SHAND MORAHAN & COMPANY, INC.
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

If you obtained this application at www.markelshand.com, please submit this application through your local insurance professional.

APPLICATION FOR AMBULATORY SURGERY CENTERS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) Full name of Applicant: _____

   (b) Principal practice address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) Secondary practice locations: _____

   _____

   _____

   (d) (i) Phone: _____ (ii) Fax: _____

   (iii) E-Mail Address: _____ (iv) Website Address: _____

   (e) (i) Year Established: _____

2. Type of practice: [ ] solo proprietorship [ ] joint venture
   [ ] professional corporation [ ] professional association*
   [ ] limited liability company [ ] partnership*
   [ ] other _____

3. Does the Applicant own or operate any business other than shown ins Question 1.(a) above ? ..... [ ] Yes [ ] No
   If Yes, provide the name, address and nature of business. _____

   _____

4. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No
   If Yes,
   (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? [ ] Yes [ ] No
   (b) Provide the name and title of the Applicant's Privacy Officer. _____
   Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

II. OPERATIONS

1. Provide the name and specialty of the Applicant's Medical Director: _____

2. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered? ..... [ ] Yes [ ] No
   If Yes, provide details. _____

3. Is the Applicant accredited by:

   (a) JCAHO? ..... [ ] Yes [ ] No
   (b) AAAHC? ..... [ ] Yes [ ] No
   (c) AAAASF? ..... [ ] Yes [ ] No
   Other: _____ [ ] Yes [ ] No

   If Yes, to any of the above attach a copy of each most recent accreditation survey.

4. Applicant's Gross Revenues:

	Last Twelve Months	Next Twelve Months
Fee for Service	$ _____	$ _____
Medicare/Medicaid Funds	$ _____	$ _____
Research	$ _____	$ _____
Other (describe)	$ _____	$ _____
TOTAL GROSS REVENUES	$ _____	$ _____

5. Are Harvard Standards for the administration of all anesthesia adhered to? .....[ ] Yes [ ] No
   If No, provide details._____

6. Does the state that the Applicant is located in regulate the use of:

   (a) General anesthesia outside of a hospital?.....[ ] Yes [ ] No
   If Yes, is the Applicant licensed or otherwise approved? .....[ ] Yes [ ] No

   (b) Sedation outside of a hospital? .....[ ] Yes [ ] No
   If Yes, is the Applicant licensed or otherwise approved? .....[ ] Yes [ ] No

7. Does the Applicant permit professionals other than licensed Nurse Anesthetists and Anesthesiologists to administer and/or monitor sedation or general anesthesia? .....[ ] Yes [ ] No
   If Yes, do RN's administer Propofol sedation for any procedures? [ ] Yes [ ] No
   If Yes,
   (a) Do all such RN's have current certification in ACLS? .....[ ] Yes [ ] No
   (b) Attach patient selection guidelines and protocols for administration and monitoring.

8. Does the Applicant maintain any beds for overnight occupancy:
   (a) On the Applicant's premises? .....[ ] Yes [ ] No
   If Yes,
   (i) No. of beds: ____
   (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.
   (b) Off the Applicant's premises? .....[ ] Yes [ ] No
   If Yes,
   (i) No. of beds: ____
   (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

9. Does the Applicant have
   (a) A formal emergency response policy which includes written transfer agreements with the receiving acute care hospital(s)?.....[ ] Yes [ ] No
   If No, explain._____
   (b) A dedicated telephone line to the closest appropriate hospital Emergency Department? [ ] Yes [ ] No
   (c) Two-way communication with EMS?[ ] Yes [ ] No

   If any of the above is answered No, explain._____

10. What is the distance from the Applicant to the nearest acute care hospital Emergency Department? _____

11. Applicant's hours of operation: _____

12. Is the Applicant staffed with professional personnel trained in emergency response during all hours of operation?.....[ ] Yes [ ] No
    If No, explain. _____

III. STAFF

1. Do all staff:
   (a) Physicians, surgeons, dentists and podiatrists maintain a Professional Liability Insurance Policy with limits of liability of at least $1,000,0000 each claim / $3,000,0000 aggregate?.....[ ] Yes [ ] No
   If No, what are the minimum limits of liability that the Applicant requires?
   $_____each claim / $_____ aggregate

   (a) Nurse anesthetists maintain a Professional Liability Insurance Policy with limits of liability of at least $1,000,0000 each claim / $3,000,0000 aggregate?.....[ ] Yes [ ] No
   If No, what are the minimum limits of liability that the Applicant requires?
   $_____ each claim / $_____ aggregate

2. Does the Applicant have a formal:

(a) Policy for hiring/screening professionals and paraprofessionals including nurse anesthetists who provide and/or participate in providing patient care for or on behalf of the Applicant? .....[ ] Yes [ ] No
If No, explain. _____

_____

(b) Privileging process for all surgeons, anesthesiologists including primary source verification of professional training and experience? .....[ ] Yes [ ] No
If Yes, does it include the following:
(i) Review/approval of requested privileges/procedures for ambulatory surgery staff either through an automated or manual system?.....[ ] Yes [ ] No
(ii) Continuous updates of new or deleted privileges for ambulatory surgery center staff either through an automated or manual system?.....[ ] Yes [ ] No

(c) Can the Applicant's staff refuse to schedule a surgery or procedure that is not:
(i) On an individual provider's list of approved privileges? .....[ ] Yes [ ] No
(ii) Authorized at the Applicant's surgical center? .....[ ] Yes [ ] No

(d) Does the Applicant have a formal peer review process? .....[ ] Yes [ ] No
If No, explain._____

3. (a) Indicate the number of professional employees and privileged practitioners, including any owners or partners who render professional services on behalf of the applicant, whether or not surgical.

	No. of Employees	**No. of Privileged Practitioners**
(i) Physicians: No Surgery other than incision of boils and superficial abscesses; suturing of skin or superficial facia	_____	_____
(ii) Anesthesiologists; Pain Management Specialists	_____	_____
(iii) Dermatologist; Cardiologists; Gastroenterologists; Internists; Proctologists; Ophthalmologists; Urologists	_____	_____
(iv) General Surgeons; Cardiac Surgeons ;Otolaryngologists no plastic surgery	_____	_____
(v) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	_____	_____
(vi) Thoracic Surgeons; Vascular Surgeons; Neurosurgeons; and Orthopedic Surgeons	_____	_____
(vii) Bariatric Surgeons	_____	_____
(viii) Podiatrists	_____	_____
(ix) Dentists; Oral Surgeons	_____	_____
(x) Moonlighting Residents:	_____	_____
(xi) Interns, Residents and Fellows in a formal program in the Applicant's facility	_____	_____
(xii) Nurse Anesthetists	_____	_____
(xiii) Anesthesiologist Assistants	_____	_____
(xiv) Physicians' and Surgeons' Assistants; Nurse Practitioners (describe duties on separate sheet)	_____	_____
(xv) Perfusionists	_____	_____
(xvi) Pharmacists	_____	_____
(xvii) Optometrists	_____	_____
(xviii) Chiropractors	_____	_____
(xix) RNs, LPNs	_____	_____
(xx) X-Ray Technician; Lab Technician	_____	_____
(xxi) Physical, Respiratory and Inhalation Therapists	_____	_____

(b) Are all of the above individuals licensed in accordance with applicable state and federal regulations?..... [ ] Yes [ ] No
If No, attach an explanation.

IV. PROFESSIONAL SERVICES

1. (a) Indicate the number of procedures provided by year.

Type of Procedure	Number of Procedures		
	Last Year	Current Year	Estimate Next Year
Bariatric Surgery			
Cosmetic Surgery			
Dental/Oral Surgery			
Elective Abortions*			
1st Trimester			
2nd Trimester			
Endoscopy/Colonoscopy			
General Surgery			
Gynecological Surgery			
Manipulation Under Anesthesia			
Ophthalmology			
Orthopedic Surgery			
Otorhinolaryngology with Plastic			
Otorhionolaryngology No Plastic			
Pain Management (other than Anesthesia or other specialties)			
Plastic/Reconstructive Surgery			
Podiatry			
Radiological/Nuclear/ Chemotherapy**			
Other (describe)_____			
Total Each Year			

* If the Applicant provides pregnancy termination complete Supplement for Abortion Centers (SM-31002-01).

