

**OneBeacon Insurance Company
Homeland Insurance Company of New York
York Insurance Company of Maine**

**AMBULATORY SURGERY CENTER
PROFESSIONAL LIABILITY APPLICATION**

NOTICE: CERTAIN COVERAGE PARTS OF THE POLICY WHICH IS BEING APPLIED FOR APPLY ONLY TO "CLAIMS" THAT ARE FIRST MADE AGAINST THE "INSURED" DURING THE "POLICY PERIOD" AND REPORTED TO THE UNDERWRITER DURING THE "POLICY PERIOD" OR DURING THE EXTENDED REPORTING PERIOD, IF APPLICABLE.

A. APPLICANT

1. Legal name of Applicant: _____
2. Address: _____
City: _____ County: _____ State: _____ Zip: _____
3. Telephone number: _____
4. How many years has the Applicant been in operation? _____
5. How many years has the Applicant been under present ownership? _____
6. Website: _____
7. Please describe the ownership structure. List all affiliates and subsidiaries to which this insurance is to apply. Please include a complete description of the operations of each affiliate/subsidiary and the relationship to the Applicant. (Please attach a separate sheet if necessary.)

B. REQUESTED COVERAGE STRUCTURE:

? Primary ? Excess

Effective Date: _____ Retroactive Date: _____

Per Claim Limit: _____ Aggregate Limit: _____

Per Claim Deductible/Retention: _____ Aggregate Deductible/Retention: _____
(circle Deductible or Retention)

Expiring Premium _____

C. GENERAL INFORMATION

1. Is the Applicant accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)? ? Yes ? No

Date of last accreditation: _____

Accreditation period: _____

(Please attach a copy of the most recent survey.)

Is this facility licensed by the State? ? Yes ? No

(Please attach a copy of the most recent State license survey.)

Is the surgery center accredited? If so, by which accrediting body? _____

2. Has the Applicant or other associated entity ever lost a license or been placed on

probation by any governmental licensing agency? ? Yes ? No

If "Yes," please explain: _____

3. Has the Applicant entered into any joint ventures or limited partnerships? ? Yes ? No
If "Yes," please explain on a separate sheet of paper.

4. Is any part of the Applicant operated/leased by a management corporation? ? Yes ? No
If "Yes," please give the name of the corporation and details of structure.
Please attach a separate sheet of paper.

5. Does the Applicant participate in any teaching programs? ? Yes ? No
If "Yes," please describe the type of programs: _____

Is the program hospital-sponsored? ? Yes ? No
If "Yes," please provide the name of the sponsoring institution: _____

6. Does the Applicant anticipate any facility expansions within the next year? ? Yes ? No
If yes, please explain _____

D. PERSONNEL

1. Indicate the number of persons employed by or working under the control of the Applicant in each of the following classifications:

- | | |
|--|---|
| <input type="checkbox"/> Certified Registered Nurse Anesthetists | <input type="checkbox"/> Registered Nurses |
| <input type="checkbox"/> Dentists* | <input type="checkbox"/> Respiratory Therapists |
| <input type="checkbox"/> Interns | <input type="checkbox"/> Pharmacists |
| <input type="checkbox"/> Laboratory or X-ray Technicians | <input type="checkbox"/> Physician Assistants |
| <input type="checkbox"/> Licensed Vocational/Practical Nurses | <input type="checkbox"/> Physicians and Surgeons* |
| <input type="checkbox"/> Nurse Practitioners | <input type="checkbox"/> Residents* |

Other (explain): _____

* (A separate application may be required for each Physician or Surgeon prior to commencement of coverage)

2. Please provide a list of all physicians and anesthesia providers who have privileges to provide services at this facility.

a. What are the minimum limits of malpractice insurance required for providers?
_____ per occurrence/_____ aggregate

3. Are Agency Personnel utilized? If yes, what % of total staff _____

4. ANESTHESIA SERVICES

a. Staffing is by: Contracted Physicians Employed Physicians Residents
 Certified Registered Nurse Anesthetists (CRNAs)

Number of Anesthesiologists? _____ Full-Time _____ Part-Time

Are all physicians board certified or eligible? ? Yes ? No

If "No," please explain: _____

b. If under contract, to whom is staffing contracted? _____

c. Are contract physicians required to carry professional liability insurance? ? Yes ? No

If "Yes," what limits are required? _____

Does the Applicant obtain a Certificate of Insurance? ? Yes ? No

d. Describe the minimum qualifications required for administration of general anesthesia:

e. What types of Anesthesia are used at the surgery center? _____

f. Is there a tested plan in place to manage an adverse Anesthesia event? ? Yes ? No

g. Do you screen patients preoperatively for personal or family history of MH? ? Yes ? No

h. Do you have the MH tackle box fully stocked and readily available? ? Yes ? No

i. CRNAs

(i) Do CRNAs provide anesthesia service? ? Yes ? No

If "Yes," please describe the relationship between the Applicant and the CRNAs below:

Are they: Employed by the Applicant? ? Yes ? No

Employed by the Anesthesiologist? ? Yes ? No

Employed by the Surgeon? ? Yes ? No

Independent? ? Yes ? No

(ii) Do CRNAs work under the direct supervision of an anesthesiologist? ? Yes ? No

If "No," please submit written guidelines developed with the collaborative physician or qualified physician designee of the primary physician or the dentist responsible for the patient's immediate care.

5. RADIOLOGY SERVICES

a. Staffing is by: ___ Contracted Physicians ___ Employed Physicians ___ Residents

Number of Radiologists? _____ Full-Time _____ Part-Time

Are all physicians board certified or eligible? ? Yes ? No

If "No," please explain: _____

- b. If under contract, to whom is staffing contracted? _____

 Are contract physicians required to carry professional liability insurance? ?Yes ?No
 If "Yes," what limits are required? _____
 Does the Applicant obtain a Certificate of Insurance? ?Yes ?No
- c. Please state the number of X-ray machines owned or operated, and whether they are used for diagnosis or treatment or both. Please state by whom the treatment is given: _____

E. OPERATIONS

1. Services

Type of Surgical Procedure	# of Surgeries Projected Next 12 Months	Current Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior

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

- Bariatrics? ? Yes ? No If yes, how many? _____
- Plastic (Cosmetic) ? Yes ? No If yes, what percentage of overall number of procedures? _____
- Lasik Surgery ? Yes ? No If yes, what percentage of overall number of procedures? _____

3. Are licensed beds maintained for overnight patients?

If yes, please indicate # licensed beds _____ #occupied beds _____
 What types of procedures may warrant an overnight stay _____

Is the surgery center staffed to monitor these patients? _____

4. Is there a surgeon on-site during regular hours? _____
 Is there an anesthesiologist on-site during regular hours? _____

- e. Is there 100% compliance with the process? ?Yes ?No
- f. Is there a collaborative credentialing process through which other care providers are credentialed along with the surgeons? ?Yes ?No
If yes, who is included in the credentialing process? _____
- g. How does the surgery center use quality and outcome data in the credentialing process?

H. CONTRACTUAL AGREEMENTS

- 1. a. Does the Applicant lease or rent any equipment from others? ?Yes ?No
If "Yes," please provide a description of the equipment: _____

- b. Does the Applicant indemnify (hold harmless) the owner for liability? ?Yes ?No
If "Yes," please submit a copy of the agreement.
- 2. a. Please identify any contract professional services performed at the surgery center:

___ Housekeeping	___ Pathology
___ Laboratory	___ Pharmacy
___ Laundry	___ Other (explain): _____
- b. Does the Applicant require these contractors to provide evidence of insurance? ?Yes ?No
If "Yes," what limits of liability does the Applicant require? _____
(Please submit a copy of each contract.)
- 3. a. Are there any other service contracts in effect? ?Yes ?No
If "Yes," please describe services: _____
- b. Does the Applicant indemnify (hold harmless) the service provider? ?Yes ?No
If "Yes," please submit a copy of the contract.

I. PHYSICAL PREMISES

- 1. Please list below all the buildings the Applicant owns, controls, or occupies. Where fixed features exist for a building, please list wings, floors, or areas separately. Please attach a separate schedule if more space is needed.
 - a. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? ?Yes ?No Smoke detectors? ?Yes ?No
 - b. Address: _____
 Year built: _____ No. of stories: _____ Use: _____
 Construction (brick, fire-resistive, etc.): _____
 Total sq. ft.: _____
 Complete sprinkler system? ?Yes ?No Smoke detectors? ?Yes ?No

If additional locations, please attach a separate list.

J. AUTO LIABILITY EXPOSURE

ERROR OR OMISSION REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 3 IS EXCLUDED FROM THE PROPOSED INSURANCE.

L: ADDITIONAL INFORMATION

Please provide the following:

1. Loss History for the last ten (10) years, including the current year and a breakdown of total incurred losses, paid losses, and outstanding losses, separated by year. Please provide details of any claim paid or outstanding.
2. The Applicant's most recent annual report
3. A copy of the most recent JCAHO report and response to any contingencies
4. The Applicant's most recent financial statements
5. Copy of expiring Medical Professional Liability insurance policy

THE UNDERWRITER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. THE UNDERWRITER'S ACCEPTANCE OF THIS APPLICATION OR THE MAKING OF ANY SUBSEQUENT INQUIRY DOES NOT BIND THE APPLICANT OR THE UNDERWRITER TO COMPLETE THE INSURANCE OR ISSUE A POLICY.

IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE POLICY EFFECTIVE DATE, THE APPLICANT WILL IMMEDIATELY NOTIFY THE UNDERWRITER, AND THE UNDERWRITER MAY MODIFY OR WITHDRAW ANY QUOTATION OR AGREEMENT TO BIND INSURANCE.

NOTICE TO NEW YORK 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 EACH SUCH VIOLATION.

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 MINNESOTA, OHIO, AND ARKANSAS 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 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 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 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 NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

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.

Applicant		
By (<i>CEO/President/Chairman</i>)	Title	Date

NOTE: This Application must be signed by the Chief Executive Officer, President or Chairman of the Applicant acting as the authorized agent of all individuals and entities proposed for this insurance.

REQUIRED INFORMATION

Produced By (<i>Insurance Agent</i>) Please print and sign name _____	
Insurance Agency	
Insurance Agency Taxpayer ID or Social Security No.	Agent License No.
Address (<i>No., Street, City, State and ZIP</i>)	
E-Mail Address	

Submitted By (<i>Insurance Agency</i>)
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Insurance Agency Taxpayer ID or Social Security No.	Agent License No.
Address (<i>No., Street, City, State and ZIP</i>)	