

SERFF Tracking Number: ZURC-125836466 State: Arkansas  
Filing Company: Empire Fire and Marine Insurance Company State Tracking Number: EFT \$50  
Company Tracking Number: CW PR 27261  
TOI: 11.2 Medical Malpractice - Occurrence Only Sub-TOI: 11.2002 Ambulance Services  
Product Name: Medical Professional Liability CW PR 27261  
Project Name/Number: Medical Professional Liability CW PR 27261/CW PR 27261

## Filing at a Glance

Company: Empire Fire and Marine Insurance Company

Product Name: Medical Professional Liability SERFF Tr Num: ZURC-125836466 State: Arkansas  
CW PR 27261

TOI: 11.2 Medical Malpractice - Occurrence Only SERFF Status: Closed State Tr Num: EFT \$50

Sub-TOI: 11.2002 Ambulance Services Co Tr Num: CW PR 27261 State Status: Fees verified and received

Filing Type: Form Co Status: Not Applicable Reviewer(s): Betty Montesi, Edith Roberts

Author: Carole Amato Disposition Date: 10/01/2008

Date Submitted: 09/29/2008 Disposition Status: Approved

Effective Date Requested (New): 01/01/2009 Effective Date (New):

Effective Date Requested (Renewal): 01/01/2009 Effective Date (Renewal):

State Filing Description:

## General Information

Project Name: Medical Professional Liability CW PR 27261

Project Number: CW PR 27261

Reference Organization:

Reference Title:

Filing Status Changed: 10/01/2008

State Status Changed: 10/01/2008

Corresponding Filing Tracking Number:

Filing Description:

Earlier this year, we submitted a new Professional Liability program for your approval, which was approved and to be effective 5/1/08 (company filing# 26276, state filing# 1148). Empire Fire and Marine Insurance Company is now filing to update our Declarations page, EM 3626 ed 09 06 to reflect ISO's updates to Division Seven, Medical Professional Liability. Our exception rules are submitted under a separate SERFF filing - ZURC 125836467.

Status of Filing in Domicile: Not Filed

Domicile Status Comments:

Reference Number:

Advisory Org. Circular:

Deemer Date:

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## Company and Contact

### Filing Contact Information

Carole Amato, Supervisor carol.amato@zurichna.com  
 1400 American Lane (847) 413-5235 [Phone]  
 Schaumburg, IL 60196-1056 (847) 605-7768[FAX]

### Filing Company Information

Empire Fire and Marine Insurance Company CoCode: 21326 State of Domicile: Nebraska  
 13810 FNB Parkway Group Code: 212 Company Type:  
 Omaha, NE 68154-5202 Group Name: State ID Number:  
 (402) 963-5000 ext. [Phone] FEIN Number: 47-6022701  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: form filing  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Empire Fire and Marine Insurance Company	\$50.00	09/29/2008	22802880

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Edith Roberts	10/01/2008	10/01/2008

*SERFF Tracking Number:*      *ZURC-125836466*                      *State:*                      *Arkansas*  
*Filing Company:*              *Empire Fire and Marine Insurance Company*      *State Tracking Number:*      *EFT \$50*  
*Company Tracking Number:*      *CW PR 27261*  
*TOI:*                      *11.2 Medical Malpractice - Occurrence Only*      *Sub-TOI:*                      *11.2002 Ambulance Services*  
*Product Name:*              *Medical Professional Liability CW PR 27261*  
*Project Name/Number:*      *Medical Professional Liability CW PR 27261/CW PR 27261*

## **Disposition**

Disposition Date: 10/01/2008

Effective Date (New):

Effective Date (Renewal):

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: ZURC-125836466 State: Arkansas  
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Uniform Transmittal Document-Property & Casualty	Approved	Yes
Supporting Document	Marked Form	Approved	Yes
Form	Allied Health Care Providers Professional Liability Declarations	Approved	Yes

