MedPro Group
a Berkshire Hathaway company

ssuing Company:
National Fire & Marine Insurance Company
Omaha, Nebraska

HOSPITAL LIABILITY INSURANCE APPLICATION - RENEWAL

INSTRUCTIONS

1. Please answer all questions. If a question is not applicable, print, "n/a".
2. This application must be completed and signed by an authorized officer of the applicant.
3. If additional space is needed, please use the Supplemental Information section at the end of the application and refer to the question or an additional form.

I. PRODUCER INFORMATION

Starke Agency
Firm Name

210 Commerce Street
Mailing Address

Montgomery AL 36104
City/State/Zip

Individual Name

3342635535
Phone

info@starkeagency.com
E-Mail

II. APPLICANT INFORMATION

A. Applicant Name: Evergreen Medical Center LLC dba: Evergreen Medical Center

B. Please identify any changes to the applicant's list of subsidiaries and insureds:

None

C. Please identify any changes in the executive leadership team:

None

D. Please identify any changes in third-party managers or management of any facilities the applicant manages:

None

III. COVERAGE

A. Does the applicant want to change the current insurance structure: ☐ Yes ☒ No

If Yes, please explain the desired changes (limits, deductibles, SIR, etc.) _____

B. Self-Insured Retention (SIR):

1. Please identify any change in SIR coverage: None
2. Describe method of SIR funding, if changed:
   ☐ Dedicated Trust ☐ Balance Sheet Accrual ☐ Operating Capital ☒ Captive
3. Has an independent actuarial funding study been completed? ☐ Yes ☒ No
   If Yes, provide a copy.
4. Provide current SIR funding balance: $ $0.00 As of date: _____
5. Please identify any changes in SIR claim handling: None

   If TPA has changed, provide contact information below:
   n/a
   Third Party Administrator
   2100 Riverchase Center, Suite 218, Birmingham, AL 35244
   Mailing Address
6. Please identify any changes in law firm(s) utilized for claims: n/a

IV. EXPOSURES

HOSPITALS

A. Please complete the data below for the upcoming year and the last 5 years, or provide an attachment inclusive of all of the information requested.

Total Number of Licensed Beds: 44

	Projected this Year	Prior Year 1 (Expiring Year)	Prior Year 2	Prior Year 3	Prior Year 4	Prior Year 5
Occupied Beds by Type						
Acute Care	35	35	35	35	35	35
Bassinets & Cribs						
Neonatal						
Chemical Dependency						
Long Term Acute Care (LTAC)						
Psychiatric						
Rehabilitation						
Skilled Nursing/Hospice						
Sub-Acute Care Beds						
Intermediate Care Beds						
Assisted Living Beds						
Residential/Independent Living Beds						
All Other, please describe: _____						
Procedures						
Births						
Outpatient Surgeries			369	340	355	360
Inpatient Surgeries			124	133	118	140
Outpatient Visits (Provide number of patient visits, not number of procedures)						
Emergency	6000	6145	5952	5527	5378	5512
Home Health	4400	4318	4753	5124	5430	5501
Physician Office Practice	6000	5324	4118	4262	2128	1367
Psychiatric						
All Other, please describe: _____						
Ancillary Services (if a revenue generating business for other than the applicant's patients)						
Med & X-Ray Labs Receipts						
Pharmacies Receipts						

IV. EXPOSURES (continued)

ALLIED PROFESSIONALS

B. <u>If coverage is requested</u>, please provide the information below or attach a spreadsheet with the same information:

	Active Number of FTE's				
Class	**Current Year**	**Prior Year**	**Retro Date if other than applicant's**	**Limits Shared (SH) or Separate (SE)**	**Employed (E) or Contracted (C)?**
Certified Registered Nurse Anesthetist (CRNA)				☐ SH ☐ SE	☐ E ☐ C
Nurse Midwife				☐ SH ☐ SE	☐ E ☐ C
Nurse Practitioner				☐ SH ☐ SE	☐ E ☐ C
Physician's Assistant				☐ SH ☐ SE	☐ E ☐ C
Podiatrist				☐ SH ☐ SE	☐ E ☐ C
Other:				☐ SH ☐ SE	☐ E ☐ C

If separate limits are indicated above, or separate limits are required for State Fund/PCF compliance, please complete the Ancillary Healthcare Professional Liability Application or if the applicant prefer providers to be specifically named on the policy schedule, please complete the following or attach a spreadsheet with the same information.

Name of Medical Professional Last Name, First Name, Middle Name	Employed (E) or Contracted (C)?	State	Class	Retro Date	License Number
	☐ E ☐ C				
	☐ E ☐ C				
	☐ E ☐ C				
	☐ E ☐ C				
	☐ E ☐ C				

If the applicant has continuing risk in connection with departed providers, please provide a roster with such providers' names, specialties, hire dates, termination dates, number of hours worked, and license numbers.

IV. EXPOSURES (continued)

PHYSICIAN/SURGEON

C. Please provide the information below for each physician, surgeon, resident, intern, fellow, dentist and oral surgeon for whom coverage is to be provided under this policy. If additional space is needed, please use an additional piece of paper and include all information requested in the Schedule of Medical Professionals, below.

Coverage is provided on a limited duty and scope basis unless otherwise requested. If coverage for separate limits is required for State Fund/PCF compliance or outside activities is being requested please complete the Hospital Physician Application. Coverage is designed to provide retroactive dates equal to the hire date of the applicant unless otherwise requested.

Employee Status: (C)ontract; (E)mployed; (F)aculty; (R)esident
Limits: (SH) Shares limits with the facility, restricted to the named insured's operations.
(SE) Separate limits, restricted to the named insured's operations.

If the applicant has continued exposure from departed physicians, please include in the table below.

SCHEDULE OF MEDICAL PROFESSIONALS—PHYSICIANS, SURGEONS, DENTISTS AND ORAL SURGEONS

Name of Medical Professional Last Name, First Name, Middle Name	Status (C) (E) (F) (R)	State	County	Specialty ISO-Code-List all that apply. (Please see ISO Code Reference)	Retro Date	Hire Date	Termination Date (if applicable)	Number of hours per week if less than 40	License #	Limits (SH) (SE)
All Certified Registered Nurse	E	Alabama							[redacted]	
Provider FTE 1	E	Alabama			10/20/1977					
Jeffrey Dean Voreis MD	E	Alabama			03/19/2020				[redacted]	
Benjamin Louie Stalnaker Jr MD	E	Alabama			04/01/2022		10/02/2023		[redacted]	
William Roy Farmer III MD	E	Alabama			06/01/2014		10/02/2023		[redacted]	

TOTAL EMPLOYEES

D. Provide the total number of employees: 150

E. Provide the total number of full time equivalents (FTE's): 105

V. SERVICES

Please identify any change in business/services over the past 12 months:

☐ Discontinued Operations ☐ New Construction ☐ New Services added ☐ Acquisitions ☒ Other

None

VI. GENERAL LIABILITY

A. Please identify any changes in GL exposure (i.e. Day Care Center, Habitational Risk, Restaurant, Special Athletic or Fund-Raising Events, Swimming Pool, Fitness Center, Helipad/Heliport, Watercraft, Security Service, Environmental Exposures):

B. Estimated number of helipad/heliport landings per year: 50

VII. EXCESS LIABILITY

A. Please include current vehicle declarations and schedule.

B. Please provide underlying policy information:

Coverage	Carrier or SIR	Policy Number	Policy Period	Limits of Liability	CM or OCC	Premium
Professional Liability (PL)						$
General Liability (GL)						$
Employee Benefits Liability						$
Auto Liability						$
Employers Liability						$
Helipad Liability						$
Aviation Liability						$
Other: _____						$
Other: _____						$
Other: _____						$

VIII. RISK MANAGEMENT

A. Please identify any changes in the certifications/accreditations held by the applicant:

☒ CMS Certificate of Compliance with Conditions of Participation

☐ TJC ☐ CARF ☐ NCQA ☐ HBIP ☐ DNV ☐ HFAP ☐ Other: _____

B. When was the last accreditation/survey conducted by an outside entity?

Date/facility: 11/02/2023 Name (DOH, TJC, etc.): Alabama Department of Public Health

Total number of deficiencies: 5 Date Corrective Action Plan accepted: 12/20/2024

If multiple surveys, attach a summary or copies of the survey documents.

C. Risk Management representative contact information for a telephonic or on-site review of the applicant's facility:

Name/Title: [redacted] Case Management

Telephone Number: [redacted] E-mail Address: [redacted]

IX. CLAIMS AND LOSS HISTORY

A. Who is responsible for reporting claims to insurers?

[redacted] Case Management [redacted] [redacted]

Name Title Phone E-mail

B. Have all circumstances and incidents that are reasonably likely to give rise to a claim been reported to current insurers? ☒ Yes ☐ No

C. Specify preferred defense counsel: [redacted]

D. Provide 10 years loss history: (Excel format preferred)

1. Currently valued
2. Detailing each loss, status (open/closed) and line of coverage (PL/GL)
3. Paid and Reserve amount
4. Insurer loss runs supporting other formats

E. Are the losses submitted ground-up and unlimited? ☒ Yes ☐ No

F. If excess coverage is requested, provide recently valued loss run(s) for underlying coverages i.e. Auto, Helipad, Aviation, etc.

X. ATTACHMENT CHECKLIST

Please include the following:

- [x] Audited Financial Statements
- [x] Organizational Structure Chart
- [ ] List of Subsidiaries and Affiliates, etc., for which coverage is requested
- [x] Latest Accreditation Survey(s)
- [ ] Current policy(ies)
- [ ] Copy of unique policy language/endorsement
- [x] Medical Provider's roster
- [ ] Supplemental Applications for Allied Providers and/or Physicians & Surgeons (if applicable per Section IV).
- [ ] Schedule of Owned Vehicles
- [ ] Supplemental Applications for Behavioral, Research Activity, Bariatric, and/or Limited Short Term Pollution Coverages
- [ ] Loss Runs

For SIR and/or Reinsurance:

- [ ] Actuarial Funding Study
- [ ] Funding Balance
- [ ] Captive Policy Language

XI. IMPORTANT NOTICE

This insurance may contain claims-made and reported coverage. Certain coverages of this insurance may be limited to liability for injuries for which claims are first made during the policy period arising out of incidents or acts that first occurred on or after the applicable retroactive date which are reported to the Company during the policy period or any applicable extended reporting period. Please read and review the policy carefully.

XII. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DECEIVE, OR DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.

TM
INITIAL HERE

XIII. STATE SPECIFIC NOTICES

If Delaware: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under The Delaware Civil Union & Equality Act of 2011 and Delaware Bulletin No. 46 including the following: Parties to a civil union shall have all of the same rights, protections and benefits, and shall be subject to the same responsibilities, obligations and duties, under Delaware law as are granted to, enjoyed by, or imposed upon married spouses. A party to a civil union shall be included in any definition or use of the terms "dependent", "family", "husband and wife", "immediate family", "next of kin", "spouse", "stepparent", "tenants by the entirety", and other terms, whether or not gender-specific, that denote a spousal relationship or a person in a spousal relationship, as those terms are used throughout Delaware law. For all purposes of Delaware laws that refer to marriage or marital status, other than Chapter 1 of Title 13 of the Delaware Code, parties to a civil union will be included in such reference. The Act automatically recognizes as civil unions for all purposes of Delaware law legal unions between two persons of the same sex, such as civil unions, marriages and domestic partnerships that are validly formed in jurisdictions other than Delaware and are substantially similar to Delaware civil unions.

If Illinois: National Fire & Marine Insurance Company recognizes the rights afforded to individuals under Illinois Bulletin 2011-06 And The Religious Freedom Protection and Civil Union Act which states: "The parties to a civil union are entitled to the same legal obligations, responsibilities, protections and benefits that are afforded or recognized by the laws of Illinois to spouses. The law further provides that a party to a civil union shall be included in any definition or use of the terms "spouse," "family," "immediate family," "dependent," "next of kin," and other terms descriptive of spousal relationships as those terms are used throughout Illinois law. This includes the terms "marriage" or "married" or variations thereon. If policies of insurance provide coverage for children, the children of civil unions must also be provided coverage. The Act also requires recognition of civil unions or same sex civil unions or marriages legally entered into in other jurisdictions."

If Rhode Island: **THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.**

XIV. PLEASE READ AND SIGN

By my signature, I hereby represent that the Named Insured has extended to me full authority to execute this application on their or the facility/entity's behalf and that I am authorized to represent and sign on behalf of the Named Insured, or any person, or facility/entity requesting coverage in this insurance application. I also represent that I have reviewed the responses contained in this application and represent them to be complete and accurate to the best of my knowledge. In addition, I understand and agree that such representations are binding upon the Named Insured and all persons and facility(ies)/entity(ies) even though I am executing this application on their behalf.

I further acknowledge that any and all responses to questions, statements and explanations made in this application, or in any and all documents, supplemental pages or other attachments (hereinafter "**Attachments**") are true and that neither I, nor any applicant, have knowingly suppressed or misstated any material facts and I, and any applicant, agree that this application, and any **Attachments**, shall be the basis of the contract with the Company.

XIV. PLEASE READ AND SIGN (continued)

I AGREE THAT IF I FAIL TO COMPLY WITH THESE TERMS THE APPLICANT **WILL HAVE NO COVERAGE FOR ANY CLAIM** UNDER ANY POLICY OF INSURANCE FOR WHICH WE ARE APPLYING.

Completion of this form does not bind coverage or obligate the Company to offer coverage. The Company's receipt of the applicant's acceptance of the Company's quotation is required before the coverage may be bound and the policy issued. I further understand and agree that I, or any applicant, have no right to demand or expect coverage until the Company has: (1) received the completed application(s); (2) offered a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due.

I agree to cooperate with the Company in implementing an ongoing program of loss control and will allow the Company to review and monitor such programs that the applicant undertakes in managing its professional and general liability insurance exposures.

I understand and agree that a credit report, a credit score, an annual report, and an actuarial study may be obtained, reviewed or used in connection with the submission of this application.

I understand and agree that the Company may wish to contact persons, hospitals, employers, insurance agents, prior insurance carriers or other entities to verify and/or ascertain information regarding credentials and background both prior to and if bound after the issuance of a contract of insurance, therefore.

The applicant hereby authorizes and directs any person or organization whatsoever to release and furnish to the Company, and its agents or representatives, any and all information requested which may relate to insurability under the policy. The applicant furthermore authorizes the release of all such information by the Company as required by law to any governmental agency or professional society or association. The applicant furthermore releases and agrees to hold harmless the Company, and all of its agents and representatives, any prior insurer, governmental agency, or professional society or association from any liability arising out of the release or review of any and all information released or furnished pursuant to this authorization and application for insurance, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

By signing this application on behalf of the applicant (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I represent that I am an Officer, Shareholder, Partner, or other Authorized Representative of the group or entity applying for coverage.

This application must be signed by the President, Chief Executive Officer, or other Officer, Shareholder, or Partner of a PC or PA, or the equivalent Authorized Representative.

Signature of Officer or Authorized Representative	[redacted]	09/24/2025
	Title	Date

XV. SUPPLEMENTAL INFORMATION

APPENDIX

Schedule of Medical Professionals - Physicians, Surgeons, Dentists and Oral Surgeons

1. **Name** [redacted]
   Employment Status E
   State Alabama
   Retroactive Date 06/05/2024
   Start Date 06/05/2024

Certificate of Completion

Summary

Title	MedPro Group Hospital Liability Renewal
File name	MedPro Group Hospital Liability Renewal.pdf
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