How to Get a Claims History

To request your claim history, please download (PDF) complete & sign the claims form and Email to WRA@UHhospitals.org OR Fax the completed & signed form to 216-201-4402.

If you have any questions, please feel free to email WRA@uhhospitals.org and someone with respond to your request within 72 hours.

University Hospitals

UH SPONSORED PHYSICIAN PROGRAM

July 1, 2023

Subject:	Medical Professional Liability Information for UHCMC Residents &/or Fellows
Insurance Carrier:	Western Reserve Assurance Co., Ltd., SPC
Policy Number	WRUHPHPL
Limits of Liability:	$1,000,000 per occurrence/ $3,000,000 annual
Policy Term:	aggregate 7/1/2023 through 06/30/2024

Dear Physician:

Residents and Fellows of University Hospitals Case Medical Center are afforded medical professional liability coverage under University Hospitals General Liability insurance policy under the policy number listed above. This CLAIMS MADE coverage is currently underwritten by The Western Reserve Assurance Co., Ltd., SPC. Coverage under this policy goes back to July 1, 2002 and extends to all UH employees, including residents and fellows, while acting within the course and scope of their employment at University Hospitals. Because the limits of this coverage are shared with the hospital, residents and fellows are not required to purchase an Extended Reporting Period Endorsement ("Tail" coverage) upon their graduation.

Prior to July 1, 2002, University Hospitals of Cleveland (UHC) was self-insured. All residents and fellows during this time were covered under the Hospital's self-insured program for activities within the scope of their residency and/or fellowship.

If you require additional verification of your coverage and claims history information, please email WRA@UHhospitals.org. Please note that our office requires your signed authorization to release details relating to your residency or fellowship at University Hospitals Health System. For your convenience, a release of information form is attached to this memo. Please fax the completed requests to 216-201-4402. All inquiries about insurance coverage provided by Western Reserve Assurance Co., Ltd., SPC should be sent to the UH Corporate Risk Management Department at the address listed below.

UH Corporate Risk Management Department
3605 Warrensville Center Road
Mail Stop: MSC 9120
Shaker Heights, OH 44122

Thank you in advance for you cooperation, and congratulations and good luck with your medical career!

Sincerely,

UH Corporate Risk Management Department

University Hospitals

UH SPONSORED PHYSICIAN PROGRAM

REQUEST FOR CLAIM HISTORY &/OR LOSS DATA

Authorization to Release Information

To request your claim history, please legibly complete as much of the information below as possible. Please either email the completed & signed form to WRA@UHhospitals.org **OR** fax this completed & signed form to 216-201-4402. If you have any questions, please feel free to email WRA@UHhospital.org and someone will get back to you as soon as possible.

Coverage Status: ☐ **a Resident** ☐ **a Fellow** ☐ **Employed by UH** ***Allied Health Professional*** ☐ **Employed Physician Participant** ***(UHMG/UHMP)***

Provider Full Name: _____

Dates of Coverage *or Employment*: _____

Location / Facility / Entity: _____

Policy Number: _____

Social Security #: _____

Phone Number: _____

Email Address: _____

UH may use this email address to respond to this request only. It will not be used for any other purpose.

Forward information to: ☐Email address as above, ***&/or:***

Name: _____

Address: _____

_____

Fax #: _____

Phone #: _____

Email Address: _____

I request and therefore authorize the release of information and documents concerning my claims &/or loss history, as it pertains to my employment, Residency or Fellowship at **University Hospitals**, **UH Case Medical Center**, or to my participation in the **UH Sponsored Physician Program**. These programs are currently insured through the Western Reserve Assurance Co., Ltd, SPC.

I release all persons and entities from any liability for supplying information and documents in response to such a request. I authorize the use of a copy of this authorization in place of the original.

_____

Printed Name: Date:

_____ ☐MD ☐DO ☐____

Signature: Degree:

Corporate Risk Management MSC 9120 3605 Warrensville Center Road, Shaker Heights, OH 44122

Email: WRA@UHhospitals.org ~ Fax: 216-201-4402

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 06/13/2023

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER Marsh Management Services Cayman Ltd. 23 Lime Tree Bay Avenue, Governor's Square Bldg. 4, 2nd Floor - P.O. Box 1051 Grand Cayman KY1-1102 CAYMAN ISLANDS CN101925416-ok-UHCMC-23-24 UniHos	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED University Hospitals Health System, Inc. dba University Hospitals 3605 Warrensville Center Road Shaker Heights, OH 44122	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** WESTERN RESERVE ASSURANCE CO., LTD. SPC **INSURER B :** **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** CLE-006723736-55 **REVISION NUMBER:** 2

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS		
A	X **COMMERCIAL GENERAL LIABILITY**			WR-UH-PHPL-2023	07/01/2023	07/01/2024	EACH OCCURRENCE	$	1,000,000
	X CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$	1,000,000
							MED EXP (Any one person)	$	N/A
							PERSONAL & ADV INJURY	$	1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$	3,000,000
	X POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$	1,000,000
	☐ OTHER:							$	
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$	
	☐ ANY AUTO						BODILY INJURY (Per person)	$	
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$	
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$	
								$	
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$	
	☐ **EXCESS LIAB** ☐ CLAIMS-MADE						AGGREGATE	$	
	☐ DED ☐ RETENTION $							$	
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER		
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** N	N / A					E.L. EACH ACCIDENT	$	
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$	
							E.L. DISEASE - POLICY LIMIT	$	
A	PROFESSIONAL LIABILITY			WR-UH-PHPL-2023	07/01/2023	07/01/2024	GENERAL AGG		3,000,000
	CLAIMS-MADE						EACH CLAIM		1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

COVERAGE IS EXTENDED TO INCLUDE ALL EMPLOYEES OF THE INSURED ENTITY, INCLUDING BUT NOT LIMITED TO: NURSES, PHYSICIAN ASSISTANTS, NURSE PRACTIONERS, CERTIFIED REGISTERED NURSE ANESTHETISTS,MIDWIVES, RESIDENTS, FELLOWS AND ADMINISTRATIVE ACTIVITIES OF PHYSICIANS, WHILE ACTING WITHIN THE COURSE AND SCOPE OF THEIR EMPLOYMENT WITH THE ABOVE NAMED INSURED.

ADDITIONAL INSUREDS ARE COVERED PER THE ATTACHED ENDORSEMENT.

CERTIFICATE HOLDER

TO WHOM IT MAY CONCERN

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Marsh Management Services Cayman Ltd.

BLANKET ADDITIONAL INSURED ENDORSEMENT

This Policy is amended in that coverage provided hereunder shall extend to cover as an Additional Insured any person, organization, or governmental entity for whom you have agreed, in writing, to provide liability insurance. This coverage:

- Applies only to coverage and limits of insurance required by written agreement, but in no event exceeds either the scope of coverage or the limits of insurance provided by this policy.

- As respects coverage provided under Part I – Professional Liability, is limited to Professional Services provided by the Named Insured for community events and fund raising activities; research agreements; Professional Services provided for non-University Hospitals Health System, Inc. facilities; or similar agreements unless specifically agreed in advance by the Company.

Shall apply as primary insurance where specifically agreed, in writing, as part of an Insured Contract