Diagnostic Imaging Facilities

Claims-Made Professional Liability Coverage Application

Instructions:

1. **Please read the instructions carefully.** Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. **All application questions must be fully answered.** If a question does not apply, please write "N/A".
3. **If more space is needed,** continue on a separate sheet of the applicant's letterhead and indicate the question number.
4. **To this application, please attach copies of:**
   a. Marketing or Advertising brochures or descriptive materials provided to clients.
   b. Latest annual financial statement.
   c. Claim loss runs for the past 5 or more years for all coverages being applied for.
   d. If the applicant is a new business submit professional qualifications (i.e. resume or C.V.) of each owner, partner, officer and key employee.
   e. Most recent state survey reports and accreditation survey reports as applicable.
   f. Quality Improvement/Risk Management plan.
5. This application must be completed, signed and dated by a principal of the business.

The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate. A separate physician application is required for all physicians requesting coverage under this policy.

I. GENERAL INFORMATION

1. Name of Applicant (legal name): _____

2. Physical Address: _____

3. Mailing Address: (if different) _____

4. Corporate Address: (if different) _____

City: _____ State: _____ Zip Code: _____ County: _____

5. Corporate Contact: _____ E-Mail Address: _____

Tel. Number: ( ) _____ Fax Number: ( ) _____ Website: _____

6. Date Established: _____ ☐ Corporation ☐ Partnership ☐ Professional Assoc ☐ For Profit ☐ Not for Profit ☐ Individual

7. In what state(s) is the Applicant registered and licensed to practice? _____

8. Please specify any professional societies or associations which you are a member: _____

_____

II. COVERAGE/LIMITS/DEDUCTIBLES

Indicate which coverages you are applying for: (if you are applying for any of the GL coverages, also complete a supplemental application)

☐ Professional Liability ☐ Employee Benefits Liability ☐ Non-Owned Auto ☐ General Liability ☐ Sexual Molestation/Abuse

1. Requested Effective Date _____
2. Requested Prior Acts Date _____
3. Requested Limits of Liability _____ Each Claim _____ Aggregate
4. Deductible _____ Each Claim

5. Does the state the applicant is operating in have a Patient Compensation Fund? ☐ Yes ☐ No
   If yes, is the applicant currently enrolled in the Patient Compensation Fund? ☐ Yes ☐ No
6. Is the firm engaged in, owned by, associated with, or controlled by any other business? ☐ Yes ☐ No
7. Is the firm owned by any physician? ☐ Yes ☐ No
8. Is the firm owned by any hospital, or are any services hospital based? ☐ Yes ☐ No
9. Have there been any changes in ownership of the business since the date the entity was established? ☐ Yes ☐ No
10. Description of services provided: _____
11. Does the applicant have any point of care operations? ☐ Yes ☐ No

    If yes, please explain: _____
12. Does the applicant own any other medical-related business not shown on this application? ☐ Yes ☐ No
13. Gross Revenue:

	Projected	Current Year	1 Year Prior	2 Years Prior	3 Years Prior
Gross Revenue	$	$	$	$	$

14. How many years has the applicant been in operation? _____
15. Within the next twelve month period, does the applicant plan to: (If yes to any of the below, please explain)
    - Obtain another operation or entity? ☐ Yes ☐ No
    - Add to the number of employees? ☐ Yes ☐ No
    - Expand the number of locations? ☐ Yes ☐ No
    - Eliminate/add current services? ☐ Yes ☐ No
    - Operate in other states? ☐ Yes ☐ No
16. Within the past five years has the applicant acquired, sold or discontinued any operations: ☐ Yes ☐ No

    If yes, please explain: _____
17. Are all services provided by a medical prescription or physician order? ☐ Yes ☐ No
18. Where does the applicant provide services for the client? Must equal 100%

☐ Applicant's Locations	____ %	☐ Patient's Homes	____ %	☐ Physician Offices	____ %
☐ Long Term Care Facility	____ %	☐ Hospital	____ %		
☐ Mobile Facility	____ %	☐ Schools	____ %		
☐ Jail/Prison	____ %	☐ Other (explain)	____ %		

Organizational Accreditation/Certification

Accredited*? ☐ Yes ☐ No If yes, by what organization and specific to what operation? _____

Certified? ☐ Yes ☐ No If yes, by what organization and specific to what operation? _____

***If accredited, please provide a copy of your most recent report**

19. Has the applicant's accreditation, certification or license been suspended or revoked? ☐ Yes ☐ No

    If yes, please explain: _____

Please provide information on your professional liability insurance history:

	Current Year	1st Prior Year	2nd Prior Year
Policy Year			
Company			
Limits of Liability			
Liability Deductible (if any) or Self-Insured Retention	☐ Deductible $ ☐ SIR $	☐ Deductible $ ☐ SIR $	☐ Deductible $ ☐ SIR $
Claims Made or Occurrence	☐ CM ☐ Occurrence	☐ CM ☐ Occurrence	☐ CM ☐ Occurrence
If Claims Made, Retroactive Date			
Premium			

20. Has any insurance carrier canceled or refused to renew coverage? _____ ☐ Yes ☐ No
    If yes, please explain: _____

IV. ADMINISTRATION AND STAFF

A. Provide information for the Medical Director providing services at applicant's facility.

Attach additional sheet if necessary.

Medical Director	Specialty Board Certification	Ins. Carrier, Policy Number and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month

B. Provide information for the physician/surgeon providing services at applicant's facility. Attach additional sheet if necessary.

Physicians/Surgeons	Specialty Board Certification	Ins. Carrier, Policy Number and Limits	State of Licensure	License Number	Employee/ Contractor	Hours/ Month

1. Are physicians and licensed independent practitioners credentialed? ☐ Yes ☐ No
2. Is credentialing and privileging formalized? ☐ Yes ☐ No
3. Is new technology included in the delineation of privileges? ☐ Yes ☐ No
4. Does the applicant require employed or contracted physicians and surgeons to carry professional liability insurance?
   ☐ Yes, in by-laws ☐ Yes, in contract ☐ No (If no, please explain)
   _____
5. Indicate minimum professional liability insurance limits required for:
   Employed/Contracted Physicians/Surgeons $_____Each Claim $ _____ Aggregate
6. How often do you verify Professional Liability Insurance? _____
7. Has there **ever** been any review by a state medical board or other federal, state, or non-governmental oversight entity of any health care professional with privileges at the applicant's facility? ☐ Yes ☐ No
8. Has any health care professional with privileges in the applicant's facility **ever** had their license suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
9. Has any health care professional with privileges in the applicant's facility **ever** had their DEA license suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
10. Have any limitations or conditions **ever** been imposed on any health care professional's privileges? ☐ Yes ☐ No

Allied Healthcare Professionals

Indicate number of personnel in each applicable category:

	Employees		Contractors		Volunteers	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
Administration (Office/Clerical)						
Nurses						
Technologist - Nuclear						
Technologist - Radiologic						
Technologist – Ultrasound (Sonographers)						
Other:						

V. HIRING/SCREENING/TRAINING PROCEDURES

1. Do your screening/hiring procedures contain any of the following?
   - Educational background ☐ Yes ☐ No
   - Previous employers/employment history (PRIOR to hiring or placement) ☐ Yes ☐ No
   - Personal references ☐ Yes ☐ No
   - How are references checked? ☐ Written ☐ Verbal ☐ Both
   - Hospital privileges for physicians ☐ Yes ☐ No
     How often do you update your list of specific privileges? _____
   - Pending license suspensions, revocations ☐ Yes ☐ No
   - Pending disciplinary actions by other facilities ☐ Yes ☐ No
   - Criminal background check ☐ County ☐ State ☐ Federal ☐ None
   - Medical professional claims history ☐ Yes ☐ No
2. Are each of your hiring procedures indicated above followed and documented? ☐ Yes ☐ No
3. If an individual has had a previous claim, license suspension or revocation, how does that impact your procedures for hiring that person? Are any additional criteria applied? ☐ Yes ☐ No
4. What training is provided for new staff (e.g. aides, volunteers, technicians)?

   _____
5. Are written job descriptions established for all employees and volunteers? ☐ Yes ☐ No
6. Before staff can provide care, is a competency based checklist used to assess and document their skills? ☐ Yes ☐ No

VI. RISK MANAGEMENT/QUALITY ASSURANCE

1. Does the applicant utilize a formal written Quality Improvement? ☐ Yes ☐ No
2. Does the applicant utilize a formal written Risk Management Program? ☐ Yes ☐ No
3. Does the governing body periodically review the program for effectiveness and approve necessary changes? ☐ Yes ☐ No
4. Is there a peer review process in place? ☐ Yes ☐ No

Medical/Patient Records

1. Are records stored: ☐ Electronically ☐ Paper Files ☐ Both
2. How long are records stored? _____
3. If electric, how often are backups made? _____
4. If paper, where are records stored? ☐ On site ☐ Off site
5. Do the buildings in which paper records are stored contain sprinklers? ☐ Yes ☐ No
6. Who has the overall responsibility for Risk Management & Quality Assurance?

   Name _____

   Title _____

   Telephone Number _____

   E-Mail Address _____

VII. PROFESSIONAL LIABILITY EXPOSURES

Please describe the type of procedure or imaging being performed (in revenue):

Type of Imaging Procedure	Projected Visits	Projected Revenue	Current Year Visits	Current Year Revenue	1st Prior Year Visits	1st Prior Year Revenue
Angiography						
Bone Density Scan						
MRI						
CAT/CT						

Mammogram						
Sonograms, Ultrasound						
X-Ray						
PET Scan						
EKG and EEG						
ESI, Electron Microscopic Imaging						
Fluoroscopy						
Gamma Camera						
Non-Vascular Interventional						
Vascular Interventional						
Particle Accelerators						
Stress Tests						
Terahertz Radiation						
Therapeutic Radiology, Cobalt						
Other (describe)						

For any “No” answers, please explain:

Contrast Media

a. Are there policies and procedures regarding the use of contrast agents and localization markers? ☐ Yes ☐ No

b. If the applicant is injecting contrast media, complete the following:

☐ Ionic _____% of use

☐ Nonionic _____% of use

☐ Low Osmolar _____% of use

c. Are there protocols for the use of contrast media?

Ionic	☐ Yes	☐ No	☐ N/A
Nonionic	☐ Yes	☐ No	☐ N/A
Low Osmolar Weight	☐ Yes	☐ No	☐ N/A

d. If the applicant is injecting contrast medial is a physician present during the procedure? ☐ Yes ☐ No

If no, explain level of supervision: _____

e. Is informed consent for special or invasive procedures including injection of contrast or other media obtained? ☐ Yes ☐ No

f. Is the informed consent documented in the medical record? ☐ Yes ☐ No

g. Before any contrast media is administered, is the patient asked about previous allergic responses or sensitivity? ☐ Yes ☐ No

h. Is there a written policy for handling allergic reactions including cardiac or respiratory arrests? ☐ Yes ☐ No

i. Is emergency resuscitation equipment (oxygen, suction, defibrillator, monitor, emergency drugs) available? ☐ Yes ☐ No

j. Are all technologists directly supervised by a radiologist during all invasive procedures? ☐ Yes ☐ No

Policies and Procedures

a. Are all results reviewed by an employed/contracted radiologist? ☐ Yes ☐ No

b. Does the same radiologist interpret the film, dictate and sign the report? ☐ Yes ☐ No

c. Is there a procedure to properly match the correct patient with the correct diagnostic exam? ☐ Yes ☐ No

d. Is there a written procedure for communicating results to patients and the patients' practitioner via letters or phone calls? ☐ Yes ☐ No

e. Is there a recall or reminder system for repeat exams? ☐ Yes ☐ No

f. Is there a policy and procedure to ensure communication of abnormal findings with referring healthcare providers? ☐ Yes ☐ No

g. Are there policies and procedures for written communication of mammogram results directly to patients as well as to referring healthcare providers within 30 days? ☐ Yes ☐ No

h. Is there a policy and procedure for the release of original mammogram films at the patient's request? ☐ Yes ☐ No

i. Does the policy include a procedure for copying released original films and tracking and return of released original films? ☐ Yes ☐ No

j. Is there a policy and procedure for referral of self-referred patients to a physician when clinically indicated? ☐ Yes ☐ No

k. Is there a policy and procedure for archiving films of x-ray image data in an accessible format for a specific period of time? ☐ Yes ☐ No

l. Has the applicant implemented a digital PAC radiology system? ☐ Yes ☐ No

m. Are there policies and procedures to ensure compliance with the security and privacy regulations of identifiable healthcare information under the healthcare Insurance portability and Accountability Act? ☐ Yes ☐ No

