Urgent Care Center Application

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This is an Application for Professional Liability coverage written on a claims made basis. Coverage is limited to liability for claims first made against an Insured and reported to us during the policy period or any applicable Extended Reporting Endorsement period immediately after the expiration of the policy period or to any retroactive data applied in the rating process.

The Applicant represents that the statements and facts are true and no material facts have been omitted, suppressed or misstated. If a policy is issued, this Application will become part of the policy as if physically attached. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

Instructions:
1. Please type or print clearly.
2. Answer ALL questions completely, leaving no blanks. If questions do not apply, mark with "N/A".
3. If you need more space for responses, continue on a separate sheet and indicate question number.
4. This form must be completed, dated and signed by a principal of your facility.

I. General Information

Applicant/ Business Name:		Date Business Started:		Federal Tax ID#:	
Business Address:					
Mailing Address:					

Contact:							
Phone:		Fax:		E-mail:		Website:	

Please complete the following as it relates to the location of your facility:

Location #1:	Address:
Date this location opened:	Estimated # of annual patient visits seen at this location:
Distance to nearest hospital:	Level of Hospital E.D. ☐ 1 ☐ 2 ☐ 3

Location #2:	Address:
Date this location opened:	Estimated # of annual patient visits seen at this location:
Distance to nearest hospital:	Level of Hospital E.D. ☐ 1 ☐ 2 ☐ 3

Location #3:	Address:
Date this location opened:	Estimated # of annual patient visits seen at this location:
Distance to nearest hospital:	Level of Hospital E.D. ☐ 1 ☐ 2 ☐ 3

For additional locations use separate sheet of paper or reverse side.

☐ Institutional Urgent Care Center	Urgent care services are the primary activities of your organization. Your organization may be considered a designated emergency department. Locations are serviced with multiple physicians who may have the ability to hold patients for several hours. Some or all locations may have the ability to provide a full scope of x-ray and lab services.
☐ Urgent Care Center	Urgent care services are the primary activities performed by your organization. Physicians regularly staff your locations with the support of mid-level providers. Services provided are sometimes broader in scope than those typically found in a physician's office. Locations may offer a range of services including physical therapy, occupational therapy, occupational health (Workers Compensation exams), on site x-ray and clinical lab. No hospital admissions.
☐ Convenience Care Center	Locations are generally staffed by nurse practitioners and physician assistants. Physicians are not usually present at your locations. Medical treatment is typically offered at small offices with a limited level of non-emergent care relative to a physician's office.
☐ Other	Please provide a description of your organization if it does not readily reflect one of the above categories. Note the nature and extent of operations dealing with workers compensation and occupational medicine. Note any operations involving surgical procedures. Note if your operations more closely resemble a Primary Care facility, or if the facility works in conjunction with a Primary care facility. (Please attach a separate page.)

Requested Effective Date:	Requested Retroactive Dates provide schedule by physician:
Current Coverage for Professional Liability: ☐ Claims-made: Retroactive date:	☐ Occurrence

Applicant is a:	☐ Corporation	☐ Partnership	☐ Partnership Association
	☐ Sole Proprietorship	☐ Joint Venture	☐ Other (Please Explain)

Limits of Liability: ☐ $250,000/$750,000 ☐ $1,000,000/$3,000,000 ☐ Other:

Has the applicant sold, acquired, or discontinued any operations in the past ten (10) years? ☐ Yes ☐ No

If yes, please explain (Attach a separate sheet if necessary):

II. Physician Roster

Physician Member	Employment Date	Hours Per Week Worked	Primary Location Worked

Please indicate all services provided by your facility, giving requested information for each classification. Information given should be projected visits for the next 12 months. "Visits are defined as the number of patients treated at your facility.

Type of service provided: (Services listed are not limited to the examples used.)	# of Visits Projected for Next 12 Months	# of Visits for the Current Year
Preventative/Diagnostic This includes Corporate Health, Physicals, Immunizations, Allergy Shots, Alcohol/ Drug Testing and Blood Pressure Screenings.		
Non-Emergent Care This includes Abrasions, Animal and Insect Bites, Minor Burns, Cough, Earaches, Flu, Minor Fractures, Minor Lacerations, Sore Throat and Sprains.		
Emergent Care This includes Moderate/Severe Burns, Fractures, Allergic Reactions, Breathing Difficulties,Chest Pain or Pressure.		
Occupational Medicine dealing with workers compensation claimants		

III. Clinical Operations

Please check any auxiliary services provided by your Urgent Care Facility or any of its subsidiaries.

☐ Radiology	☐ Laboratory	☐ Pharmacy	☐ Treatment for chronic pain
☐ PT/OT	☐ Family Practice	☐ Pre-Surgical Physicals	☐ Medi-Spa
☐ Women's Health Services	☐ Pediatrics	☐ Other:	

If you have a Pharmacy or dispense samples do you have a policy and procedure for dispensing, stocking and documentation?	☐ Yes ☐ No
If yes, is the Pharmacy or samples dispensed by an automated system. Note: If "yes then no", please provide documentation (i.e. Bar Coding, connected to Electronic Medical Records, paper label system for medical charts, securing room and drug cabinets, documentation managing samples etc).	☐ Yes ☐ No
If you provide X-Rays, are they digital?	☐ Yes ☐ No
Are your X-Rays over read by a Radiologist?	☐ Yes ☐ No
If "yes", are they: ☐ All reviewed ☐ Only certain types reviewed % Over Read: Additional details:	
If not over read by a Radiologist, does a Physician review 100% of the X-Rays?	☐ Yes ☐ No
Is there a MD, DO, NP, or PA-C onsite during all hours of operation?	☐ Yes ☐ No
Does the Urgent Care Facility or any of its subsidiaries participate in any experimental, investigational or other unconventional therapies including any alternative medicine activities?	☐ Yes ☐ No
Does the Urgent Care Facility or any of its subsidiaries participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?	☐ Yes ☐ No
Does the Urgent Care Facility or any of its subsidiaries contract to provide services to any federal or non federal prisons?	☐ Yes ☐ No
Does the Urgent Care Facility or any of its subsidiaries contract to provide services to any nursing home or long term care facility?	☐ Yes ☐ No
Is triage performed by a MD, DO, NP, PA-C, or RN?	☐ Yes ☐ No

IV. Quality Assurance

Please indicate by checking the appropriate box(es) the accreditation(s) your facility currently has, if applicable			
☐ AAUCM	Most recent survey date:	☐ AAAHC	Most recent survey date:
☐ JCAHO	Most recent survey date:	☐ NAFAC	Most recent survey date:
☐ UCAOA	Most recent survey date:	☐ AAAASF	Most recent survey date:
Please list any other accreditations and include the most recent survey date:			

Is there a committee or provider in place that performs quality reviews?	☐ Yes ☐ No
Do you perform chart audits?	☐ Yes ☐ No
If "yes", how often are audits performed?	
If "yes", is there feedback given to the providers and staff?	☐ Yes ☐ No
If "yes", do the audits include specific high risk diagnosis reviews with feedback to the staff?	☐ Yes ☐ No
Are medical records reviewed against specific criteria on a regular basis?	☐ Yes ☐ No
Do any of your Physicians or Mid Level providers annually attend seminars, conferences or presentations that address risk reduction and patient safety?	☐ Yes ☐ No
Do you or a contracted company maintain your Medical Equipment QA logs and is the equipment checked per the manufacturer's recommendations?	☐ Yes ☐ No
If there is more than one location, do you have in place common P&Ps, RM and QA plans?	☐ Yes ☐ No
Do you have an internal training program for your support staff and PAs? If "yes", please attach a description to this application.	☐ Yes ☐ No
What is the length of the orientation and training period for new employees and volunteers?	
Does it include training for the proper use of equipment and special training for high tech areas?	☐ Yes ☐ No
Do you utilize an Electronic Medical Record Keeping System?	☐ Yes ☐ No
If "yes", please identify the company:	
Do you maintain a crash cart?	☐ Yes ☐ No
If "yes", is there someone with ALS training on site during all hours of operation?	☐ Yes ☐ No
Do you have a defibrillator on premises?	☐ Yes ☐ No
If applicable, will you cooperate with your Medical Professional Liability Insurer's risk reduction recommendations?	☐ Yes ☐ No
Are PA's supervised by on staff Physicians?	☐ Yes ☐ No
How many PA's are currently on staff?	

V. Credentialing/Hiring Practices

Does the Credentialing/Hiring Policies ensure:	
Application criteria are applied consistently?	☐ Yes ☐ No
Primary source verification is performed initially and at least every two years thereafter?	☐ Yes ☐ No

Please indicate all of the hiring/screening procedures used for professionals and allied healthcare professionals who provide patient care services at your facility:
☐ Check of educational background, or residency program, when applicable
☐ Check of previous employers ☐ In Writing ☐ By telephone
☐ Check of personal references ☐ In Writing ☐ By telephone
☐ Check on hospital privileges for physicians, nurse practitioners or physician's assistants
☐ Perform criminal background checks
☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities
☐ Require information on any professional liability or work-related claim that has previously been made against any individual

How often do you update your list of specific privileges applicable to your clinic?	
Are current licenses kept on file?	☐ Yes ☐ No
Are there written job descriptions for each category of employee and contractor?	☐ Yes ☐ No
Do you require that your Physicians and Mid Level Providers attend annual CE programs?	☐ Yes ☐ No
Are your Physicians Board Certified in Urgent Care Medicine, Emergency Medicine, Family Practice, or Pediatrics?	☐ Yes ☐ No
If no, please describe:	

VI. Patient Follow-Up

Please provide samples of post visit patient instructions.	
Do you have a Patient Follow-up/Call-back Procedure? Please describe:	☐ Yes ☐ No
Who is responsible for making the calls?	
Time frames for making the call? ☐ 24 hours ☐ 48 hours ☐ Other	
Documentation requirements?	
Parameters for physician communication?	
Do you have a formal waiting time and patient satisfaction survey system in place?	☐ Yes ☐ No
If "yes", how often for each one?	
If "yes", do you use an Interactive Electronic Patient Satisfaction Survey System as the patient is leaving your care?	☐ Yes ☐ No

VII. Loss History

Loss Description – On the attached Claims Questionnaire, please list any liability claims or suits made or brought against your facility or providers during the past five years.	
If no claims have been reported to you, then initial here:	
Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim?	☐ Yes ☐ No

Please Return the Application to: FAX (847)440-9126 Attn: Jordan Ready

I hereby certify that all of the information provided in this application, including any supplemental information requested and provided, is true and correct. I authorize the release and exchange of all information considered relevant by the company to the underwriting of this application and authorize any exchange of information between agents, government licensing agencies, any professional society or association of which I am a member, hospitals, health insurers, managed care organizations. I agree to indemnify and hold harmless from liability or expense any organization or individual supplying information to the company in good faith.

I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. Any information supplied that is found to be intentionally false and misleading may result in the voiding of coverage.

I understand this is a short version application intended to receive a pricing indication only. A completed long application will be necessary to complete underwriting review and provide coverage terms and pricing.

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Insurance is not effective until the full application is completed and approved by us, and a premium quotation with policy terms is issued by us, and the quotation and terms are accepted by you.

The policy issued by UCAC RRG will contain the following statement:

“This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group. Therefore, these funds will not play your claims or protect your assets if your risk retention group, the insurer, becomes insolvent and is unable to make payments as promised.”

Medical Malpractice Liability Application – Additional Information

Please include the following:

1. Copy of the written discharge instruction form you use after patients have received your care.
2. List of providers, their specialties, retroactive dates, CV's, loss statements (see last page).
3. Copy of current policy.
4. Currently valued; Med Mal Loss Runs – Current and prior four years (if applicable)
5. Completed claims questionnaire for each claim or incident (if applicable)

NOTES:

Entity Claim History Questionnaire

This form must be completed for every suit, incident or claim that has occurred prior to the date of your application for insurance.

Please provide copies of settlement or judgment in cases that are complete and copies of the complaint and other relevant papers, including hospital and medical records where appropriate in cases that are currently in progress.

Individual and Group Name:

Name of Patient:

Patient's Age and Sex:

Period during which you performed your services:

Nature of the complaint (Allegation) against you:

Was a lawsuit ever commenced in connection with this complaint? ☐ Yes ☐ No

If "Yes" specify the court in which it was filed and the date of filing:

Names of other defendants or potential defendants:

Name of your insurance carrier at the time:

What was the final outcome of this claim?

☐ Judgment or settlement for the plaintiff against you in the amount of:

☐ Judgment or settlement for the plaintiff against others in the amount of:

☐ Judgment or settlement for the defendant

☐ Claim or suit was withdrawn.

☐ Claim or suit is still pending.

Provide a summary of the clinical facts. (Use additional paper if necessary.)

Physician Claim History Verification

For each Physician covered under the policy we require either a signed “No Known Loss” statement or copy of their loss runs for the past 4 years.

Urgent Care Assurance Company
C/O Assurance Agency, Ltd.
One Century Centre 1750 East Golf Road
Schaumburg, Il 60173
Re: Claims History

To whom it may concern:

Please accept this statement as evidence of a clear loss history for the past four years. There have been NO claims brought against myself under any Malpractice policies for the past four years.

Sincerely,

Physicians Name (Printed):	
Signature:	Date: