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

- 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 SURGICAL CENTERS, FREE STANDING EMERGENCY CENTERS PROFESSIONAL LIABILITY INSURANCE

(CLAIMS MADE BASIS)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full Name of Applicant: _____ Business Phone: (___) _____

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

(Please attach list of any additional locations.)

c. Total sq. ft. occupied by you (all locations): _____

d. Year established: _____

e. Limits requested: _____ (per claim) _____ (aggregate) _____ Deductible

f. [ ] Professional Corporation (for profit) [ ] Professional Corporation (non-profit) [ ] Partnership
[ ] Independent Center [ ] Hospital or Hospital Associated Center [ ] Other (describe)
[ ] Professional Association
Business, corporate or partnership name: _____

h. Professional societies or associations in which you are a member.

_____

_____

2. APPLICANT OPERATIONS

a. Please list all partners or members of the firm who provide professional services: _____

_____

b. Please provide name of medical director and professional specialty: _____

_____

c. In what states are you registered and licensed to practice? _____

_____
(If none, please attach explanation.)

d. Your professional specialty: _____

e. Do you maintain any beds for overnight occupancy? [ ] Yes [ ] No If yes, please explain. _____

_____

f. Indicate three (3) largest (patient volume) departments by specialty.
(i) _____ approximate percentage to total volume _____%
(ii) _____ approximate percentage to total volume _____%
(iii) _____ approximate percentage to total volume _____%

g. Number of Minor Surgical Procedures performed: _____ Number of Major Surgical Procedures performed: _____

h. Do you have the following equipment at the center?

		Yes	No
(i) Laboratory, with the following capabilities -- CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine?	(i)	[ ]	[ ]
(ii) X-ray with on-premises processing?	(ii)	[ ]	[ ]
(iii) EKG -- 12 lead?	(iii)	[ ]	[ ]
(iv) Monitor/Defibrillator?	(iv)	[ ]	[ ]
(v) Crash cart with full cardiac life support capabilities and necessary intravenous fluids?	(v)	[ ]	[ ]
(vi) Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage?	(vi)	[ ]	[ ]
(vii) Oxygen?	(vii)	[ ]	[ ]
(viii) Suction?	(viii)	[ ]	[ ]
(ix) Pneumatic anti-shock trousers?	(ix)	[ ]	[ ]
(x) Dedicated telephone lines to the closest appropriate hospital emergency department and/or two-way communication with EMS?	(x)	[ ]	[ ]

i. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? [ ] Yes [ ] No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? [ ] Yes [ ] No

(ii) 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.

3. APPLICANT PROCEDURES

	Yes	No
a. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? If yes, please attach detailed explanation of this activity.	[ ]	[ ]
b. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? If yes, please attach a copy of ALL of the advertisements.	[ ]	[ ]
c. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? If yes, please attach detailed explanation and a copy of ALL of the advertisements.	[ ]	[ ]
d. Do you maintain adequate medical records for each patient?	[ ]	[ ]

(i) How often and by whom are the medical records reviewed? _____

_____

(ii) What arrangements are made for transmitting medical records to other requesting physicians?

_____

_____

e. Please give names and locations of any hospitals or institutions that you use in practice.

_____

_____

f. Please describe in detail your role and function in the local emergency medical services system, including:

(i) Time and distance from the center to the nearest appropriate hospital.

(ii) Physician direction and supervision of personnel, facilities, and equipment for the provision of medical services under emergency conditions. _____

_____

_____

g. Is anesthesia (other than topical or by means of local infiltration) administered by either you or others? [ ] Yes [ ] No
If yes, attach detailed explanation and a copy of written policies and/or guidelines of the anesthesia services.

4. APPLICANT SERVICES

a. (i) Does the clinic provide medical services for other than fee for service? [ ] Yes [ ] No
If yes, give details or arrangements, including copy of contract(s).

(ii) What is patient mix? Fee for service: _____% Prepaid: _____%

(iii) Percent of prepaid patients referred to outside physicians: _____%

b. Does clinic attract patients because of reputation in any particular field of medicine? [ ] Yes [ ] No If yes, in which field?

c. Indicate percentage elective surgery _____% Non-elective _____%

d. Do you perform hospital emergency room care for patients not your own? [ ] Yes [ ] No If yes, please attach explanation and advise the number of "patient contact" hours MONTHLY by your:

(i) Emergency Room Physicians _____ hrs. (iii) Nurses _____ hrs.

(ii) Paramedics _____ hrs. (iv) Other_____ _____ hrs.

e. Do you use drugs for weight reduction of patients? [ ] Yes [ ] No If yes, attach list of drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed.

f. Number of annual X-ray exposures: for diagnosis _____; for treatment _____.

g. If X-ray treatment is given, what qualifications are required of the staff? _____

_____

5. APPLICANT STAFF

a. Do you own or operate any business other than that shown in Question 1(a) above? [ ] Yes [ ] No
If yes, please give details on separate sheet.

b. Please describe hiring and verification processes for all employed/independently contracted physicians degrees and experience. _____

_____

_____

c. Do you have any restricted licensed physicians on staff? [ ] Yes [ ] No If yes, please explain.

_____

_____

_____

d. Do you have any physicians on staff that do not maintain staff privileges at a hospital? [ ] Yes [ ] No If yes, please explain. _____

_____

_____

e. Please describe peer review process for surgeons. _____

_____

_____

f. Does the center require Certificates of Insurance from all staff doctors? [ ] Yes [ ] No If yes, what are minimum limits of liability that are required? _____ (per claim) _____ (aggregate)

g. Hours of operation:

h. Do you have qualified physician(s) and other personnel trained in emergency medical care in center during all hours of operation? [ ] Yes [ ] No Please describe. _____

_____

_____

i. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, PLEASE STATE NONE.

		No of Employees And Volunteers	No. of Independent Contractors
(i)	Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures:	(i) _____	_____
(ii)	Physicians: Minor surgery or obstetrical procedures not constituting major surgery:	(ii) _____	_____
(iii)	Proctologists, Ophthalmologists and Urologists:	(iii) _____	_____
(iv)	General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery):	(iv) _____	_____
(v)	Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery:	(v) _____	_____
(vi)	Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons:	(vi) _____	_____
(vii)	Physicians' & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet):	(vii) _____	_____
(viii)	Interns/residents:	(viii) _____	_____
(ix)	Unlicensed Interns:	(ix) _____	_____
(x)	Dentists (no oral surgery):	(x) _____	_____
(xi)	Orthodontists:	(xi) _____	_____
(xii)	Oral Surgeons:	(xii) _____	_____
(xiii)	Nurse Anesthetists:	(xiii) _____	_____
(xiv)	Optometrists, Opticians:	(xiv) _____	_____
(xv)	Pharmacists:	(xv) _____	_____
(xvi)	Perfusionists:	(xvi) _____	_____
(xvii)	Podiatrists:	(xvii) _____	_____
(xviii)	Chiropractors:	(xviii) _____	_____
(xix)	RNs, LPNs:	(xix) _____	_____
(xx)	X-ray Technician:	(xx) _____	_____
(xxi)	Physical therapist/pulmonary therapists:	(xxi) _____	_____
(xxii)	Other miscellaneous medical personnel; (please specify and attach a list):	(xxii) _____	_____

j. Are all of the above individuals licensed in accordance with applicable state and federal regulations? [ ] Yes [ ] No If no, please attach explanation.

k. Do you supervise any individuals other than your own employees? [ ] Yes [ ] No If yes, please attach explanation of responsibilities and relationship to the entity which employs these individuals.

Please indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

6. APPLICANT REVENUE/VISITS

a. State sources and amounts of total revenue:

Source	Amount This Fiscal Year	Amount Next Fiscal Year
A. Charitable Contributions	$ _____	$ _____
B. Government Funding	$ _____	$ _____
C. Fee for Service	$ _____	$ _____
D. _____	$ _____	$ _____
TOTAL GROSS REVENUE	$ _____	$ _____

b. Provide number of outpatient visits:

Type of Visit	Number of Visits Last 12 Months	Number of Visits Next 12 Months
Clinic	_____	_____
Laboratory	_____	_____
	_____	_____
TOTAL NO. OF VISITS	_____	_____

7. APPLICANT HISTORY

a. List prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No
							[ ]	[ ]
							[ ]	[ ]
							[ ]	[ ]

b. If prior professional liability insurance was on a claims made basis, the retroactive exclusion date was: _____

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Have you or any of your employees listed in question 5(i):		Yes	No
(i) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by a governmental or an administrative agency, hospital or professional association?	(i)	[ ]	[ ]
(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	(ii)	[ ]	[ ]
(iii) Ever been treated for alcoholism or drug addiction?	(iii)	[ ]	[ ]
(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	(iv)	[ ]	[ ]
(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?	(v)	[ ]	[ ]

8. CLAIMS

a. Has any claim or suit been brought against you and/or any of your employees? [ ] Yes [ ] No If yes, a supplemental claim information form must be completed for each claim or suit.

b. Are you aware of any circumstances which may result in a malpractice claim or suit being made against you or any of your employees? [ ] Yes [ ] No If yes, give details on separate sheet.

9. ADDITIONAL INFORMATION

a. A copy of your letterhead/business stationery.

b. A copy of your protocol(s) for stabilization and transportation of patients requiring hospital or other care unavailable at the center.

c. List of all surgical procedures performed at the center.

d. List of activities/procedures performed, not otherwise described in this application.

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, 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.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I 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 of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I authorize the release of claim information from any prior insurer to Markel Shand, Inc., Ten Parkway North, Deerfield, Illinois 60015.**

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

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: