

**INDIANA RESIDUAL MALPRACTICE INSURANCE AUTHORITY
HOSPITAL PROFESSIONAL LIABILITY APPLICATION**

IRMA RISK MANAGER
5814 Reed Road
Fort Wayne IN 46835-3568
Phone: 1-800-836-5727 Fax: 260-486-0782

Submitted by: _____ (Agency)

General Information – All questions must be completed “see attached” is unacceptable unless additional space is required). If additional space is required, it must be in the same format as the application. Please do not alter the application.

1. Legal Name of Hospital: _____
2. Registered DBA if applicable: _____
3. Address: _____

Street (must include physical address)	City	State	Zip	County
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4. Are there additional locations under the same license? YES NO
NOTE: If YES, all information for these locations must be reflected on the application (# of beds, visits etc).
5. Does the hospital/facility have a risk management program in place? YES NO
6. Ownership and type – Check all that apply:
 Individual Partnership Corporation Governmental Osteopathic
 For Profit Not For Profit Member AHA Medicare Approved Approved by Joint Commission on Accreditation

Attach a copy of the hospital license under IC 16-21-2 and a copy of the most recently completed DOH application to Operate as a Hospital.

Policy Information

7. Requested Effective Date: ____ / ____ / ____
8. Latest Insurer: _____ Policy #: _____ Expiration Date (mm/dd/yy): _____

Notes:

- a) Average number of beds occupied is the sum of the daily number of beds used for patients during the preceding 12 months divided by 365.
- b) Outpatient visits means the total number of visits made by patients who did not receive bed and board services.
- c) Please indicate “N/A” for any type of services not provided.

Inpatient Beds for Hospitals

	Total Number Maintained	Average Number Occupied
Hospital (Acute Care & Intensive Care)		
Mental Health/Rehabilitation		
Extended/Intermediate Care/Residential		
Nursing Home/Critical Extended Care		
Health Institution/Assisted Living/Other		
Bassinets		

Outpatient Visits for Hospitals

	Number of Visits
Emergency Room	
Clinics/Others	
Mental Health Rehabilitation	
Health Institution	
Home Health Care	

Surgeries/Births for Hospitals

	Number of Surgeries/Births
Births	
Outpatient Surgeries	
Inpatient Surgeries	

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Employee Information

9. Does the hospital employ any Physicians & Surgeons (MDs and DOs), *not contracted*?

- YES NO

If yes, please complete the following Employee Information section in full. Do not list full time administrative employees. All sections must be complete. If the answer is No, None or NA, please indicate this on the application.

Attach additional pages as necessary using the same format for each section. If there are more than 20 total employees, please send a disk containing an Excel file listing the employees in the same format as the application.

Name and Professional Designation	Indiana	Specialty	Sub-specialty	Surgery			OB	
	License #			None	Minor	Major	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Y	<input type="checkbox"/> N

10. Does the hospital employ any Dentist (*not contracted*)? YES NO

If yes, please complete the following Employee Information section in full. Indicate any listed techniques/procedures performed (CPT/CDT codes, where applicable). Do not list full time administrative employees. Attach additional pages as necessary.

Name and Professional Dental Designation _____ Indiana License # _____

Specify Practice
 General Dentistry Oral Surgery Dental Anesthesiology Oral Pathology Other _____

- Select from the following any techniques or procedures you perform:
- None
 - Unconscious Sedation
 - Intravenous/Intramuscular Conscious Sedation
 - Third Molar Extractions – Fully Impacted (D7240, D7241, D7250)
 - Third Molar Extractions – Partially Impacted (D7210, D7220, D7230)
 - Third Molar Extractions – Erupted (D71110, D7120)
 - Radiation Therapy

Name and Professional Dental Designation _____ Indiana License # _____

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HOSPITAL EXPOSURE WORKSHEET FOR SURCHARGE CALCULATION

Name of Hospital: _____

License Number: _____

List all facilities and/or services operated under the hospital license as identified on the Department of Health Application for License to Operate as a Hospital (**this section must be completed**):

CATEGORY	EXPOSURE
Provide # of Beds Maintained	
	Hospital (Acute care and Intensive Care)
	Mental Health/Rehabilitation
	Extended Care/Intermediate Care/Residential
	Nursing Home/Critical Extended Care
	Health Institution/Assisted Living
	Bassinets
# of Outpatient Visits	
	Emergency Room
	Clinics/Other
	Mental Health/Rehabilitation
	Health Institution
	Home Health Care
# of Surgeries/Births	
	Births
	Outpatient Surgeries
	Inpatient Surgeries
	# of Employed Physicians Sharing Limits

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IMPORTANT Please Read Carefully and Sign

By completing this application for professional liability insurance as the authorized representative of the applicant, I hereby affirm that all entities and employees seeking coverage are licensed to provide professional services in their specialty in the state of Indiana. I further affirm that I have made a diligent effort to obtain coverage as required by Indiana Code (IC) 34-18-17-6 and have been declined by two or more insurers as evidenced by the attached declination letters. I do hereby apply for coverage with IRMIA and warrant the above statements and answers. I also authorize the release of claim and suit information from any prior insurer.

The Medical Protective Company is the appointed "Risk Manager" for IRMIA and is providing the application solely under those auspices. As a result, the application for insurance is provided solely for the purpose of evaluating the applicant's qualifications for coverage under IRMIA and should not be seen as an offer of insurance from The Medical Protective Company. Pursuant to I.C. 34-18-17-3, The Medical Protective Company's separate, personal, and independent assets are not liable for or subject to use or expenditures for the purpose of providing insurance by IRMIA.

If the "Risk Manager" declines to accept your application, you will be notified of the decision in writing, including the reasons for the declination. If this occurs, you will have 10 days from the date of the notice to file an appeal with the Commissioner of Insurance who will review the decision of the "Risk Manager" and enter an appropriate order.

_____ Signature of Authorized Representative	_____ Title	_____ Date of Signature
_____ Printed Name of Authorized Representative		_____ Telephone Number
		_____ Fax Number

IMPORTANT: This application must be signed by both the applicant and the producer (if applicable).

_____ Signature of Producer	_____ Indiana P & C License Number	_____ Date of Signature	
_____ Name of Agency/ Independent Agent	_____ Telephone Number		
_____ Agency IRS Number	_____ Fax Number		
	_____ E-Mail Address		
_____ Agency Mailing Address	_____ City	_____ State	_____ Zip