Staffing

a. Do technicians/technologists hold specialized certificates? ☐ Yes ☐ No
   If yes, please list:_____

b. Are all technologists graduates of formal education programs or appropriately certified (e.g. by the American Registry of Radiologic Technologists or by the American Registry of Clinical Radiograph Technologists)? ☐ Yes ☐ No

c. Are all technologists state registered or licensed? ☐ Yes ☐ No

d. Do technicians performing mammograms meet the education and training requirements of MQSA regulations? ☐ Yes ☐ No

e. Are any technicians "grandfathered" or hold limited permits? ☐ Yes ☐ No

f. Qualifications of radiation safety officer: _____

Tele-radiology

a. Is Tele-radiology used? ☐ Yes ☐ No
   If yes, answer the following:
   - Are films transmitted interstate? ☐ Yes ☐ No
   - Are all radiologists participating in Tele-radiology credentialed? ☐ Yes ☐ No
   - Is the "reading" physician licensed in all states in the service area? ☐ Yes ☐ No

   Please list all states that services are provided in: _____

   Please list all physicians providing Tele-radiology services and the states:

Physician Name	State

   - Does the reading physician reside outside of the US and its territories? ☐ Yes ☐ No
     If yes, explain:_____
   - Is there a Tele-radiology policy concerning maximum amount of image compression needed to ensure accurate transmission of images for diagnostic purposes? ☐ Yes ☐ No
   - Do you provide or are you contracted with a "nighthawk" radiology service? ☐ Yes ☐ No
     If yes, provide a copy of your contract.

Mobile Radiology Services

a. Does the applicant transport any radiology equipment? ☐ Yes ☐ No
   If yes, answer the following:
   1. What is the percentage of service overall that mobile radiology represents?_____%
   2. Do you provide services using mobile equipment at off site locations? ☐ Yes ☐ No
      If yes, to whom:_____

      What services are you providing?_____

Patient Safety

Are patient safety precautions taken, including:

a. Identifying the patient and the exam? ☐ Yes ☐ No

b. Wearing gonad shields and lead aprons (when appropriate)? ☐ Yes ☐ No

c. Asking all female patients if they could be pregnant, notifying the physician, and recording this information in the patient's medical record? ☐ Yes ☐ No

d. Identification of patients who cannot be safely scanned by MRI? ☐ Yes ☐ No

Equipment Safety

a. Is there a comprehensive quality assurance/safety program that includes calibrating equipment, identifying operating irregularities, utilizing controls/phantoms, etc? ☐ Yes ☐ No

b. Is there complete documentation of proper use and maintenance of equipment? ☐ Yes ☐ No

If yes, does documentation include:

1. Records of periodic calibrations? ☐ Yes ☐ No
2. Monthly inspection and preventive maintenance activities? ☐ Yes ☐ No
3. Documentation of routine safety surveys? ☐ Yes ☐ No

c. Is there a documented radiologic internal disaster plan available that is reviewed and tested at least yearly? ☐ Yes ☐ No

d. Are carbon dioxide or other approved fire extinguishers available in the facility? ☐ Yes ☐ No

e. Is there a policy and procedure for use, administration, and disposal of radio-pharmaceuticals? ☐ Yes ☐ No

VIII. GENERAL LIABILITY

Do you desire general liability coverage? ☐ Yes ☐ No *If yes, complete this section. If no, skip to Section XI.*

1. Is there a preventive and corrective maintenance program in place for the bio-medical equipment and surgical machines or devices at the facility? ☐ Yes ☐ No
   a. How often are non-expendable medical or surgical machines or devices inspected and maintained?
   _____
   b. Who performs the maintenance of the above equipment? ☐ Employees ☐ Independent Contractors
   c. If independent contractor, what is the minimum general liability limit that you require them to carry?
   $_____ / $_____
   d. Do you obtain a certificate of insurance annually to verify this coverage is in place? ☐ Yes ☐ No
2. Is any of the bio-medical equipment used at your facility owned by physicians? ☐ Yes ☐ No
   If yes, who is responsible for the preventive maintenance, inspection and repair of the equipment?
   _____
3. Do you lend or donate your bio-medical equipment to others for their use? ☐ Yes ☐ No
   If yes, describe: _____
4. Do you rent or lease medical equipment from others? ☐ Yes ☐ No
   If yes, who is responsible for the maintenance of the equipment? _____
5. Do you use an advertising agency? ☐ Yes ☐ No
   If yes, what is the minimum professional liability limit that you require them to carry? $_____ / $_____
   a. Are you included as an additional insured on the advertising agency's policy? ☐ Yes ☐ No
   b. Is there a hold harmless agreement in the contract in favor of your facility? ☐ Yes ☐ No
6. Are there any plans for new construction or renovations during the next 12 months? ☐ Yes ☐ No
   If yes, please describe the changes planned including the time frame and the estimated cost: _____
   _____
7. Please indicate below which of the following apply and specify the corresponding projected number or amount of receipts for the next 12 months:
   Habitational Risk: Indicate if an: ☐ Apartment ☐ Dwelling ☐ Hotel
   Number of units: _____ Year built: _____
   a. Are there at least two exits located remotely from each other? ☐ Yes ☐ No
   b. For apartment buildings and hotels, are there lighted emergency exit signs? ☐ Yes ☐ No
   ☐ Pay Parking Receipts per year: _____
   ☐ Special Athletic or Fund Raising Events Receipts per year: _____
   Describe planned events for the upcoming year and indicate if alcohol will be served:
   _____
   _____
   _____

8. Do you lease or rent space to others? ☐ Yes ☐ No
   If yes, indicate the following:
   City, State and Zip Code: _____
   Square Footage: _____ Occupancy/Use of Space: _____
   a. Does your lease require the tenant to carry general liability insurance with at least a $1,000,000 limit? ☐ Yes ☐ No
   b. Do you obtain a certificate of insurance annually to verify this coverage is in place? ☐ Yes ☐ No
   c. Is the tenant required to list you as an additional insured on their general liability policy? ☐ Yes ☐ No

IX. Excess Liability

Do you desire excess liability coverage? ☐ Yes ☐ No *If yes, complete this section. If no, complete application.*

1. Excess Liability request limit $_____ per claim, $_____ aggregate in excess of primary coverage limits.
2. Have your excess professional or commercial general liability limits been increased within the last five year? ☐ Yes ☐ No
   If yes, what was the prior limit an when was it increased? _____
   _____

X. LITIGATION/CLAIMS HISTORY/SANCTIONS/FINES

If the response is yes to any question below, additional information must be provided on the applicant's letterhead.
Please submit actual loss runs from the previous carriers for the past five or more years.

d. Has the applicant had any Professional or General Liability claims or suits brought against them in the past five years? ☐ Yes ☐ No
e. Is the applicant aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ☐ No
f. Has the facility/operations license ever been suspended, revoked or voluntarily surrendered? ☐ Yes ☐ No
g. Has any Insurance Company declined, canceled or refused to renew or accept any of the applicant's liability insurance? ☐ Yes ☐ No
h. Has the Company with whom the applicant been previously affiliated with become insolvent? ☐ Yes ☐ No
i. Has any federal or state civil or criminal investigation or action been initiated or filed that directly or indirectly involve the applicant's organization? ☐ Yes ☐ No
j. Has the applicant ever been sanctioned or decertified by Medicare? ☐ Yes ☐ No
k. Has the organization or any of it's officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional medical society, accreditation agency or other governmental or non-governmental oversight entity? ☐ Yes ☐ No

Provide the following for each claim, suit or incident (attach additional sheets if necessary):

Date of Accident:	Date of Notice:
Amount Paid or Reserved: $	Claimant:
Insurance Carrier:	
Allegations:	
Description of Treatment Rendered:	

Date of Accident:	Date of Notice:
Amount Paid or Reserved: $	Claimant:
Insurance Carrier:	
Allegations:	
Description of Treatment Rendered:	

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

This application does not bind the Applicant to buy, or the Company to issue the Insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the date of this application and the time when the policy is issued, the Applicant will immediately notify the Company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

SIGNATURE OF APPLICANT X_____ **DATE X** _____

(Must be signed by principal partner or officer of group or individual applying for insurance.)

Producer: _____ Phone Number: _____

Producer's Address: _____

Tax I.D. Number:_____

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 five thousand dollars and the stated value of the claim for each such violation.

Note: The professional liability coverage being applied for is Claims Made. If there are questions concerning these coverages, please contact your insurance agent.