Renewal Information
Facility/Ambulatory Surgery Center Professional Coverage

Facility Name: _____

Address: _____

Renewal Date: _____ Expiring Policy Number: _____

Tax ID #: _____

Contact Person: _____ Telephone #: _____

E-Mail Address: _____

1. Limits of Insurance:

	Yes	No
Are any changes to the expiring limits desired?	☐	☐

If yes, describe below:

_____

_____

2. Statistics:

Census Data: From:_____ To: _____

Inpatient	Licensed Number	Patient Days
Hospital Days – Acute	_____	_____
Hospital Days – Swing Bed	_____	_____
Extended Care	_____	_____
Psychiatric	_____	_____
Bassinets	_____	_____

Outpatient	Number
Emergency Room Visits	_____
Home Health Visits	_____
Psychiatric Visits	_____
Outpatient Surgeries	_____
Outpatient Visits (lab, x-ray, other services)	_____

Other	Number
Live Births	_____
Still Births	_____
Units of Blood	_____
Total Patient Admissions	_____

3. Special Events:

   Describe any special events sponsored by the hospital, e.g., carnivals, athletic events, tournaments, etc.

   _____
   _____
   _____

4. Premises Information:

   Describe any changes made to the facility's premises, e.g., additions, new purchases, disposal of property, new parking, property donated to the hospital, etc.

   _____
   _____
   _____

5. Additional Insureds:

   List any new additional insureds to be considered.

   _____
   _____
   _____

6. New Services:

   Does the hospital have plans for any new services or operations? Does the hospital plan to discontinue any services currently being offered?

   _____
   _____
   _____

7. Organization:

   Has the hospital made any changes to the organizational structure, e.g., mergers, acquisitions, subsidiaries, etc.?

   _____
   _____
   _____

8. Contracts:

   Has the hospital been involved in any new contracts that include a transfer of liability or hold harmless agreement?

   _____
   _____
   _____

9. Email Addresses:

   a. Administrator Name - _____
      Email - _____
   b. Risk Manager Name - _____
      Email - _____

10. Signature: _____

    Print Name: _____

    Title: _____

    Date: _____

AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance hereby authorizes applicant's present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which applicant is or has been a member, all hospitals in which applicant now holds or has held staff privileges, any state licensing board in any state which applicant has practiced, the Department of Health and Environment or any other similar agency in which applicant has practiced or resided, and any and all physicians having information regarding the undersigned, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants and employees and the Company, its directors, officers, employees, agents and members from any liability arising out of the release or use of any information released or furnished pursuant to the authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photo static copy of this Authorization, which shall be of equal validity with the signed original.

Signed: _____ Address: _____

Date: _____ _____