# HOSPITALS AND HEALTH SYSTEMS
## MEDICAL PROFESSIONAL LIABILITY RENEWAL QUESTIONNAIRE

**Underwritten by a Curi Company**

**Medical Mutual Insurance Company of North Carolina**
**MMIC Insurance, Inc. | UMIA Insurance, Inc.**
**MMIC Risk Retention Group, Inc.**

**Required Documents**

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

1. Currently valued prior carrier Loss Runs covering the past ten (10) years if the Applicant has been insured with us for less than ten (10) years.
2. If Excess Liability coverage is provided:
   - Currently valued loss runs covering the past ten (10) years for all underlying coverages not insured by us
   - Declarations page for each underlying policy.
3. Roster of all employed and contracted physicians, residents, interns, externs, podiatrists, chiropractors and dentists insured with a different carrier or under a separate Curi policy. Refer to section E.4 for a list of information needed.
4. Organizational Ownership Chart reflecting all legal entities and DBAs.
5. Audited Consolidated Financial Statements for the past two (2) years.
6. Statement of Values or List of Locations with corresponding operations.

## A. APPLICANT INFORMATION

**The term "Applicant" used throughout this application shall mean all entities proposed for coverage.**

| | |
|---|---|
| Name of Policyholder: | Policy Number: |
| *To update current contact information, please provide the new contact information below, or select 'no change'.* | |
| Mailing c/o or Attn, if applicable: | ☐ **No change** |
| Mailing Address: | |
| Billing Address: | |
| Main Contact Name: | Email/Phone: |
| Risk Management Contact: | Email/Phone: |
| Claims Contact: | Email/Phone: |

## B. OPERATIONAL CHANGES

**1.** Considering the Applicant's operations within the **past twelve (12) months**, select all that apply and include an explanation in the Comments section. If none of the following apply, please select 'No change'.

☐ Obtained another operation or entity
☐ Sold or discontinued any operation or entity
☐ Added or reduced number of employees by more than 20%
☐ Added or reduced the number of locations
☐ Added or reduced services
☐ Operated in a new state
☐ Entered into a joint venture or limited partnership
☐ **No change**

**2.** Considering the **next twelve (12) months**, does the Applicant anticipate any operational changes? ☐ Yes ☐ No

If yes, please explain:

**3.** Considering the **next twelve (12) months**, does the Applicant plan to start any construction or renovation projects on property owned by or leased from the Applicant? If yes, answer the following: ☐ Yes ☐ No

**a.** Provide a description of the project(s):
**b.** Estimated total cost of the project(s): $
**c.** Estimated duration of the project(s):
**d.** Will the Applicant purchase General Liability coverage for this project? ☐ Yes ☐ No

If yes, select the type of insurance purchased:
☐ Builder's Risk with general liability coverage
☐ Owner-Controlled Insurance Program ("OCIP")
☐ Other liability policy (describe):

## C. GENERAL OPERATIONS

**1.** List all states where the Applicant is providing services. If there is more than one state, provide the estimated percentage of work by state. *This list should include states where telemedicine is provided.*

**2.** Does the Applicant own any skilled nursing beds that are managed by others? If yes, provide a list of the skilled nursing facilities, location and number of licensed beds below. ☐ Yes ☐ No

| Skilled Nursing Facility Name | Address | # of Licensed Beds |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**3.** Does the Applicant provide management services to others for a fee? If yes, please explain: ☐ Yes ☐ No

**4.** Answer the following survey questions:

a. When was the Applicant's last accreditation survey?

b. Who performed the inspection?

c. Total number of deficiencies identified:

d. Did the survey result in the Applicant being placed on Immediate Jeopardy? ☐ Yes ☐ No

e. How many patient/family complaints or grievances were filed in the past year?

How many grievances/complaints were substantiated?

**Provide the number of events that occurred within the past twelve (12) months.**

**5.** Emergency Department return visits within 72 hours of discharge:

**6.** Surgical patients who experienced a major post-operative complication:

**7.** Complaints or grievances filed:

## D. HOSPITAL EXPOSURES

**1.** Complete this section using the definitions provided below.

| | |
|---|---|
| **Occupied Beds** | Provide the projected, current, and previous 12-month (365 day) exposure count for each classification. If the Occupied Bed count is unavailable, provide either the total inpatient days or the average daily census. |
| **Outpatient Visits** | Count each appearance of an outpatient in a hospital unit, regardless of the number of procedures or treatments performed within each unit. |
| **Revenue** | Use annual gross revenues resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period. |
| **Acute Beds** | All beds licensed by the state, including but not limited to all beds designated for burn, coronary, intensive care, medical surgical, pediatric or other acute care patients receiving medical care. |
| **Extended Care** | Intermediate care - the provision of health-related care and services, on a regular basis to individuals who do not require the degree of care or treatment that a skilled care nursing unit is designed to provide. |
| **Personal Care** | Provides housing, meals and help with activities of daily living. |
| **Skilled Care** | All beds licensed or approved as such by the state and utilized for patients requiring either skilled nursing care or the supervision of skilled nursing care on a continuous or extended basis. |

| | Occupied Beds | | | |
|---|---|---|---|---|
| **INPATIENT BEDS** | **Projected 12 Months** | **Current 12 Months** | **Previous 12 Months** | **Total Licensed Beds** |
| Extended Care | | | | |
| Personal Care | | | | |
| Skilled Care | | | | |
| Acute | | | | |
| Behavioral Health and Psychiatric | | | | |
| Chemical Dependency | | | | |

| | | | | |
|---|---|---|---|---|
| Cribs and Bassinets | | | | |
| Intensive Care | | | | |
| Neonatal | | | | |
| Other (describe): | | | | |
| **SURGERIES** | **Projected 12 Months** | **Current 12 Months** | **Previous 12 Months** | |
| Inpatient | | | | |
| Outpatient | | | | |
| **OUTPATIENT VISITS** | **Projected 12 Months** | **Current 12 Months** | **Previous 12 Months** | |
| Emergency Room | | | | |
| Home Health | | | | |
| Physical and Occupational Therapy | | | | |
| Behavioral Health | | | | |
| Substance Abuse | | | | |
| Urgicenter | | | | |
| Dialysis Center | | | | |
| Clinic | | | | |
| Other Outpatient (describe): | | | | |
| **DELIVERIES (Births)** | **Projected 12 Months** | **Current 12 Months** | **Previous 12 Months** | |
| Total Deliveries | | | | |

**2.** Considering all DELIVERIES in the current twelve (12) month period, please provide the estimated percentage (%) of deliveries performed by each **provider type** and **delivery method** below.

| Provider Type | Deliveries |
|---|---|
| OB/GYN Physicians | % |
| Family or General Practice Physicians | % |
| Nurse Midwives | % |
| Physician Assistants & Nurse Practitioners | % |
| Other (describe): | % |
| **Total** | **100%** |

| Delivery Method | Deliveries |
|---|---|
| Vaginal | % |
| C-section | % |
| VBAC | % |
| **Total** | **100%** |

| REVENUE | Projected 12 Months | Current 12 Months | Previous 12 Months |
|---|---|---|---|
| Applicant's Total Revenue | $ | $ | $ |
| Retail Pharmacy (non-patients only) | $ | $ | $ |
| X-Ray and Other Imaging | $ | $ | $ |
| Durable Medical Equipment | $ | $ | $ |
| Fitness Center – Public Use | $ | $ | $ |
| **GENERAL LIABILITY** | **Projected 12 Months** | **Current 12 Months** | **Previous 12 Months** |
| Apartment Units (total number of units for all buildings) | | | |
| Daycare Enrollees – Adult | | | |
| Daycare Enrollees – Child | | | |
| Dwelling Units (total number of units for all dwellings) | | | |
| Parking (gross revenue) | $ | $ | $ |
| Storage (square footage) | | | |
| Vacant Land (total acreage) | | | |

## E. MEDICAL STAFF

**1.** Provide the total number of employees, including non-medical staff:

**2.** Specify the number of employed and contracted medical professionals working on behalf of the Applicant.

| Provider Type | Employed | Contracted | Provider Type | Employed | Contracted |
|---|---|---|---|---|---|
| Physicians (MDs & DOs) | | | Podiatrists | | |
| Residents | | | Chiropractors | | |
| Interns & Externs | | | Dentists | | |

**3.** Are any of the employed or contracted providers above insured with a different carrier or under a separate Curi policy? ☐ Yes ☐ No

If yes, please attach a roster and include the following information:

- Full Name (First, Middle Initial, Last) and Designation
- Date of Birth
- Social Security Number
- NPI Number
- Medical Specialty
- Surgical Category: No Surgical Procedures, Minor Surgical Procedures or Surgery
- Prior Acts Date (if claims-made)
- State Medical License Number(s)
- Employment Status (employed or contracted)
- Hours worked for any part-time providers
- Specify if coverage is desired. If not, specify current carrier.

**4.** Using the chart below, specify all other medical professionals working on behalf of the Applicant. Compute full-time equivalents (FTE) for all part-time providers by using 40 hours per week as one full-time equivalent.

| Type | Employed FTE | Contracted FTE | Type | Employed FTE | Contracted FTE |
|---|---|---|---|---|---|
| Anesthesia Assistants | | | Pharmacists | | |
| Emergency Medical Technicians | | | Physical Therapists | | |
| Laboratory or X-Ray Technicians | | | Physician Assistants | | |
| Licensed Practical Nurses | | | Speech Therapists | | |
| Nurse Anesthetists | | | Psychologists | | |
| Nurse Midwives | | | Registered Nurses | | |
| Nurse Practitioners | | | Other: | | |
| Occupational Therapists | | | Other: | | |
| Optometrists | | | Other: | | |
| Paramedics | | | Other: | | |

**Considering all medical staff employed or contracted by the Applicant, please answer the following questions. Please explain all "yes" answers in the Comments section.**

| | | |
|---|---|---|
| **5.** | Has any medical staff's license been restricted, suspended, surrendered or revoked? | ☐ Yes ☐ No |
| **6.** | Has any medical staff been accused of sexual misconduct, including unfounded accusations? | ☐ Yes ☐ No |
| **7.** | Has any medical staff been hired who has a criminal record? | ☐ Yes ☐ No |
| **8.** | Has the Applicant made a report to the National Practitioner Data Bank on any provider(s)? | ☐ Yes ☐ No |
| **9.** | Are there any medical staff or volunteers for whom you do not conduct both state and nationwide criminal background checks, including checks for sexual offenses? | ☐ Yes ☐ No |

## F. OBSTETRICAL SERVICES ☐ N/A

If obstetrical services are performed, complete the following questions or check N/A above.

| | | |
|---|---|---|
| **1.** | Are all high risk deliveries performed by obstetricians? | ☐ Yes ☐ No |
| **2.** | Can a c-section be performed in 30 minutes or less from decision to incision? | ☐ Yes ☐ No |
| **3.** | Do all deliveries occur within the hospital? | ☐ Yes ☐ No |
| **4.** | Is electric fetal monitoring performed on all patients in active labor? | ☐ Yes ☐ No |
| **5.** | Are all obstetrical staff (including RN's) required to maintain NICHD fetal monitoring certification? | ☐ Yes ☐ No |

| Considering the past twelve (12) months, specify the following: | |
|---|---|
| **6.** Infants born with an Apgar of six (6) or less, at five (5) minutes: | ☐ N/A |
| **7.** Number of water birth deliveries in the past 12 months: | ☐ N/A |
| **8.** C-sections performed by Family or General Practice Physicians: | ☐ N/A |
| **9.** VBAC's performed by Family or General Practice Physicians: | ☐ N/A |
| **10.** C-sections that exceeded 30-minute decision to incision criteria: | ☐ N/A |

## G. SHARED EXCESS COVERAGE ☐ N/A

**1.** If Shared Excess coverage is desired, select the applicable underlying policies or check the N/A box above. For each coverage selected, please provide details and attach a current policy declarations page for each selected coverage.

| Coverage Desired | Coverage Type | Carrier | Policy Number | Policy Period | Limits of Liability |
|---|---|---|---|---|---|
| ☐ | Auto Liability | | | | |
| ☐ | Employers Liability | | | | |
| ☐ | Helipad Liability | | | | |
| ☐ | Non-Owned Aircraft Liability | | | | |
| ☐ | Other Liability: | | | | |

**2.** Current automobile liability premium: $

**3.** Current number of owned and leased company vehicles by type:

Private Passenger: Light Service: Medium Service: Heavy Service:

Ambulance: Passenger Vans: Other (describe):

**4.** Indicate the number of employees driving:

a. Company vehicles: b. Personal vehicles on behalf of the Applicant:

**5.** How often are Motor Vehicle Records reviewed for staff who drive company or personal vehicles on behalf of the Applicant?

**6.** If the Applicant provides transportation services, please answer the following:

a. Are transportation services provided to the public? ☐ Yes ☐ No

b. Are passengers carried for a fee? ☐ Yes ☐ No

c. Describe the transportation services offered by the Applicant:

## H. CLAIM INFORMATION

1. Are you aware of any claims, suits or potential claims that have not been reported to us? ☐ Yes ☐ No

If yes, provide a description of each claim(s) in the Comments section and answer the following:

a) Will the claim(s) be reported to us? ☐ Yes ☐ No ☐ NA

b) If no, provide explanation (e.g. is this claim covered by a different insurance carrier?):

## I. COMMENTS

**Please explain all "yes" answers in the Comments section below. Please include section and question number.**

**FRAUD WARNING/STATEMENT:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Any person who includes any false or misleading information on an application for an insurance policy may be guilty of a crime and subject to penalties that include imprisonment, fines and denial of insurance benefits. Refer to the State Fraud Warning Notices document for your state specific fraud warning notice, if applicable. This document is located on our website at curi.com.

**PRIVACY STATEMENT:** We may communicate the results of the application to the Applicant's authorized representative. To review detailed information on how we collect and use the Applicant's personal information, visit the company website at curi.com.

**APPLICANT ACKNOWLEDGEMENT:** The Applicant declares this information is complete and accurate. Applicant acknowledges a continuing duty to supplement any information that may materially affect this information.

| Applicant Signature | Title | Date |
|---|---|---|