

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](mailto:WRA@UHhospitals.org) OR [Fax the completed & signed form to 216-201-4402](tel:216-201-4402).

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

UH SPONSORED PHYSICIAN PROGRAM

July 1, 2024

Subject: Medical Professional Liability Information for UHCMC Residents &/or Fellows

Insurance Carrier: Western Reserve Assurance Co., Ltd., SPC WRUHPHPL
Policy Number Limits of Liability: Policy Term: \$1,000,000 per occurrence/ \$3,000,000 annual aggregate
7/1/2024 through 06/30/2025

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 your cooperation, and congratulations and good luck with your medical career!

Sincerely,

UH Corporate Risk Management Department



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: _____

Signature: _____

MD DO _____
Degree:



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 06/10/2024
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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-UHCOC-24-25 UniHos	CONTACT NAME: ..	
	PHONE (A/C, No, Ext): E-MAIL ADDRESS:	FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE	
	INSURER A : WESTERN RESERVE ASSURANCE CO. LTD. SPC	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	
INSURED University Hospitals Health System, Inc. dba University Hospitals 3605 Warrensville Center Road Shaker Heights, OH 44122		

COVERAGES CERTIFICATE NUMBER: CLE-008723736-63 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	ADOL INSD	SUBR WVD	POLICYNUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input checked="" type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			WR-UH-PHPL-2024	07/01/2024	07/01/2025	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 1,000,000 MED EXP (Any one person) \$ N/A PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 1,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A				PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
A	PROFESSIONAL LIABILITY <input checked="" type="checkbox"/> CLAIMS-MADE			WR-UH-PHPL-2024	07/01/2024	07/01/2025	GENERAL AGG 3,000,000 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 PRACTITIONERS, 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 CANCELLATION

 <h2>TO WHOM IT MAY CONCERN</h2>	<p>SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.</p> <p>AUTHORIZED REPRESENTATIVE <i>Marsh Management Services Cayman Ltd.</i></p>
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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