Ambulatory Surgery Centers Professional Liability Application for Corporations and Partnerships

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON A CLAIMS-MADE BASIS AND COMMERCIAL GENERAL LIABILITY COVERAGE WRITTEN ON EITHER A CLAIMS-MADE OR AN OCCURRENCE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THE APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTION BE ANSWERED ACCURATELY AND COMPLETELY.

Please type or print clearly.

- **Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.**
- **If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.**
- **This form must be completed, dated and signed by the CEO, CFO or Risk Manager/Administrator of the proposed insured.**

1. GENERAL INFORMATION

Applicant Name:

_____

Business Address: Street _____ City, State _____ ZIP _____

Mailing Address: Street _____ City, State _____ ZIP _____

Telephone #: _____

Website (if applicable) _____ Date Facility Opened: _____

Key Contact at Insured: _____ Hours of Operation: _____

Federal Tax ID: _____ Management Co: _____

Estimated Gross Revenue (Next 12 months): _____

APPLICANT IS (Check all that applies): **Please provide list of separate list of ownership breakdown of the Center**

A.

- ☐ Limited Liability Corp
- ☐ Partnership
- ☐ Joint Venture

B.

- ☐ Licensed by the State
- ☐ Accredited by AAAHC
- ☐ Medicare Approved
- ☐ Accredited by JCAHO
- ☐ Other

C. Requested Coverage: Effective Date: _____

Professional Liability (Claims Made Only):

Limit: $_____per claim $_____aggregate _____ Retroactive Date

Deductible: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ Other _____

General Liability:

Limit: $_____per claim $_____aggregate _____ Retroactive Date

☐ Occurrence ☐ Claims-Made

Deductible: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ Other _____

Employee Benefits Liability (Claims Made Only):

Limit: $_____per claim $_____aggregate _____ Retroactive Date

Deductible: ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ Other _____

II. EXPOSURE DATA

1. Type and number of surgical procedures performed at the facility

Type of Procedure (Physician Specialty ie – Ortho)	**Next 12 Months Projected**	**Current Year**	**1st Year Prior**	**2nd Year Prior**	**3rd Year Prior**	**4th Year Prior**	**5th Year Prior**
Cardiac							
Colon and Rectal							
Endoscopy/Colonoscopy							
Dentists – Oral Surgery							
Gastroenterology							
General Surgery							
Gynecology							
Hand Surgery							
Head and Neck							
Neurology							
Ophthalmology							
Orthopedic							
ENT							
Pain							
Plastic (Cosmetic)							
Plastic (Reconstructive)							
Podiatrist							
Urology							
Thoracic							
Vascular							
Other _____							

2. Are any of the following procedures performed at the center:

Bariatrics? ☐ Yes ☐ No
If yes, how many? _____

Lasik Surgery? ☐ Yes ☐ No
If yes, what percentage of overall number of procedures? _____

Abortions? ☐ Yes ☐ No
If yes, how many? _____

3. Facility class definitions by type of anesthesia (Check all that apply)

☐ Class A
All surgical procedures are performed in the facility under local or topical anesthesia.

☐ Class B
Surgical procedures are performed in the facility under local or topical anesthesia and/or intravenous or parenteral sedation, regional anesthesia, analgesia, or dissociative drugs (excluding Propofol) without the use of endotracheal or laryngeal mask incubation or inhalation general anesthesia (including nitrous oxide).

☐ Class C
Surgical procedures are performed in the facility under local or topical anesthesia and / or intravenous or parenteral sedation, regional anesthesia, analgesia, or dissociative drugs, including Propofol, spinal or epidural anesthesia, endotracheal or laryngeal mask incubation or inhalation general anesthesia (including nitrous oxide), administered by an anesthesiologist or certified nurse anesthetist.

4. Health Care Professionals

Professional Employees: (indicate total number of employees in each category)

Position	Full-Time (E)mployed/(C)ontracted/(V)olunteers	Total FTE	
Physicians/Surgeons	____	_____	____
Dentists	____	_____	____
CRNA's	____	_____	____
Nurse Practitioners	____	_____	____
Physician/Surgeons Assistants	____	_____	____
Podiatrist	____	_____	____
RN's/LPN/LVNs	____	_____	____
Technicians	____	_____	____
Other (describe):	____	_____	____

5. Do you confirm that all practitioners working at the center have current hospital privileges? ☐ Yes ☐ No
If no please provide a list of those physicians who do not have privileges and explanation.

6. Do you treat professional athletes? ☐ Yes ☐ No

7. Has any insurance company ever canceled, refused to renew, restricted coverage through endorsements to the policy or only offered coverage to you with a deductible or in a higher rating plan? ☐ Yes ☐ No

8. Are other specialties besides Anesthesiologists privileged to perform Pain Management? ☐ Yes ☐ No
If yes, please provide a list of those other specialties that are privileged.

III. Management

1. Total number of shareholders? _____

2. Total number of voting securities owned by the Insured Entities directors and officers? _____

3. Does any security holder own five percent (5%) or more of the voting securities? ☐ Yes ☐ No
If yes, list names and percentage of holdings:
_____
_____

4. Have there been any changes in the Board of Directors or Senior Management within the past three years? ☐ Yes ☐ No
If yes, please explain:
_____
_____

5. Has the insured entity in the past twenty four (24) months completed, or agreed to, within the next twelve (12) months contemplated a merger, acquisition, or consolidation with another entity? ☐ Yes ☐ No
If yes, please explain:
_____
_____

6. Are you currently HIPPA Compliant? ☐ Yes ☐ No

IV. Risk Management/Quality

1. Risk Management/Performance Improvement
   a. Who coordinates your risk management program?
   Name: _____Title: _____
   Mailing Address:_____
   _____
   Telephone: (_____) _____ E-mail:_____

2. Credentialing
   a. Is history of previous employment verified for all employees or physicians? ☐ Yes ☐ No
   b. Are references checked for all employees or physicians? ☐ Yes ☐ No
   c. Has the license of any employed/contracted physician or surgeon ever been restricted or suspended? ☐ Yes ☐ No
   If yes, please provide details_____
   d. What are the minimum limits of malpractice insurance required for providers?
   _____ per occurrence/ aggregate _____
   e. Are providers allowed to post bonds or letters of credit instead of insurance? ☐ Yes ☐ No
   If so, how is this verified?
   _____
   _____

3. Hold Harmless and Indemnification Agreements

   a. Has the facility agreed to hold harmless or indemnify others under contract? ☐ Yes ☐ No
      If yes please attach a copy of contract.
   b. Does the facility rent or lease any equipment from others? ☐ Yes ☐ No
      If a. or b. is yes, please explain: _____

Environment, Policy and Procedures

For all the questions answered "No" below, please provide a written explanation.

1. Is each operating room of a size adequate for the presence of all equipment and personnel necessary for the performance of the surgical procedures, and complies with all local, state, and federal requirements? ☐ Yes ☐ No

2. Is a weekly spore test is performed and the results filed for each autoclave? ☐ Yes ☐ No

3. Each sterilized pack is marked with the date of sterilization and, when applicable, with the expiration date? ☐ Yes ☐ No

4. Does the facility maintain a standard defibrillator or AED which is checked at least weekly? ☐ Yes ☐ No

5. Are Nasopharyngeal airways and laryngeal mask airways always available? ☐ Yes ☐ No

6. Are all medications included in the ACLS Algorithm available on the emergency cart and a copy of the ACLS and Malignant Hypothermia Algorithms are maintained on the cart? ☐ Yes ☐ No

7. Are all narcotics and controlled substances secured with a double lock? ☐ Yes ☐ No

8. Is there a dated sequential narcotic inventory and control record which includes the use of narcotics on individual patients? ☐ Yes ☐ No

9. Is the narcotic inventory checked and verified at least daily by two qualified professionals? ☐ Yes ☐ No

10. Are all medications inventoried (outdated purged) and recorded in the patient's record when administered? ☐ Yes ☐ No

11. Are the following stored in the facility at all times:
    - Amiodarone? ☐ Yes ☐ No
    - Preservative free H2O diluents for Dantrolene? ☐ Yes ☐ No
    - NaHCo3? ☐ Yes ☐ No
    - Dantrolene? ☐ Yes ☐ No
    - Intravenous corticosteroids? ☐ Yes ☐ No
    - Anti-hypertensives? ☐ Yes ☐ No

12. Are all intravenous and subcutaneous fluids recorded as to type and volume? ☐ Yes ☐ No

13. Are intravenous fluids available in the facility and does the facility have a means for obtaining or administering blood or blood products? ☐ Yes ☐ No

14. Is there a written protocol for the administration of blood products that includes typing, cross matching, double checks and verifications? ☐ Yes ☐ No

General Safety

1. Have all the National Patient Safety Goals been fully implemented? ☐ Yes ☐ No

2. Is there is a written policy in place for:
   - Patient identification? ☐ Yes ☐ No
   - Surgical site verification? ☐ Yes ☐ No
   - Patient positioning? ☐ Yes ☐ No
   - Laser / electrical safety? ☐ Yes ☐ No
   - Continuous physiological monitoring? ☐ Yes ☐ No
   - Documentation of all intra-operative orders? ☐ Yes ☐ No
   - Disposition of all pathology and other specimens? ☐ Yes ☐ No
   - Verification of sponge, needle, and instrument counts? ☐ Yes ☐ No
   - Documentation of patient condition, mode of transport for hospital transfers? ☐ Yes ☐ No
   - Completion and signing of operative reports which includes a written, immediate post surgical report? ☐ Yes ☐ No

3. Is there is a written emergency transport policy and agreement with a local hospital? ☐ Yes ☐ No
   How many miles to the nearest hospital? _____

4. Is a medical history and physical exam recorded on all patients for major surgery and those minor surgery patients whose age, medical condition, and complexity of procedure merit it? ☐ Yes ☐ No

5. Are medical records kept secure and confidential in a manner consistent with HIPAA? ☐ Yes ☐ No

6. Are all Operating Room and Recovery Room employees Basic Life Support Certified at a minimum? (ACLS is preferred). ☐ Yes ☐ No

7. Is there a written Performance Improvement Plan? (If "Yes", attach a copy.) ☐ Yes ☐ No

8. Is there is a written Risk Management Plan? (If "Yes", attach a copy.) ☐ Yes ☐ No

9. Is there a formal Peer Review Process that includes both review of random cases as well as unanticipated events (such as complications and infection) for both surgery and anesthesia? ☐ Yes ☐ No

10. Is credentialing which includes primary source verification performed on all providers? ☐ Yes ☐ No

11. Are specific privileges awarded to individual physicians made aware and readily available for all staff? ☐ Yes ☐ No

12. Is a Patient's Bill of Rights posted in a prominent place and distributed to patients? ☐ Yes ☐ No

Anesthesia Care

1. Is there is a written process in place for patient selection (ASA criteria or other)? ☐ Yes ☐ No

2. Are all anesthetics delivered by either a qualified physician or CRNA (under physician supervision if required by the state or the facility)? ☐ Yes ☐ No

   Intravenous sedation other than Propofol may be administered by a RN if supervised by an appropriately qualified and privileged physician.

3. Is a physician responsible for determining the medical status of the patient immediately before surgery? ☐ Yes ☐ No

4. Has a physician verified that the patient—or responsible adult— engaged in a comprehensive informed consent process and has signed a surgical consent? ☐ Yes ☐ No

5. Are all patients assessed by cardiac and O2 monitoring during surgery and recovery from anesthesia? ☐ Yes ☐ No

6. Is a post anesthesia care area used to recover all patients after anesthesia administration? ☐ Yes ☐ No

7. Is a written post anesthesia care record maintained? ☐ Yes ☐ No

8. Is a physician, CRNA, or RN with Advanced Cardiac Life Support (ACLS) certification or who is otherwise qualified in resuscitation immediately available until all patients have met the criteria for discharge from the facility? ☐ Yes ☐ No

9. Do all recovering patients remain under direct observation and supervision until discharge from the recovery room? ☐ Yes ☐ No

10. Are written post operative instructions provided to all patients? ☐ Yes ☐ No

11. Are patients required to meet established written and recorded criteria for stability before discharge? ☐ Yes ☐ No

12. Are patients who receive anesthesia, other than local, prohibited from driving themselves home? ☐ Yes ☐ No

13. Are facilities with 23 hour or overnight stays in compliance with all regulations? ☐ Yes ☐ No

V. Commercial General Liability Exposure

1. Attach separate sheet if needed

Location	Area	Age	Type of Construction	# of Floors	Type of Fire Protection (City, State)
Patient Care Buildings					
Other Buildings					

2. Employee Benefits Liability Exposures
   a. Number of Employees? _____
   b. Is Employee benefits Self Administered? ☐ Yes ☐ No

3. Other Exposures
   a. Are there elevators or escalators on any premises owned, leased or occupied by the insured? ☐ Yes ☐ No
      If so, how many? _____
   b. List the number and type of owned or leased vehicles:
      _____
      _____

Do you sell or lease any medical equipment or products to patients or others in connection with your operation? ☐ Yes ☐ No

c. Has the applicant sold, acquired, or discontinued any operations in the past ten (10) years?
If yes please explain: _____ ☐ Yes ☐ No

e. Is the applicant considering any changes in operations or products over the next 12 months?
If yes please explain: _____ ☐ Yes ☐ No

VI. Prior Insurance History

Most recent five (5) Years: (separate Primary General Liability, Professional and Excess/Umbrella, if applicable).

Primary Coverage

Policy Period	Carrier	Limits (HPL/GL)	Deductible (HPL/GL)	Total Premium	Claims Made or Occurrence	Retro Date
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				

VII. CLAIMS HISTORY

1. Have any claims ever been made against you? ☐ Yes ☐ No
   Please provide currently valued carrier loss runs

2. Are you aware of any incident, circumstance or loss which has occurred after the proposed retroactive date, which is likely to result in a claim? ☐ Yes ☐ No

   If yes, please provide details

   Have they been reported to your current or previous carrier(s)? ☐ Yes ☐ No

Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in Questions 1 and 2 is excluded from the proposed coverage.

Please include the following:

1. Loss History: (supply the following)
   a. Claims listing of ten years currently valued, including current year, detailed loss information (preferably in electronic form). **Please see ADDENDUM A for the format**
   b. Carrier loss runs to support information in 1.a. above.
   c. Full details of allegation on all losses paid or currently open in excess of $50,000.
2. Most recent accrediting agency (JCAHO, AAAHC.) and state licensure report with recommendations and the institution's response to any contingencies. Please provide copy of original report from agency (not the internet summary)
3. Current Audited Financial Statements or Pro Formas
4. Medical Staff By – Laws
5. Transfer Agreements
6. Organizational Chart

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE APPLICANT AGREES 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 MEDICAL PROFESSIONALEXPOSURES.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

Signature of Applicant:_____

Printed Name:_____

Title:_____

Date: _____