Surgery/Service	# of visits Non-FTCA	# of visits FTCA
Family Practice and General Visits (excluding general podiatric visits):	<input type="text"/>	<input type="text"/>
General Podiatric Visits:	<input type="text"/>	<input type="text"/>
Prenatal and Postnatal Visits:	<input type="text"/>	<input type="text"/>
General Dental Visits (excluding oral surgery):	<input type="text"/>	<input type="text"/>
Mental Health Counseling Visits:	<input type="text"/>	<input type="text"/>
* Deliveries (including cesarean delivery):	<input type="text"/>	<input type="text"/>
* Abortions:	<input type="text"/>	<input type="text"/>
* Administration of Anesthesia other than topical or by means of local infiltration:	<input type="text"/>	<input type="text"/>
* Oral Surgery:	-----	-----
Cleft lip and palate surgery	<input type="text"/>	<input type="text"/>
Dental implants	<input type="text"/>	<input type="text"/>
Orthognathic surgery	<input type="text"/>	<input type="text"/>
Tempromandibular joint surgery	<input type="text"/>	<input type="text"/>
Wisdom tooth extraction (By Dentist or Oral Surgeon)	<input type="text"/>	<input type="text"/>
Other oral surgery (specify procedures):	<input type="text"/>	<input type="text"/>
<input type="text"/>		

Procedure/Surgery/Service	# of visits Non-FTCA	# of visits FTCA
Minor Procedures and Surgeries:	-----	-----
Biopsy of lesions limited to the mucous membranes of the nose, mouth, throat, vagina, uterine cervix or rectum	<input type="text"/>	<input type="text"/>
Surgical treatment of cysts, abscesses or superficial or and traumatic wounds using local infiltration anesthesia	<input type="text"/>	<input type="text"/>
Other minor procedures and surgeries:	<input type="text"/>	<input type="text"/>
<input type="text"/>		

Intermediate Procedures and Surgeries	# of visits Non-FTCA	# of visits FTCA
Amniocentesis	<input type="text"/>	<input type="text"/>
* Carpal tunnel release	<input type="text"/>	<input type="text"/>
Catheterization	<input type="text"/>	<input type="text"/>
* Circumcision	<input type="text"/>	<input type="text"/>
Cystoscopy	<input type="text"/>	<input type="text"/>
Dilation and curettage of the uterus (other than for the termination of a pregnancy)	<input type="text"/>	<input type="text"/>
Endoscopy procedures	<input type="text"/>	<input type="text"/>
Herniorrhaphy (inguinal or femoral only)	<input type="text"/>	<input type="text"/>
* Hemorrhoidectomy and other procedures limited to the anal ring	<input type="text"/>	<input type="text"/>
Hysteroscopy	<input type="text"/>	<input type="text"/>
Injection treatment of varicose veins	<input type="text"/>	<input type="text"/>
Lithotripsy	<input type="text"/>	<input type="text"/>
Myringotomy	<input type="text"/>	<input type="text"/>
* Orthopedic operations of the interphalangeal joints	<input type="text"/>	<input type="text"/>
* Tonsillectomy and adenoidectomy	<input type="text"/>	<input type="text"/>
Transurethral procedures on the kidney, ureter, bladder or urethra	<input type="text"/>	<input type="text"/>
* Vasectomy and other procedures involving cutting of the scrotal sac	<input type="text"/>	<input type="text"/>
Other intermediate procedures and surgeries (specify):	<input type="text"/>	<input type="text"/>
<input type="text"/>		

Procedure/Surgery/Service	# of visits Non-FTCA	# of visits FTCA
Major Surgery:	-----	-----
* Amputations	<input type="text"/>	<input type="text"/>
Angiography	<input type="text"/>	<input type="text"/>
Angioplasty	<input type="text"/>	<input type="text"/>
Episiotomy repair	<input type="text"/>	<input type="text"/>
Fracture repair – plating, pinning or open reduction	<input type="text"/>	<input type="text"/>
* Mastectomy	<input type="text"/>	<input type="text"/>
* Reconstructive vascular surgery, thromboembolectomy and thrombectomy of the arteries and veins and arterial-venous fistula creation/revision	<input type="text"/>	<input type="text"/>

Major Procedures and Surgeries	# of visits Non-FTCA	# of visits FTCA
* Neurological surgery	<input type="text"/>	<input type="text"/>
Oophorectomy	<input type="text"/>	<input type="text"/>
* Ophthalmic surgery	<input type="text"/>	<input type="text"/>
* Operations within the middle inner ear	<input type="text"/>	<input type="text"/>
* Orthopedic surgery (other than orthopedic operations on the interphalangeal joints)	<input type="text"/>	<input type="text"/>
* Plastic (cosmetic or reconstructive) surgery	<input type="text"/>	<input type="text"/>
* Prostatectomy	<input type="text"/>	<input type="text"/>
* Submucous nasal resection and other sinus surgery	<input type="text"/>	<input type="text"/>
Stenting – coronary and noncoronary	<input type="text"/>	<input type="text"/>
* Thyroidectomy	<input type="text"/>	<input type="text"/>
* Any surgical procedure on malignant lesions (other than for diagnostic purposes)	<input type="text"/>	<input type="text"/>
* Any cutting into or on the kidney, urethra or bladder or appendix	<input type="text"/>	<input type="text"/>
* General Surgery - Any surgical procedure involving cutting into or within the abdominal cavity, cranial cavity, orbital cavity, spine or facial sinuses (not already identified in the major surgery section)	<input type="text"/>	<input type="text"/>
Other major surgery (specify):	<input type="text"/>	<input type="text"/>
<input type="text"/>		

2. Please complete the following table by providing the estimated number of persons enrolled or the average number of occupied beds for the following services to be provided on behalf of the clinic/organization for the current (and complete) calendar year. If the clinic/organization has deemed status under the Federal Tort Claims Act (FTCA), please estimate numbers for those services that are not covered by the FTCA and those that are.

Service	# of visits Non-FTCA	# of visits FTCA
Adult Day Care Services (average number enrolled)	<input type="text"/>	<input type="text"/>
Child Day Care Services (average number enrolled)	<input type="text"/>	<input type="text"/>
Halfway House (average number of occupied beds)	<input type="text"/>	<input type="text"/>
Long Term Inpatient Mental Health (average number of occupied beds)	<input type="text"/>	<input type="text"/>
Nursing Home (average number of occupied beds)	<input type="text"/>	<input type="text"/>
Residential Treatment Center (average number of occupied beds)	<input type="text"/>	<input type="text"/>
Aerobics (square feet of dedicated space)	<input type="text"/>	<input type="text"/>
Other services (specify):	<input type="text"/>	

SECTION VI**GENERAL PRACTICE INFORMATION - FTCA**

ONLY FTCA DEEMED CLINICS NEED TO COMPLETE THIS SECTION

1. Does the clinic/organization currently have deemed status under the Federal Tort Claims Act (FTCA)? Yes No

If yes, please complete the following:

- a. Please attach a copy of the clinic's/organization's most recent scoping document and deeming letter.
- b. Does the clinic/organization have deemed status for all of the services that it provides and for all of the procedures performed on its behalf? Yes No

If no, in the Remarks Section, please explain and identify those services and/or procedures for which the clinic/organization does not have FTCA protection:

2. Deliveries Performed – Please complete if the Clinic is an Indian Clinic or FTCA deemed

- a. Are deliveries performed by clinic employed Physicians, contracted Physicians or full-time contracted or employed Nurse Mid-wives? Yes No
- b. Does the clinic bill for the deliveries or the contracting physician bills accompanied by a 1099 form? Yes No
- c. Is the location where the deliveries are performed approved by HSRA? Yes No

If the answer is NO to any of the above questions, please explain in the Remarks Section.

3. Within the next 12 months, are there any planned material changes for the clinic/organization (for example, the addition of a new location, establishment of another entity or changes in the type of procedures performed and/or services provided)? Yes No

If yes, please explain in the Remarks Section.

SECTION VII**RISK MANAGEMENT****Risk Management/Quality Improvement**

1. Does the clinic/organization have a formal risk management program? Yes No

a. If yes, who (name and title) is responsible for the risk management program and what other job responsibilities does this person have?

b. If no, please explain why the clinic/organization does not have a formal risk management program:

2. Does the clinic/organization have a formal process to evaluate and address concerns of unexpected patient outcomes? Yes No

3. Does the clinic/organization have a formal process to evaluate patient complaints? Yes No

4. Does the clinic/organization conduct patient satisfaction surveys? Yes No

If yes, how often:

5. Does the clinic/organization have any current risk management or quality improvement initiatives in place? Yes No

If yes, please describe:

Credentialing

1. Does the clinic/organization have a formal process to credential its health care providers?

Yes No

a. **If yes**, please identify who performs the initial credentialing (for example, employee, hospital or outside company):

b. **If no**, please explain the process for determining which health care providers the clinic/organization will hire or with whom it will contract:

2. Are all health care providers required to maintain and provide proof of hospital privileges for the procedures/surgeries they intend to perform on behalf of the clinic/organization? Yes No

If no, please explain and identify the credentialing process used to ensure that these individuals are qualified to perform the applicable procedures/surgeries:

REPRESENTATIONS, WARRANTIES, AUTHORIZATION TO RELEASE INFORMATION AND FRAUD STATEMENTS

NOTE: "Warrant" in the following statement is not applicable to Arizona or New Mexico clinics/organizations. By statute, Arizona or New Mexico clinics/organizations are only required to represent the truth of their statements and information.

I understand that this application and any supplemental information supplied by me or on my clinic's/organization's behalf are incorporated into and made a part of any policy of insurance that may be issued to my clinic/organization by NORCAL ("the Company").

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between the clinic/organization and NORCAL, the dispute will be submitted to binding arbitration.

I understand that this policy, if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that in the event this coverage is canceled, any unearned premiums will be refunded to the person or clinic/organization that paid NORCAL (that is, the payer).

I understand that I must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on the clinic's/organization's behalf, including changes in its partners or associates, medical licenses, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that is assumed under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by my clinic/organization or others trading under my clinic's/organization's name.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and any past and present association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where any members presently hold, are applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my clinic's/organization's insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about my clinic/organization and its members that is done in good faith and without malice.

Notice to New Mexico 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 civil fines and criminal penalties.

Signature *(If you have completed the application digitally, please print and sign it)*

Date

(mm/dd/yyyy)

Name *(Print)*



*Our Passion Protects
Your Practice*

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