



**Southern California**  
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**Northern California**  
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**Pacific Islands**  
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## APPLICATION FOR AMBULATORY SURGERY CENTERS

1. Full Name of Applicant: (Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. Mailing and Location Address: (If multiple addresses include an attachment with a complete schedule of all locations)

3. Website Address (if applicable)

4. Date Established:

5. Type of Entity:  Corporation  Partnership  Individual  Other (Specify):

6. Is this entity owned by, associated with or controlled by any other entity?

YES

NO

If Yes, please give details:

7. Does the Applicant have Risk Management and Risk Control Programs in place?

YES

NO

Who from your firm should we contact regarding Admiral's Risk Management Services and Newsletters?

Name:

Title:

Telephone:

E-mail:

8. Limits Requested:

Each Claim: \$

Aggregate: \$

9. Deductible Requested:  \$5,000  \$10,000  \$15,000  \$20,000  Other (Specify):

10. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?

YES

NO

If Yes, (a) Has the applicant implemented procedures to comply with the HIPAA Privacy Rule?

YES

NO

(b) Provide the name and title of the applicant's privacy officer:

11. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

|                              | <u>Employee or Volunteer</u> | <u>Independent Contractor</u> | <u>Insured On Own Med Mal Policy</u>               | <u>Insured Limits</u> |
|------------------------------|------------------------------|-------------------------------|----------------------------------------------------|-----------------------|
| Physicians/Surgeons          | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Physician/Surgeon Assistants | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Surgical Technicians         | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Chiropractors                | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| CRNA'S                       | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Nurse Practitioners          | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Podiatrists                  | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Registered Nurses            | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| LPN's or LVN's               | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| X-Ray Technicians            | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Medical Assistants           | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Optometrists                 | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |
| Pharmacists                  | <input type="text"/>         | <input type="text"/>          | <input type="radio"/> YES <input type="radio"/> NO | <input type="text"/>  |

12. If you have a Medical Director, provide name, speciality and C.V.:

a) Are the Medical Director's duties administrative only?

YES  NO

b) Does the Medical Director provide direct patient care?

YES  NO

c) What medical malpractice limits is Medical Director required to carry?

13. Are all of the above individuals licensed in accordance with applicable State and Federal regulations?  YES  NO

If No, please provide a detailed explanation.

14. Is credentialing which includes primary source verification performed on all providers?  YES  NO

If No, explain:

15. Are references checked for all providers?  YES  NO

If No, explain:

16. Has the applicant or any of the above employees and/or independent contractors:

a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association?  YES  NO

b) Ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense?  YES  NO

c) Ever been treated for alcoholism or drug addiction?  YES  NO

d) 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?  YES  NO

Please attach an explanation for any "YES" response above.

17. Surgical category and estimated number of procedures (please provide totals at bottom):

| <u>Type of Procedure</u>    | <u>Number of Procedures</u> |                     |                            | <u>Type of Procedure</u>         | <u>Number of Procedures</u> |                     |                            |
|-----------------------------|-----------------------------|---------------------|----------------------------|----------------------------------|-----------------------------|---------------------|----------------------------|
|                             | <i>Last Year</i>            | <i>Current Year</i> | <i>Estimated Next Year</i> |                                  | <i>Last Year</i>            | <i>Current Year</i> | <i>Estimated Next Year</i> |
| Abortions                   |                             |                     |                            | Ophthalmology                    |                             |                     |                            |
| Bariatric (lap band only)   |                             |                     |                            | Oral/Non-Cosmetic                |                             |                     |                            |
| Bariatric (all other)       |                             |                     |                            | Oral/Cosmetic                    |                             |                     |                            |
| Botox Injections - Cosmetic |                             |                     |                            | Orthopaedic/Incl. Hand/No Spine  |                             |                     |                            |
| Cardiology                  |                             |                     |                            | Orthopaedic/Incl. Spine          |                             |                     |                            |
| Chiropractic                |                             |                     |                            | Otorhinolaryngology/Non-Cosmetic |                             |                     |                            |
| Cosmetic Injectable         |                             |                     |                            | Otorhinolaryngology/Cosmetic     |                             |                     |                            |
| Dermatology/Non-Cosmetic    |                             |                     |                            | Plastic/Cosmetic                 |                             |                     |                            |
| Dermatology/Cosmetic        |                             |                     |                            | Plastic/Reconstructive           |                             |                     |                            |
| Endoscopy/Colonoscopy       |                             |                     |                            | Pain Management                  |                             |                     |                            |
| Gastroenterology            |                             |                     |                            | Podiatry                         |                             |                     |                            |
| General                     |                             |                     |                            | Rheumatology                     |                             |                     |                            |
| Gynecology                  |                             |                     |                            | Thoracic                         |                             |                     |                            |
| Liposuction                 |                             |                     |                            | Urology - no penile implants     |                             |                     |                            |
| Neurology                   |                             |                     |                            | Urology - penile implants        |                             |                     |                            |
| Obstetrics                  |                             |                     |                            | Other <input type="text"/>       |                             |                     |                            |
|                             |                             |                     |                            | Total                            |                             |                     |                            |

18. Please indicate percent of pediatric surgical procedures performed at your facility:

19. Applicant's Gross Revenue

|                            | <u>Last 12 months</u>   | <u>Estimate for next 12 months</u> |
|----------------------------|-------------------------|------------------------------------|
| Medicare/Medicaid          | \$ <input type="text"/> | \$ <input type="text"/>            |
| Fee for service            | \$ <input type="text"/> | \$ <input type="text"/>            |
| Other <input type="text"/> | \$ <input type="text"/> | \$ <input type="text"/>            |
| Total Gross Revenues:      | \$ <input type="text"/> | \$ <input type="text"/>            |

20. Is the facility Licensed by state?  YES  NO
- Medicare Certified?  YES  NO
- Accredited?  YES  NO
- If Accredited: By JCAHO  YES  NO
- By AAAHC  YES  NO

21. Has the applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered?  YES  NO

If Yes, provide details

22. Is the patient's written authorization for the specific surgical procedure (s) and is the patient's written "informed consent" required prior to surgery?  YES  NO

If no, please explain:

23. Is there a written policy in place for:

- |                                                                                                      |                           |                          |
|------------------------------------------------------------------------------------------------------|---------------------------|--------------------------|
| Patient Identification                                                                               | <input type="radio"/> YES | <input type="radio"/> NO |
| Surgical site verification                                                                           | <input type="radio"/> YES | <input type="radio"/> NO |
| Patient positioning                                                                                  | <input type="radio"/> YES | <input type="radio"/> NO |
| Laser/electrical safety                                                                              | <input type="radio"/> YES | <input type="radio"/> NO |
| Continuous physiological monitoring                                                                  | <input type="radio"/> YES | <input type="radio"/> NO |
| Documentation of all intra-operative orders                                                          | <input type="radio"/> YES | <input type="radio"/> NO |
| Disposition of all pathology and other specimens                                                     | <input type="radio"/> YES | <input type="radio"/> NO |
| Verification of sponge, needle, and instrument counts                                                | <input type="radio"/> YES | <input type="radio"/> NO |
| Documentation of patient condition, mode of transportation for hospital transfers:                   | <input type="radio"/> YES | <input type="radio"/> NO |
| Completion and signing of operative reports which includes a written, immediate post surgical report | <input type="radio"/> YES | <input type="radio"/> NO |

PROVIDE EXPLANATION FOR ALL "NO" ANSWERS BELOW:

24. Prior to start of every surgical procedure, does the surgical team conduct a "time out" that includes:

- |                                                                                                                                                                                                         |                           |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|--------------------------|
| a. Final verification of the correct patient, procedure, site and, as applicable, implants?                                                                                                             | <input type="radio"/> YES | <input type="radio"/> NO |
| b. Active communication among all members of the surgical/procedure team?                                                                                                                               | <input type="radio"/> YES | <input type="radio"/> NO |
| c. Consistent initiation of "time out" by a designated member of the team, conducted in a "fail-safe" mode that allows no further surgical action until any and all questions or concerns are resolved? | <input type="radio"/> YES | <input type="radio"/> NO |

PROVIDE EXPLANATION FOR ALL "NO" ANSWERS BELOW:

25. Normal hours of operation:

26. Indicate the number of operating rooms in the facility:

27. Indicate the number of recovery rooms (including number of beds) in the facility?

28. Is "overnight" stay permitted at the facility?  YES  NO

If yes, provide explanation:

29. In the event of complications, what are the emergency handling procedures at the facility?

30. With what hospital(s) has the facility a "transfer agreement" for handling of emergency cases?

31. What is the travel time and distance (in miles) to this hospital?

32. What is the level of anesthesia provided?

Level A - Local or topical anesthesia

Level B - Local or topical anesthesia and/or IV or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia (including nitrous oxide).

Level C - Levels listed above plus and/or surgical procedures with epidural anesthesia, endotracheal or laryngeal mask intubation or inhalation anesthesia, spinal or epidural.

If Level C anesthesia is provided, is it administered by an anesthesiologist or certified registered nurse anesthetist (CRNA)?

If no, please explain:

33. Are all CRNA's with privileges at your facility required to carry their own professional liability coverage:  YES  NO

If Yes, at what limit:

Do you require proof of insurance  YES  NO

If no, please provide an explanation

34. Please provide a list of all physicians who have been granted privileges to perform procedures at the facility and indicate their medical specialty.

35. Are all physicians with privileges at your facility required to carry their own medical malpractice policy?  YES  NO

If Yes, what are the minimum limits required?  Per Claim  Aggregate

Do you require proof of this insurance?  YES  NO

If No, please provide an explanation.

36. Do any physicians with privileges at your facility have medical malpractice coverage with a Risk Retention Group or Captive Insurance Company?  YES  NO If Yes, please provide the name of the physician (s) and their malpractice carrier.

37. Are providers allowed to post bonds or letters of credit instead of insurance?  YES  NO

If Yes, how is this verified?

38. Please provide the following information as respects that last five years of PROFESSIONAL LIABILITY coverage beginning with the most current coverage:

| Carrier | Limit | Deductible | Premium | Policy Term | Retro Date |
|---------|-------|------------|---------|-------------|------------|
|         |       |            |         |             |            |
|         |       |            |         |             |            |
|         |       |            |         |             |            |
|         |       |            |         |             |            |
|         |       |            |         |             |            |

39. Does the applicant carry General Liability insurance?  YES  NO

Are you interested in a quote for General Liability?  YES  NO

If Yes, please attach a completed GL Acord Application with a schedule of locations and the square footage of each location.

40. Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage?  YES  NO

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

41. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed?  YES  NO

If Yes, please provide details including name of carrier and dates.

42. Has any claim ever been made against the applicant or any of its employees?  YES  NO

If Yes, how many?

If Yes, please complete the Supplemental Claim Information Form with your submission of this application. [Form Link](#)

43. Is the applicant aware of any circumstances which may result in any claim against them or their employees?  YES  NO  
Is Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.

44. Please provide 5 years, currently valued, company loss runs.

I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Current Date

Title

**If you prefer not to return application with an electronic signature, please print and sign below:**

Signature of Applicant or Authorized Representative

Current Date:

Title

Type or print your name & title

Type or print your phone number

Type or print your e-mail address