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 Product Name: Medical Professional Liability CW PR 27261  
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## Form Schedule

Review Status	Form Name	Form #	Edition Date	Form Type Action	Action Specific Data	Readability	Attachment
Approved	Allied Health Care Providers Professional Liaibility Declarations	EM 36 26	09 08	Declaration Replaced s/Schedule	Replaced Form #:0.00 EM 36 26 0906 Previous Filing #: 1148		EM3626 0908 Prof Dec for Ambulance.p df

# Allied Health Care Providers Professional Liability Declarations



Policy Number: \_\_\_\_\_

Renewal Number: \_\_\_\_\_

<b>INSURANCE COMPANY:</b>	<b>AGENT:</b>
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Named Insured:
Mailing Address:
Policy Period: From _____ To _____ At 12:01 A.M. standard Time At Your Mailing Address Shown Above

**IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.**

<b>LIMITS OF INSURANCE</b>	
<b>COVERAGE A</b>	
Each Medical Incident Limit	_____
Individual Professional Liability Aggregate Limit	_____
<b>COVERAGE B</b>	
Each Business Entity Incident Limit	_____
Partnership, Limited Liability Company, Association Or Corporation	_____
Professional Liability Aggregate Limit	_____

<b>RETROACTIVE DATE (PR 00 06 ONLY)</b>
This insurance does not apply to injury arising out of a "medical incident" or "business entity incident" which occurs before the retroactive date, if any, shown below.
Retroactive Date: _____ (Enter Date Or "None" If No Retroactive Date Applies)

<b>DESCRIPTION OF BUSINESS</b>
FORM OF BUSINESS:
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Trust <input type="checkbox"/> Limited Liability Company
<input type="checkbox"/> Organization, including a Corporation (But not including a Partnership, Joint Venture Or Limited Liability Company)
BUSINESS DESCRIPTION: _____

CLASSIFICATION AND PREMIUM				
CLASSIFICATION	CODE NO.	PREMIUM BASE	RATE	ADVANCE PREMIUM
		Premium For Endorsements		_____
		State Tax Or Other (If Applicable)		_____
				_____
		Total Premium (Subject To Audit)		_____
PREMIUM SHOWN IS PAYABLE:		At Inception		_____
		At Each Anniversary		_____
		(if policy period is more than one year and premium is paid in annual installments)		
AUDIT PERIOD (IF APPLICABLE)	<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly

ENDORSEMENTS
ENDORSEMENTS ATTACHED TO THIS POLICY:

**THESE DECLARATIONS, TOGETHER WITH THE COMMON POLICY CONDITIONS AND COVERAGE FORM(S) AND ANY ENDORSEMENT(S), COMPLETE THE ABOVE NUMBERED POLICY.**

Date of Issue: \_\_\_\_\_ Countersigned By \_\_\_\_\_  
Authorized Representative

*SERFF Tracking Number:*      *ZURC-125836466*                      *State:*                      *Arkansas*  
*Filing Company:*              *Empire Fire and Marine Insurance Company*      *State Tracking Number:*      *EFT \$50*  
*Company Tracking Number:*      *CW PR 27261*  
*TOI:*                      *11.2 Medical Malpractice - Occurrence Only*      *Sub-TOI:*                      *11.2002 Ambulance Services*  
*Product Name:*              *Medical Professional Liability CW PR 27261*  
*Project Name/Number:*      *Medical Professional Liability CW PR 27261/CW PR 27261*

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: ZURC-125836466 State: Arkansas  
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## Supporting Document Schedules

**Satisfied -Name:** Uniform Transmittal Document-  
Property & Casualty **Review Status:** Approved 10/01/2008

**Comments:**

**Attachment:**

NAIC Transmittal form.pdf

**Satisfied -Name:** Marked Form **Review Status:** Approved 10/01/2008

**Comments:**

**Attachment:**

EM3626 0908 Prof Dec for Ambulance markup.pdf

## Property & Casualty Transmittal Document

<b>1. Reserved for Insurance Dept. Use Only</b>	<b>2. Insurance Department Use only</b> a. Date the filing is received: b. Analyst: c. Disposition: d. Date of disposition of the filing: e. Effective date of filing: <table style="width: 100%; border: none;"> <tr> <td style="width: 60%; border: none;">New Business</td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">Renewal Business</td> <td style="border: none;"></td> </tr> </table> f. State Filing #: g. SERFF Filing #: h. Subject Codes	New Business		Renewal Business	
New Business					
Renewal Business					

<b>3. Group Name Zurich North America</b>	<b>Group NAIC #</b>
	212

4. Company Name(s)	Domicile	NAIC #	FEIN #	State #
Empire Fire & Marine Ins. Co.	NE	21326	47-6022701	

<b>5. Company Tracking Number</b>	CW PR 27261
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**Contact Info of Filer(s) or Corporate Officer(s)** [include toll-free number]

6.	Name and address	Title	Telephone #s	FAX #	e-mail
	Carole Amato 1400 American Lane	Analyst	847-413-5235	847-605-7768	carole.amato@zurichna.com
	Schaumburg, IL 60196				
<b>7.</b>	Signature of authorized filer		<i>Carole Amato</i>		
<b>8.</b>	Please print name of authorized filer		Carole Amato		

**Filing information** (see General Instructions for descriptions of these fields)

<b>9.</b>	<b>Type of Insurance (TOI)</b>	11.2002
<b>10.</b>	<b>Sub-Type of Insurance (Sub-TOI)</b>	Med Mal - Ambulance
<b>11.</b>	<b>State Specific Product code(s)(if applicable)[See State Specific Requirements]</b>	
<b>12.</b>	<b>Company Program Title (Marketing title)</b>	Professional Liability Forms – Ambulance Program
<b>13.</b>	<b>Filing Type</b>	<input type="checkbox"/> Rate/Loss Cost <input type="checkbox"/> Rules <input type="checkbox"/> Rates/Rules <input checked="" type="checkbox"/> Forms <input type="checkbox"/> Combination Rates/Rules/Forms <input type="checkbox"/> Withdrawal <input type="checkbox"/> Other (give description)
<b>14.</b>	<b>Effective Date(s) Requested</b>	New: 01-01-2009      Renewal: 01-01-2009
<b>15.</b>	<b>Reference Filing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>16.</b>	<b>Reference Organization (if applicable)</b>	
<b>17.</b>	<b>Reference Organization # &amp; Title</b>	
<b>18.</b>	<b>Company's Date of Filing</b>	
<b>19.</b>	<b>Status of filing in domicile</b>	<input type="checkbox"/> Not Filed <input type="checkbox"/> Pending <input type="checkbox"/> Authorized <input type="checkbox"/> Disapproved

## Property & Casualty Transmittal Document—

<b>20.</b>	<b>This filing transmittal is part of Company Tracking #</b>	CW PR 27261
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<b>21.</b>	<b>Filing Description</b> [This area can be used in lieu of a cover letter or filing memorandum and is free-form text]
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Earlier this year, we submitted a new Professional Liability program for your approval that was approved effective 5/1/08. Empire Fire and Marine Insurance Company is now filing to update our declarations page in light of the ISO 2008 Multi state Revision to Division Seven – Medical Professional Liability Forms (PR-2007-OFR07).

We are submitting EM 3626 0908 Allied Health Care Providers Professional Liability Declarations. Upon approval, the previous 0906 revision will be replaced by edition 0908.

<b>2.</b>	<b>Filing Fees</b> (Filer must provide check # and fee amount if applicable) [If a state requires you to show how you calculated your filing fees, place that calculation below]
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**Check #:**  
**Amount:**

**Refer to each state's checklist for additional state specific requirements or instructions on calculating fees.**

**\*\*\*Refer to the each state's checklist for additional state specific requirements (i.e. # of additional copies required, other state specific forms, etc.)**

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## FORM FILING SCHEDULE

(This form must be provided ONLY when making a filing that includes forms)  
 (Do not refer to the body of the filing for the forms listing, unless allowed by state.)

<b>1.</b>	<b>This filing transmittal is part of Company Tracking #</b>	CW PR 27261
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<b>2.</b>	<b>This filing corresponds to rate/rule filing number</b> <small>(Company tracking number of rate/rule filing, if applicable)</small>	CW PR 27261
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3.	Form Name /Description/Synopsis	Form # Include edition date	Replacement Or withdrawn?	If replacement, give form # it replaces	Previous state filing number, if required by state
01	Allied Health Care Providers Professional Liability Declarations	EM 36 26 09/08	<input type="checkbox"/> New <input checked="" type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn	EM 36 26 0906	1148
02			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
03			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
04			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
05			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
06			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
07			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
08			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
09			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		
10			<input type="checkbox"/> New <input type="checkbox"/> Replacement <input type="checkbox"/> Withdrawn		

PC FFS-1

# Allied Health Care Providers Professional Liability Declarations



Policy Number: \_\_\_\_\_  
 Renewal Number: \_\_\_\_\_

<b>INSURANCE COMPANY:</b>	<b>AGENT:</b>
---------------------------	---------------

Named Insured: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Policy Period: From \_\_\_\_\_ To \_\_\_\_\_ At 12:01 A.M. standard Time At Your Mailing Address Shown Above

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**IN RETURN FOR THE PAYMENT OF THE PREMIUM, AND SUBJECT TO ALL THE TERMS OF THIS POLICY, WE AGREE WITH YOU TO PROVIDE THE INSURANCE AS STATED IN THIS POLICY.**

LIMITS OF INSURANCE	
<b>COVERAGE A</b>	
Each Medical Incident Limit	_____
Individual Professional Liability Aggregate Limit	_____
<b>COVERAGE B</b>	
Each Business Entity Incident Limit	_____
Partnership, Limited Liability Company, Association Or Corporation	_____
Professional Liability Aggregate Limit	_____

Deleted: (Coverage A)

Deleted: (Coverage B)

RETROACTIVE DATE (PR 00 06 ONLY)
This insurance does not apply to injury arising out of a "medical incident" or "business entity incident" which occurs before the retroactive date, if any, shown below.
Retroactive Date: _____ <small>(Enter Date Or "None" If No Retroactive Date Applies)</small>

DESCRIPTION OF BUSINESS
FORM OF BUSINESS:
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Joint Venture <input type="checkbox"/> Trust <input type="checkbox"/> Limited Liability Company
<input type="checkbox"/> Organization, including a Corporation (But not including a Partnership, Joint Venture Or Limited Liability Company)
BUSINESS DESCRIPTION: _____

Deleted: 6

CLASSIFICATION AND PREMIUM				
CLASSIFICATION	CODE NO.	PREMIUM BASE	RATE	ADVANCE PREMIUM
		Premium For Endorsements		_____
		State Tax Or Other (If Applicable)		_____
				_____
		Total Premium (Subject To Audit)		_____
PREMIUM SHOWN IS PAYABLE:		At Inception		_____
		At Each Anniversary		_____
(if policy period is more than one year and premium is paid in annual installments)				
AUDIT PERIOD (IF APPLICABLE)	<input type="checkbox"/> Annually	<input type="checkbox"/> Semi-Annually	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Monthly

ENDORSEMENTS
ENDORSEMENTS ATTACHED TO THIS POLICY:

**THESE DECLARATIONS, TOGETHER WITH THE COMMON POLICY CONDITIONS AND COVERAGE FORM(S) AND ANY ENDORSEMENT(S), COMPLETE THE ABOVE NUMBERED POLICY.**

Date of Issue: \_\_\_\_\_ Countersigned By \_\_\_\_\_  
Authorized Representative

Deleted: 6