Print Form Clear Form Save

Healthcare Facility Limited Pollution Liability Supplemental Application

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Legal Entity Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Effective Date: _____ Retroactive Date: _____ Desired Limits: _____

1. General Information

List all subsidiaries/locations to which this insurance is to apply along with a brief description of same.

Subsidiary, Site/Location	Description

2. Application Addendum

Please include the following additional information with your application:

1. State Certification for Incinerator, if applicable.
2. Any contracts for disposal of infectious waste.
3. Copy of maintenance records demonstrating state compliance for leak detection.
4. Certification of installation for *each* storage tank.
5. Copies of Certificate of Insurance furnished you by others providing other insurance for any item(s) mentioned in the "*Storage Tanks*" section below.

3. Incinerators

A. Do you operate an incinerator? ☐ Yes ☐ No
If *yes*, who is responsible for disposal of infectious waste and maintenance of incinerator?
_____

B. Do you contract for services? ☐ Yes ☐ No
If *yes*, with what company? _____

C. Is the transportation and storage of infectious waste materials documented? ☐ Yes ☐ No
If *yes*, by whom? _____

D. Do you have an established waste management program? ☐ Yes ☐ No
If *yes*, who coordinates the program? _____

E. If the facility operates an incinerator, is there a policy for monitoring of infectious waste disposal? ☐ Yes ☐ No

F. Is documentation of such monitoring maintained? ☐ Yes ☐ No

G. Is there a policy for maintenance of the incinerator? ☐ Yes ☐ No

H. Is documentation of incinerator maintenance maintained? ☐ Yes ☐ No

I. Are emissions regularly analyzed for toxicity? ☐ Yes ☐ No

J. Are "red bags" of contaminated materials deposited on landfills or dumps without first being disinfected/sterilized? ☐ Yes ☐ No

4. Nuclear Medicine/Hazardous Waste

A. What kinds of pollutant or toxic wastes do you generate and dispose of?

i. Chemical: Toxic ☐ Yes ☐ No
Reactive ☐ Yes ☐ No
Corrosive ☐ Yes ☐ No

ii. Organic (i.e., bacteriologic, viral, etc.): ☐ Yes ☐ No

iii. Radioactive: ☐ Yes ☐ No

iv. Other: _____ ☐ Yes ☐ No

B. Is the facility aware of the rule published by OSHA which extends its Hazard Communication Standard to all employers (effective May 23, 1988)? **Note**: this rule applies to any chemical which is a physical or a health hazard, and to any employee who may be exposed to hazardous chemicals under normal operating conditions or in foreseeable emergencies. ☐ Yes ☐ No

C. Is the facility in compliance with the above rule? ☐ Yes ☐ No

D. Do you operate a nuclear medicine department at this facility (or any subsidiary, site or location listed under "*General Information*" above)? ☐ Yes ☐ No

If *yes*, list below and indicate what substances are used and disposed of on a regular basis.

E. Does this facility have and promulgate a policy on the handling, disposal and management of pollutants? ☐ Yes ☐ No

F. Does this policy include monitoring of how employees dispose of hazardous materials (i.e., mercury)? ☐ Yes ☐ No

G. Does this policy include monitoring of how employees dispose of hazardous waste? ☐ Yes ☐ No

H. Is each container of hazardous chemicals in the workplace legibly labeled, tagged or marked? ☐ Yes ☐ No

5. Miscellaneous

A. Have you ever been sighted by an authority for being in violation of any environmental laws?
If *yes*, give details: ☐ Yes ☐ No

B. Are you currently or have you in the past been involved with any environmental litigation?
If *yes*, give details: ☐ Yes ☐ No

C. Do you have a program in place for monitoring your environmental liabilities on an on-going basis? ☐ Yes ☐ No

D. Are you aware of any asbestos exposures within your facility(s)?
If *yes*, describe and advise of any future plans of abatement: ☐ Yes ☐ No

E. If insurance for any of the above sections is the responsibility of other than you, does the other policy(s) include pollution incidents? ☐ Yes ☐ No

F. What are the limits of liability? _____

G. Do you have a certificate of insurance from the insurer verifying this insurance? ☐ Yes ☐ No

6. Storage Tanks

A. Do you have storage tanks? ☐ Yes ☐ No

If *yes*, please complete the chart below in full for each tank.

TANK	1	2	3	4	5	6	7	8	9	10
Capacity of tank (gallons)										
Age of tank (years)										
Installation date (months/year)										
Was the tank new upon installation?										
Was tank precision tested after installation?										
Material stored in tank (indicate by (X) under appropriate tank):										
Gasoline										
Diesel										
Kerosene										
Heating oil										
Other:										
Construction of tank (indicate by (X) under appropriate tank):										
Tank in vault										
Doubled walled tank										
Fiberglass Steel Coated										
Cathodically protected steel										
Fiberglass										
Fiberglass lined steel tank										
Spill/Overfill protection?										
Leak detection?										
Are tanks in compliance with State and Federal regulations?										
How often are tanks tested?										

B. Environmental Factors:

i. What is the distance to the nearest surface water source? _____

ii. What is the distance to the nearest drinking water source? _____

iii. What is the depth to the groundwater? _____

iv. What is the distance to the sewer line hook-up? _____

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____

Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):			
Agent:		Phone:	
Agency:		Fax:	
Address:		Email:	
		License No.:	
Signature:			

HEALTH CARE FACILITY APPLICATION ADDENDUM

PCF SCHEDULE OF ENTITIES AND D/B/A'S

NOTE: In compliance with the Indiana Patient Compensation Fund Guidelines all eligible entities and business names (D/B/A's) operating under the hospital's license must be scheduled on the Patient Compensation Fund Certificate, and remit the applicable surcharge to be extended coverage by the Patient Compensation Fund. Rating exposures (including but not limited to outpatient visits, one day surgery procedures, home health visits, inpatient days, etc.) of scheduled entities and operations are to be included on the Health Care Facility Application.

Other hospital owned or controlled eligible entities and D/B/A's operating under separate licensure must make separate PCF application, pay applicable surcharge, and meet underlying primary coverage requirements. Failure of the hospital to comply with PCF requirements could result in a declination of coverage by the Patient Compensation Fund.

Name:	**Tax ID #**	**Health Dept License #**