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| Healthcare/Hospital Facilities Liability Application |
| Ambulatory Surgery Center Supplement |
| * Ace American Insurance Company
* Illinois Union Insurance Company
* Westchester Surplus Lines Insurance Company
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**Instructions:**

The requested information is necessary before a quotation can be obtained.

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 appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use 🗷 for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

***Notice: This supplement is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions.* All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Loss Experience, Coverage Requested, Exposures (prospective and historical Professional Liability, General Liability, Home Health Care and/or Hospice Services, Staffing Agency Services, Aircraft Liability, Automobile Liability, Watercraft Liability, and Employer’s Liability), Excess Liability, Professional Employees and Staff, License/Certification Information, Risk Management, Employment Practices, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

# Section A. – Applicant/Ownership

1. List all partners, members or stockholders/owners of the applicant and their respective percentage of ownership interest:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Ownership % | Name | Ownership % |
|       |      % |       |      % |
|       |      % |       |      % |

# Section B. – Types of Services Provided

1. Does the applicant maintain beds for overnight recovery or occupancy?

|  |  |
| --- | --- |
| 1. 23 hours or less?If Yes, Number
 | Yes [ ]  No [ ]  |
| 1. 24 hours or less?If Yes, Number
 | Yes [ ]  No [ ]  |
| 1. Any licensed hospital beds or is the facility licensed as a surgical hospital?
 | Yes [ ]  No [ ]  |
| 1. Select each type of surgical service that applies to the applicant and provide the number of visits (1):
 |
| Type of Procedure | Projections for Current or Expiring Year | Projections for Requested Coverage Period | Type of Procedure | Projections for Current or Expiring Year | Projections for Requested Coverage Period |
| Bariatric |       |       | Ophthalmology (cataracts) |       |       |
| Cardiac Catheterization |       |       | Oral and Maxillofacial |       |       |
| Colon and Rectal |       |       | Orthopedic |       |       |
| Cosmetic |       |       | Otolaryngology (ENT) |       |       |
| Endoscopy |       |       | Pain Management |       |       |
| Gastroenterology |       |       | Plastic (reconstructive) |       |       |
| General |       |       | Podiatry |       |       |
| Gynecology |       |       | Thoracic |       |       |
| Hand |       |       | Urology |       |       |
| Head and Neck |       |       | Vascular |       |       |
| Neurology |       |       | Wound Care |       |       |
| Obstetrics |       |       | Other – describe:      |       |       |
| Ophthalmology (Lasik, PRK, TKP) |       |       |  |  |  |

(1) Visit: One visit applies each time a patient enters the facility for healthcare related services regardless of the number of departments visited or the number or procedures/treatments performed within each department. Each threshold crossing for a pre-surgical and post-surgical visit is counted as a separate visit apart from the number of surgeries or procedures.

# Section C. – Anesthesiology Services

1. Select all levels of anesthesia administered by the applicant:

|  |  |
| --- | --- |
| [ ]  Class A | Topical or local anesthesia including digital and pudendal blocks. |
| [ ]  Class B | Intravenous or parenteral sedation, regional anesthesia including epidural and spinal blocks, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation anesthesia (including nitrous oxide). |
| [ ]  Class C | Endotracheal or laryngeal mask intubation or inhalation anesthesia (including nitrous oxide). |

1. Using the ASA Physical Status Classification scale, indicate the percentage of the applicant’s patients rated in each category for the previous 12 month period

|  |  |  |
| --- | --- | --- |
| P1 | A normal healthy patient. |      % |
| P2 | A patient with mild systemic disease. |      % |
| P3 | A patient with severe systemic disease. |      % |
| P4 | A patient with severe systemic disease that is a constant threat to life. |      % |
| P5 | A moribund patient who is not expected to survive without the operation. |      % |
| P6 | A declared brain-dead patient whose organs are being removed for donor purposes. |      % |
| 1. Are all anesthetics administered by either a qualified physician or C.R.N.A. (under physician supervision if required by state or the facility)?

If No, explain:       | Yes [ ]  No [ ]  |

# Section D. – Credentialing

|  |  |
| --- | --- |
| 1. Number of active physician medical staff members:
 |  |
| 1. Does the applicant have a formal credentialing program that includes all physicians and anesthetists?

If No, explain:       | Yes [ ]  No [ ]  |
| 1. Does the applicant confirm that all physicians working at its facility have current hospital privileges?
 | Yes [ ]  No [ ]  |
| 1. Are clinical privileges for physicians and anesthetists based on training and peer review?
 | Yes [ ]  No [ ]  |
| 1. Are all physicians on staff board certified in the specialty in which they are practicing?

If No, explain:       | Yes [ ]  No [ ]  |
| 1. Does the applicant secure written evidence that all medical professionals on staff carry a minimum of $1,000,000 Each Occurrence/$1,000,000 Aggregate professional liability insurance?

If No, explain:       | Yes [ ]  No [ ]  |

# Section E. – General Safety

|  |  |
| --- | --- |
| 1. Are the applicant’s facilities constructed, equipped and operated in accordance with applicable local, state and federal laws and regulations including, at a minimum, a reliable source of oxygen, suction, resuscitation equipment and emergency drugs?

If No, explain:       | Yes [ ]  No [ ]  |
| 1. Has the applicant fully implemented the National Patient Safety Goals?

If No, explain:       | Yes [ ]  No [ ]  |
| 1. Does the applicant have a written policy and procedures in place for each of the following:
 | Yes [ ]  No [ ]  |
| 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 [ ]  |
| Medical Devices involved in patient injuries: | Yes [ ]  No [ ]  |
| 1. Does the applicant have written emergency transport policy and procedures and an agreement in place with a local hospital?
 | Yes [ ]  No [ ]  |
| 1. Number of miles from the applicant’s facility to the nearest hospital:
 |  |

**The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.**

**The Applicant understands that this form is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name of Applicant |  | Signature of Applicant |
|       |  |       |
| Title |  | Date |
|       |  |       |