

Darwin Professional Underwriters, Inc.

For:

Capitol Indemnity Corporation
Capitol Specialty Insurance Corporation
Platte River Insurance Company

AMBULATORY SURGERY CENTERS PROFESSIONAL LIABILITY AND COMMERCIAL GENERAL LIABILITY APPLICATION

THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON 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) _____ Years in Business: _____

Key Contact at Insured: _____ Hours of Operation: _____

Federal Tax ID: _____ Management Co: _____

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

- | | | |
|--|-------------------------------------|--|
| A. | B. | C. |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Profit | <input type="checkbox"/> Licensed by the state |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Non-Profit | <input type="checkbox"/> Accredited by AAAHC |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Charitable | <input type="checkbox"/> Medicare Approved |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government | <input type="checkbox"/> Accredited by JCAHO |
| | | <input type="checkbox"/> Other |

D. 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	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior	5 th 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 or Reconstructive)							
Podiatrist							
Urology							
Thoracic							
Vascular							
Other _____							

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

Bariatrics? Yes No
 If yes, how many? _____

Plastic (Cosmetic - Elective)? 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. 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)

<u>Position</u>	<u>Full-Time</u> (E)mployed	<u>Total FTE</u> (C)ontracted/(V)olunteers	
Physicians/Surgeons	_____	_____	_____
Aides	_____	_____	_____
Dentists	_____	_____	_____
CRNA's	_____	_____	_____
Nurse Practitioners	_____	_____	_____
Occupational Therapists	_____	_____	_____
Pharmacists	_____	_____	_____
Physical/Speech Therapists	_____	_____	_____
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

III. 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 aggregate
occurrence/ _____

- 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

IV. 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

V. 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.

Signature of Applicant: _____

Printed Name: _____

Title: _____

Date: _____