** Attached a description of services provided and staff qualifications.

2. Are any cosmetic procedures performed?..... [ ] Yes [ ] No
If Yes,
(a) Is any person other than a licensed and credentialed physician/surgeon allowed to administer Botox or any other cosmetic injectable, including fillers? ..... [ ] Yes [ ] No
If Yes, attached details and criteria for credentialing and supervision.
(b) Is liposuction performed? ..... [ ] Yes [ ] No
If Yes, volume of fluid injected and removed:
(i) before surgery _____cc's
(ii) after surgery _____cc's
(c) Are any cosmetic procedures other than those described in (a) and (b) performed? ..... [ ] Yes [ ] No
If Yes, describe. _____

3. Are any surgical procedures performed for the purpose of weight reduction? ..... [ ] Yes [ ] No
If Yes,
(a) If the Applicant provides any of the following procedures, check all that apply and provide the number of procedures performed:

Roux-en-Y:
___ Laparoscopic:
No. performed in past 12 months: _____
No. expected to perform in next 12 months: _____

___ Open:
No. performed in past 12 months: _____
No. expected to perform in next 12 months: _____

Banding:

___ Laparoscopic:
No. performed in past 12 months: _____
No. expected to perform in next 12 months: _____

___ Open:
No. performed in past 12 months: _____
No. expected to perform in next 12 months: _____

Gastric Restriction, Other (describe): _____
No. performed in past 12 months: _____
No. expected to perform in next 12 months: _____

(b) Attach protocols for selecting and monitoring patients for each type of procedure performed.

4. Does the Applicant have a:

(a) Formal laser safety and surgical fire prevention program? ..... [ ] Yes [ ] No
(b) Preventive maintenance program for all anesthesia and critical emergency equipment? ..... [ ] Yes [ ] No
(c) Formal process to minimize the risk of wrong patient/procedure/side/site surgery that includes validation by the patient/legal representative and documentation of the steps taken by all members of the surgical team to accurately identify the correct procedure, side and site including re-verification in the operating room prior to surgery? ..... [ ] Yes [ ] No
(d) Formal process to verify and document that ambulatory surgery patients have an appropriate screening by a physician to exclude high risk patients or procedures, (e.g., by ASA criteria or other formal guidelines)? ..... [ ] Yes [ ] No

If the answer to (b), (c) or (d) above is No, explain. _____

_____

5. Does the Applicant have a formal policy which requires documentation of all pre-operative care that includes the following:

(a) Pre-operative history and physical exam? ..... [ ] Yes [ ] No
(b) Pre-operative laboratory and ECG review by a surgeon and anesthesia provider? ..... [ ] Yes [ ] No
(c) Pre-operative nursing assessments? ..... [ ] Yes [ ] No
(d) Pre-operative anesthesia evaluation and airway assessment per ASA guidelines? ..... [ ] Yes [ ] No
(e) Documentation of informed consent for surgery and anesthesia prior to administration of pre-operative medication? ..... [ ] Yes [ ] No

If the answer to any of the above questions is No, explain. _____

6. Does the Applicant have a formal policy which requires documentation of all intra and post-operative care that includes the following:

(a) Patient identification, procedure, site, side re-verification? ..... [ ] Yes [ ] No
(b) Positioning, electrical and laser safety precautions? ..... [ ] Yes [ ] No
(c) Anesthesia assessment and continuous physiologic monitoring? ..... [ ] Yes [ ] No
(d) Documentation and signing of all intra-operative orders? ..... [ ] Yes [ ] No
(e) All medications and intravenous fluids? ..... [ ] Yes [ ] No
(f) Disposition of all specimens sent to pathology? ..... [ ] Yes [ ] No
(g) Validation of sponge, needle and instrument counts, actions taken if count is not correct? ..... [ ] Yes [ ] No
(h) Condition, mode of transport and clinical status of patient, transfer report upon completion of procedure and transfer to post-anesthesia care area? ..... [ ] Yes [ ] No
(i) Signing of all postoperative order and timely dictation of operative notes? ..... [ ] Yes [ ] No

If the answer to any of the above questions is No, explain. _____

_____

7. Does the Applicant have a formal discharge policy which requires that patients:

(a) Meet specific clinical discharge criteria? ..... [ ] Yes [ ] No
(b) Be examined by a licensed provider and anesthesia provider prior to discharge? ..... [ ] Yes [ ] No
(c) Receive written and individualized discharge instructions detailing emergency care procedures with signatures of the patient and discharge provider with copies retained by the Applicant? ..... [ ] Yes [ ] No
(d) Are prevented from driving themselves home or taking public transportation post procedure? ..... [ ] Yes [ ] No

(e) Receive a documented status call-back phone call from the Applicant center within 24 hours of discharge? ..... [ ] Yes [ ] No

If any of the above questions are answered No, explain: _____

_____

8. Does the Applicant offer professional advise to the public via the internet, newspapers or broadcasts? [ ] Yes [ ] No
If Yes, explain._____

9. Does the Applicant advertise professional services in any manner (other than a simple listing in a telephone directory)? ..... [ ] Yes [ ] No
If Yes, attach a copy of all advertisements.

10. Is the Applicant associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? ..... [ ] Yes [ ] No
If Yes, attach an explanation and a copy of all advertisements.

V. CLAIMS AND HISTORY

1. Has the Applicant or any of its employees ever:

(a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency? [ ] Yes [ ] No

(b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses? ..... [ ] Yes [ ] No

(c) Evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders? ..... [ ] Yes [ ] No

(d) Had any professional license or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license? ..... [ ] Yes [ ] No

2. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance? ..... [ ] Yes [ ] No
If Yes, how many? _____Complete a Markel Shand, Inc. Supplemental Claim form for each one.

3. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? ..... [ ] Yes [ ] No
If Yes, explain._____

4. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? .. [ ] Yes [ ] No
If Yes, how many? _____Complete a Markel Shand, Inc. Supplemental Claim form for each one.

5. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for this insurance in the last five years? ..... Yes [ ] No [ ]
If Yes, attach a copy of such insurer's notice.

6. List prior Professional Liability Insurance for each of the last five (5) years, including the current year:
If None, check here. [ ]

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

7. List prior General Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

VI. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					

2. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:
   - (a) Complete Sprinkler System? ..... [ ] Yes [ ] No
   - (b) At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
   - (c) Self-closing fire doors on each floor? ..... [ ] Yes [ ] No
   - (d) Automatic fire alarm system connected to a local fire department? ..... [ ] Yes [ ] No
   - (e) Smoke detectors? ..... [ ] Yes [ ] No
   - (f) Emergency electrical system? ..... [ ] Yes [ ] No
   - (g) Heat sensors? ..... [ ] Yes [ ] No
   - (h) Fire escape(s)? ..... [ ] Yes [ ] No
   - (i) Posted emergency evacuation procedures? ..... [ ] Yes [ ] No
   - (j) Properly maintained fire extinguishers? ..... [ ] Yes [ ] No

   If any of the above are answered No, provide details by attachment.

4. Does the Applicant have a written safety program in place? ..... [ ] Yes [ ] No
   If Yes, attach a copy of the written safety program.

5. Does the Applicant have written procedures for incident reporting? ..... [ ] Yes [ ] No

6. Do any of the Applicant's locations have any:

   (a) Exposure to flammables, explosive, chemicals? ..... [ ] Yes [ ] No
   (b) Catastrophe exposure? ..... [ ] Yes [ ] No
   (c) Exposure to radioactive materials? ..... [ ] Yes [ ] No

7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? ..... [ ] Yes [ ] No

8. Does the Applicant:

   (a) Loan or rent machinery or equipment to others? ..... [ ] Yes [ ] No
   (b) Own any elevators or escalators? ..... [ ] Yes [ ] No
   (c) Own or rent any parking facility? ..... [ ] Yes [ ] No
   (d) Provide any recreational facility? ..... [ ] Yes [ ] No
   (e) Have a swimming pool on the premises? ..... [ ] Yes [ ] No
   (f) Sponsor any sporting or social events? ..... [ ] Yes [ ] No

9. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? ..... [ ] Yes [ ] No

   If Yes, answer the following:
   Provide three year loss history for claims under $100,000 Loss and Expense and ten years for claims $100,000 and greater. Attach further sheets if needed.

Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved and Paid	Amount of Expenses Reserved and Paid	Open (O) or Closed (C)

10. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? ..... [ ] Yes [ ] No
    If Yes, provide details for each incident. _____

VII. ADDITIONAL INFORMATION

As part of this Application attach the following:

1. A copy of the Applicant's letterhead/business stationery.
2. Five years of currently valued Professional Liability Insurance and General Liability Insurance claim runs from current and prior insurers.
3. A list of any activities or procedures performed that are not otherwise described in this Application.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Extended Reporting Period option is exercised in accordance with the terms of the policy.

Markel Shand, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which Markel Shand, Inc. receives notice is on file with Markel Shand, Inc. and is considered physically attached to and part of the of the policy if issued. Markel Shand, Inc. and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Markel Shand, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I/We warrant to the Company, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Markel Shand, Inc. or the Company, Ten Parkway North, Deerfield, Illinois 60015.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant	Title
Signature of Applicant	Date

Notice to 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 the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS

MARKEL SHAND, INC.
Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Markel Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: