ASC APPLICATION

The Applicant represents and declares that all statements and facts set forth herein are true and no material facts have been suppressed or misstated. Any material misstatements and/or omissions may result in coverage being rescinded. The Applicant agrees that if the information supplied on this Application changes between the date of this Application and the effective date, then the Applicant will immediately notify the company of such changes. The Applicant acknowledges that the company is relying on the information contained in the Application, and it is agreed that this Application shall be the basis of the contract and shall be incorporated by reference into the policy should a policy be issued. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

INSTRUCTIONS

1) Please type or print clearly.
2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Appropriate).
3) If the applicant needs more space for responses, continue on a separate sheet of paper and indicate question number.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED

LOSS HISTORY – Submit company produced 10 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss greater than $50,000.

Copies of all marketing materials.

Most current year-end financial statements – Audited or CPA prepared.

Copies of most recent accreditation and inspection reports within the past three years.

Start-Up Facility - submit (1) business plan, (2) resumes of all physicians involved, (3) inspection application(s), and (4) loss history (10 years) for each physician involved.

GENERAL INFORMATION

Applicant's Name:

Business Address:

Mailing Address:

Website:

Years in Business: Employer Federal Tax I.D. No.: Telephone No:

Website:

Reporting/Fiscal Year Start Date:

Requested effective date:

Current Form of Insurance: Retro Date for Claims Made
Professional Liability -
Commercial General Liability -

Requested Coverage:
Professional Liability
Commercial General Liability

Requested Limits of Liability – Primary*

**Professional Liability and General Liability Limits must be the same, but apply separately*.

Deductible (applies separately to Professional Liability and General Liability)

ASC APPLICATION

Requested Limits of Liability – Excess Coverage Requested

COMPANY OVERVIEW

1. How many locations does the applicant have?
2. Are the applicant's locations part of a chain?
3. Indicate revenue by year:

Year	$ Revenues
Start date of reporting year	

4. Applicant is:

5. Applicant operates:

List all subsidiaries, date acquired and description of operations & ownership in percentages (use additional sheet if necessary):

Subsidiaries	Date Acquired	Description of Operations	% Ownership

List all acquisitions or divestitures during the past 3 years.

Acquisitions/Divestitures	Acquired/Divested	Date of Transfer	Retro Date if Claims Made

6. Describe any operations not described above.

7. Breakdown of Healthcare Professionals.

	Employees		Contractors		Minimum PL Limits Facility Requires They Carry
	FT	PT	FT	PT	
Anesthesiologists					

Surgeons					
Oral Surgeons					
Emergency Medical Technicians					
Nurse Anesthetists					
Nurse Practitioners/Clinicians					
Occupational Therapists					
Physical Therapists					
Physician Assistants					
RNs/LPNs/LVNs					
Technicians					
Other (define)					

8. If the applicant requires coverage for Contracted Health Professionals, please complete the following:

Profession	Contractors	
	Full Time	Part Time
Totals		

HISTORICAL EXPOSURE INFORMATION

9. Describe the type of procedures and number of outpatient visits per procedure:

Type of Surgery/Procedures by Specialty:	**Number of Outpatient Visits (OPVs)**		
			Projected 12 Months
Urology			
Gastrointestinal Endoscopy			
ENT			
General Surgery			
Gynecology Surgery			
Ophthalmology – Cataract			
Orthopedic Surgery			
Pain Management			
Plastic Surgery			
Podiatry			
Bariatric Surgery			
Cosmetic Surgery			
Ophthalmology - Lasik			
Other Procedures:			
List Non –Surgical Services here:			
Add More Other Specify			
TOTAL			

10. Number of beds for overnight stay?

11. Number of abortions performed per year:

12. If the applicant's facility performs any cosmetic/implant surgery, complete the following:

Type of Cosmetic Surgery	Number of Procedures Per Year

13. Explain any areas of surgery for which the applicant are not currently engaged but plan to engage in the next 12 months below.

14. State Location Exposures – please specify by state:

State Number of Visits

Total

RISK MANAGEMENT/LOSS CONTROL

15. Is there a formal process in place to minimize the risk of wrong patient/procedure/side/site surgery which includes:
    (a) Pre-operative verification of the patient?
    (b) Pre-operative verification of the site?
    (c) Marking of the operative site?
    (d) A "time out" immediately before starting the procedure?

16. Is there a formal process in place to ensure that patients selected for ambulatory surgery in this center undergo appropriately screening to de-select out high risk patients or procedures that utilize:
    (a) ASA criteria or other formal anesthesia selection guidelines?
    (b) Final decision by anesthesia based on medical status to de-select patients?
    (c) Formal list of acceptable/unacceptable procedures at this ASC?

17. Are CRNA's supervised by anesthesiologists?

18. Do all of the applicant's ASC locations have a formal credentialing and privileging process which includes primary source verification of professional credentials and privilege qualifications for all surgeons and anesthesia providers including:
    (a) Review/approval of requested privileges by the center's medical director and/or credentials committee?
    (b) Continuous updates of new or deleted privileges for ASC staff (either through an automated or manual system)?
    (c) Can ASC staff refuse to schedule surgeries or procedures not on an individual provider's list of approved privileges or a non ASC-approved procedure?
    (d) What is the applicant's formal process of assuring that physicians maintain required limits?

19. Do all of the applicant's locations have a formal laser safety and surgical fire prevention program in place including at least:
    (a) Written policies and procedures for laser safety and surgical fire prevention programs?
    (b) A formal laser safety committee?
    (c) Formal laser safety and surgical fire prevention education and competency validation for all staff at least annually?
20. Please indicate the number of ASC facilities accredited based on type of accreditation decision:

    JCAHO

    AAAHC

    AAAASF

    Number of Facilities NOT Accredited by JCAHO, AAAHC or AAAASF:

21. Do all of the ASC locations have formal policies which require documentation of all preoperative care including:
    (a) Preoperative history and physical examination in the medical record by the day of surgery?
    (b) Preoperative laboratory and ECG review by surgeon and anesthesia provider when applicable?
    (c) Preoperative nursing assessments?
    (d) Preoperative anesthesia evaluation and airway assessment per ASA guidelines?
    (e) Documentation of informed consent for surgery and anesthesia prior to the administration of preoperative medication?
22. Do all of the ASC locations have a preventative maintenance program for all biomedical equipment including anesthesia and critical emergency equipment that includes:
    (a) Proper training of all equipment users?
    (b) Controls over physician owned equipment?
    (c) Repairs by qualified personnel?
    (d) Policies and procedures for borrowing, lending, selling or donating equipment?
    (e) Documentation of all activities (preventive maintenance, repairs, education)?
23. Do all of the ASC locations have a formal emergency response policy which includes at least:
    (a) Written policies for patient transfer to the nearest available emergency department?
    (b) Immediate activation of the EMS system?
    (c) Current Advanced Cardiac Life Support (ACLS) certification for all Post Anesthesia Care Unit (PACU) staff

24. Do all ASC locations have a formal policy which requires documentation of all intra and post operative care including:
    (a) Patient identification, procedure, site, side re-verification?
    (b) Positioning, electrical and laser safety precautions?
    (c) Anesthesia assessment and continuous physiologic monitoring?
    (d) Documentation and signing of all intraoperative orders?
    (e) All medications and intravenous fluids?
    (f) Disposition of all specimens sent to pathology?
    (g) Validation of sponge, needle and instrument counts, actions taken if count is not correct?
    (h) Condition, mode of transport and clinical status of patient, transfer report upon completion of procedure and transfer to post-anesthesia care area?
    (i) Signing of all postoperative orders and timely dictation of operative notes?

25. Do all of the ASC locations have a formal discharge policy which requires that patients:
    (a) Meet specific clinical discharge criteria?
    (b) Be examined by a licensed independent provider or anesthesia provider prior to discharge?
    (c) Receive written, individualized discharge instructions which detail emergency care procedures?
    (d) Prevent patients from driving themselves home or taking public transportation post procedure?
    (e) Receive a documented status "call-back" phone call from the ASC in 24 hours of discharge?

26. Does the ASC have a parent organization?

    If yes, does the corporate entity:
    (a) Mandate standardized clinical and administrative policies and procedures for all facilities?
    (b) Have uniform quality and risk management programs implemented for all facilities?
    (c) Has an individual been designated to perform the function of risk management?

    If yes, who coordinates the applicant's Risk Management Program?

    Name:

    Title: Phone Number:

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COMMERCIAL GENERAL LIABILITY INFORMATION

27. Please provide physical plant information as requested:

Address/Occupancy	Age	Type of Construction	# Floors	Designed for Patient Care?	Designed for Overnight Guests?	Number of Exits per Floor

28. Please indicate any additional insureds to be included under the applicant's facility's General Liability Coverage, including explanation of their interest.

Name of Additional Insured	Interest

29. Are the electrical, heating and plumbing systems up to code and regularly inspected?

30. If buildings are partially and not completely sprinklered, provide details:

31. Are the fire alarms connected to a local fire station?

UMBRELLA LIABILITY

32. Is the applicant applying for excess/umbrella coverage?

33. List all Automobile Liability and Workers Compensation\Employer's Liability policies if the applicant is applying for excess/umbrella coverage:

Type of Insurance	Insurer	Policy Number	Effective Date	Expiration Date	Limits	Premium
Auto						
Workers Compensation						
Other						
Other						
Other						

34. Submit company produced 5 year Auto Liability loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).

35. (a). **If no auto claims have been reported, initial here: _____**

(b). If there are any large loss auto claims greater than $50,000, then initial here ___ and provide detailed description of each loss.

36. Please indicate the number of vehicles that the applicant owns or leases. If none, indicate "none."

If yes, indicate number:

(a) Cars	
(b) Light Trucks	
(c) Vans/Buses	
(d) Other (describe):	

37. Does the applicant's auto liability policy include liability coverage for hired and non-owned autos?

If yes, please quantify:

38. If applying for excess auto coverage, does the applicant have any vehicles garaged in any of the following states?

(a) Ohio	
(b) Florida	
(c) Louisiana	
(d) Indiana	
(e) Vermont	
(f) New Hampshire	

39. Does the applicant reject uninsured/underinsured motorist coverage in the above states?
If yes, then provide a copy of the formal rejection required form.

HISTORICAL CARRIER INFORMATION

40. Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

Type	Policy Period	Insurer	Premium	Limits	CM Or Occurrence	If CM, enter Ret Date

LOSS HISTORY

41. Please provide currently valued carrier produced loss runs for the past 10 years.

42. If no claims have been reported to the applicant, then initial here:

43. Large Loss Description – On a separate sheet of paper list any liability or auto claims or suits made or brought against the applicant's facility during the past 10 years for amounts incurred greater than $50,000.

If no claims or suits greater than $50,000 then check the box: □

None Greater than $50,000 also initial here: _____

44. Is the applicant aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim?

If yes, give dates, allegations and disposition of each claim or suit.

THE UNDERSIGNED DECLARES THAT ALL STATEMENTS SET FORTH HEREIN ARE TRUE. ANY MATERIAL MISSTATEMENTS AND/OR OMISSIONS MAY RESULT IN RESCINDED COVERAGE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT THE APPLICANT ACKNOWLEDGES THAT THE COMPANY IS RELYING ON THE INFORMATION CONTAINED IN THE APPLICATION, AND IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT AND SHALL BE INCORPORATED BY REFERENCE INTO THE POLICY SHOULD A POLICY BE ISSUED.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____

Brokerage Firm Name: _____

Producer Name: _____

Address: _____

Telephone: _____

Fax: _____