# Healthcare Facility Application
# Surgery Center—New Business

PROASSURANCE. Treated Fairly

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

## 1. Introductory Information

Legal Entity Name: ______________________________

Address: ______________________________

City: ______________ County: ______________ State: ________ ZIP: ______________

Contact Name: ______________________________

Contact Email: ______________________________

Number of Years in Operation: ______________

Telephone Number: ______________ Fax Number: ______________

Hospital Fiscal Year Begins: ______________

Tax ID Number: ______________ NPI Number: ______________

Website Address: ______________________________

## 2. Facility/Corporate Organization

Type of Entity: ☐ Government ☐ Non-Profit ☐ Profit ☐ Other ______________
☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture

Type of Facility: ______________________________

Do you have a Physician Medical Director? ☐ Yes ☐ No

Does the Medical Director provide any patient care as part of the Medical Director duties? ☐ Yes ☐ No

Please attach the following:

A. Carrier Loss History:

i. **Ten years** of historical professional liability (PL) and general liability (GL) losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.

ii. Date of loss valuation must be within the past 90 days.

iii. Loss run must include carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL) and narrative of claim.

iv. Full details of allegations on all losses paid or outstanding in excess of $100,000 even if greater than 10 years old.

B. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or, if accrediting agency reports are unavailable, please submit the state licensure report with recommendations and the institution's response to any contingencies.

C. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.

D. Identity of each employed physician including name, specialty, date of hire, retro date, primary PL carrier, is primary coverage occurrence or claims-made and PL limits (if applicable).

E. Identity related entities or subsidiaries to be considered for coverage on the policy including a brief explanation of their relationship to the applicant, scope of operations and their retro date on Schedule A (if historically written on claims-made basis).

F. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.

G. Copy of state license.

H. List of all stockholders and their percent of ownership and identify any medical designations held by any stockholder.

I. Copy of your facility accreditation.


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## 3. Current Insurance/Claim Information

| Type | Carrier or Self-Insured | Effective Date | Claims-Made or Occurrence | *Retro Date | Limits | Deductible | Premium |
|---|---|---|---|---|---|---|---|
| Primary Prof. Liability | | | | | | | |
| Primary General Liability | | | | | | | |
| Excess PL | | | | | | | |
| Umbrella GL | | | | | | | |
| Auto Liability | | | | | | | |
| Employers' Liability | | | | | | | |
| Helipad/Aviation | | | | | | | |
| Other: | | | | | | | |

**Please specify by layer if more than one Retro Date applies.*

A. Do you participate in a Patient Compensation Fund or similar type program in the state in which you operate? ☐ Yes ☐ No

If *yes*, what limit do you carry? ______

B. Have any claims ever been made or suits brought against you or any of your employees in the last five years because of any alleged malpractice, error or mistake, or from any premise accident arising in any manner out of your operations? ☐ Yes ☐ No

If *yes*, attach a separate sheet listing date of occurrence, circumstances of claim and amount paid or amount reserved.

C. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future? ☐ Yes ☐ No

If *yes*, please provide details:

## 4. Insurance Coverage Desired

| Primary: | Effective Date | Claims-Made or Occurrence | *Retro Date | Limits | Deductible |
|---|---|---|---|---|---|
| Professional Liability (PL) | | | | | |
| General Liability (GL) | | | | | |
| #Limited Pollution Liability | | | | | |
| **Excess/Umbrella:** | | | | | |
| Excess PL | | | | | |
| Umbrella GL | | | | | |

**Please specify by layer if more than one Retro Date applies.*
*#Separate Application Required – Refer to Company*

Include the following as underlying coverage on the Excess/Umbrella (if applicable). Policy information must be indicated in the "Current Insurance" section above. Provide policy declaration pages for all applicable coverage.

☐ Auto Liability ☐ Employers' Liability ☐ Helipad/Aviation ☐ Other: ______

For each Excess/Umbrella underlying line of insurance above, describe any claims in excess of $10,000.


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## 5. General Exposure Data

A. Do you maintain any beds for overnight occupancy? ☐ Yes ☐ No

Surgery Center: ______________ No. Operating Rooms Hours of Operation: ____________________________

______________ No. Occupied overnight/24-hour Beds

B. Facility is licensed as: ☐ Ambulatory Surgical Center ☐ Surgical Hospital

C. Select each type of surgical service that applies to the applicant and provide the number of annual procedures. (If new business start-up, please provide estimated number of annual procedures.)

| Type of Procedure | Annual No. Procedures for Last Fiscal Year | Type of Procedure | Annual No. Procedures for Last Fiscal Year |
|---|---|---|---|
| *Bariatric | | Gastroenterology | |
| Obstetrics | | Vascular | |
| Urology | | Cardiac Catheterization | |
| Hand | | Otolaryngology (ENT) | |
| Orthopedic | | Thoracic | |
| Colon and Rectal | | Plastic (reconstructive) | |
| Head and Neck | | Endoscopy | |
| General | | Pain Management | |
| Cosmetic | | Gynecology | |
| Podiatry | | Oral and Maxillofacial | |
| Neurology | | Wound Care | |
| Ophthalmology (cataracts) | | Other (describe): | |
| Ophthalmology (Lasik, PRK, TKP) | | | |

**Separate Application Required – Refer to Company*

D. Other services provided:

Medical Lab ____________________ Annual Receipts X-ray/Imaging Center _______________________ Annual Receipts

## 6. Other General Information

A. Are anesthesia services provided by:

☐ Employed physicians ☐ Contract group ☐ Employed CRNA's

i. If under contract, name of group: ________________________________________________________________

ii. If contract group, are certificates of insurance required? ☐ Yes ☐ No

iii. If *yes*, what minimum limits are required: ____________________ per claim ___________________ aggregate

B. Do you have the following equipment at the center:

i. Laboratory, with the following capabilities—CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine ☐ Yes ☐ No

ii. X-ray with on-premises processing ☐ Yes ☐ No

iii. EKG ☐ Yes ☐ No

iv. Monitor/defibrillator ☐ Yes ☐ No

v. Crash cart with full cardiac life support capabilities and necessary intravenous fluids ☐ Yes ☐ No

vi. Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage ☐ Yes ☐ No


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vii. Oxygen ☐ Yes ☐ No

viii. Suction ☐ Yes ☐ No

ix. Pneumatic anti-shock trousers ☐ Yes ☐ No

x. Dedicated telephone lines to the closest appropriate hospital emergency department and/or two-way communication with EMS ☐ Yes ☐ No

C. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? ☐ Yes ☐ No

If *yes*, please attach detailed explanation of this activity.

D. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? ☐ Yes ☐ No

If *yes*, please attach a copy of *all* of the advertisements.

E. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? ☐ Yes ☐ No

If *yes*, please attach detailed explanation and a copy of *all* of the advertisements.

F. Do you maintain adequate medical records for each patient? ☐ Yes ☐ No

i. How often and by whom are the medical records reviewed? ______________________________

______________________________________________________________

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

G. Is there an established procedure and agreement with a hospital to accept emergency cases? ☐ Yes ☐ No

i. Has time and distance from the center to the nearest appropriate hospital been determined and evaluated? ☐ Yes ☐ No

ii. Have procedures for Physician direction and supervision of personnel, facilities, and equipment for the provision of medical services under emergency conditions been evaluated? ☐ Yes ☐ No

iii. Is there an established procedure to secure sufficient blood supplies in emergency situations? ☐ Yes ☐ No

H. Does the facility have a procedure to screen for inappropriate procedures or patients at risk for an ambulatory surgery procedure? ☐ Yes ☐ No

I. Are any procedures performed on persons rendered unconscious through anesthesia? ☐ Yes ☐ No

If *yes*, give detailed description on a separate sheet of how anesthesia is provided, including minimum patient age and number of overnight beds on premises or affiliated.

## 7. Personnel

A. Physicians providing health care services at this entity:

| Name | Specialty | Board Certified | Limits | C=Contracted E=Employed O=Owner | Current Insurance Carrier |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Please attach additional sheets if necessary.

B. Do you require certification of Professional Liability Coverage? ☐ Yes ☐ No

If *yes*, how much? ______________________________


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**C. Non-Physician Personnel**

| Non-Physician Personnel | No. Employed | No. Contracted |
|---|---|---|
| Anesthesiology Assistant | | |
| *Dentists | | |
| EEG or EKG Operators | | |
| Inhalation/Respiratory Therapists | | |
| Laboratory Technicians | | |
| LPN's | | |
| Medical Technicians | | |
| *Nurse Anesthetists - Are they supervised by an anesthesiologist? ☐ Yes ☐ No | | |
| *Nurse Practitioners/Clinical Nurse Specialists | | |
| Occupational/Physical Therapists | | |
| Paramedics or EMT's | | |
| Pharmacists | | |
| *Physician Assistants | | |
| *Podiatrists | | |
| RNs | | |
| Scrub Nurses | | |
| *Surgical Assistants (Certified or Licensed) | | |
| X-ray or Radiology Technicians | | |
| X-ray or Radiology Therapists | | |
| Other (describe): | | |

**Separate Application Required – Refer to Company*

## 8. Premises and Operations

A. Are there any construction plans for the next twelve months? ☐ Yes ☐ No
If *yes*, please provide cost of project: ____________________

B. Total square footage of parking lots or decks: ____________________

C. Total number of swimming pools: ____________________

D. Total number of lakes: ____________________

E. Total number of fountains: ____________________

F. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

G. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

**Fraud Warning** – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

**Consent to Conditions of Consideration of the Application for Insurance**

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

**Important**: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: ____________________ Title: ____________________

Signature: ____________________ Date: ____________________


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Insurance Agent/Broker (if applicable):

Agent: ______________________ Phone: ______________________

Agency: ______________________ Fax: ______________________

Address: ______________________ Email: ______________________

______________________ License No.: ______________________

Signature: ______________________


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**Insured Entities and D/B/A's**
**Schedule A**

Entity Name: ______________________________
Address: ______________________________
______________________________
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
______________________________
Description of all operations and activities: ______________________________
______________________________

Entity Name: ______________________________
Address: ______________________________
______________________________
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
______________________________
Description of all operations and activities: ______________________________
______________________________

Entity Name: ______________________________
Address: ______________________________
______________________________
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
______________________________
Description of all operations and activities: ______________________________
______________________________

Entity Name: ______________________________
Address: ______________________________
______________________________
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ______________________________
______________________________
Description of all operations and activities: ______________________________
______________________________

Please attach additional sheets if necessary.


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# Important Notice About the Policy of Insurance for Which You Have Applied

## This Document Affects Your Legal Rights

### Read the Following Information Carefully

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

**Acknowledgement of Arbitration Agreement**

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

| Applicant's Signature | Date | Time |
|---|---|---|
| Agent | Date | Time |

**Note:** You will need to sign this notice to be considered for coverage.