POSITIVE PHYSICIANS
Insurance Company

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Phone: 888.335.5335 Fax: 610.644.5265

APPLICATION FOR AMBULATORY SURGERY CENTER FACILITY PROFESSIONAL & COMMERCIAL GENERAL LIABILITY INSURANCE

Instructions:

1. Please use Adobe to type text directly onto the application. Answer **ALL** questions which are appropriate to your operation completely, leaving no blanks. If any questions, or part thereof, do not apply, state "N/A." If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number. When necessary, check all boxes that apply. This form must be completed, dated, and signed by a principal or an officer of the applicant.

2. Please include the following information with the completed application:
   - Previous insurance company loss runs for the past ten (10) years including current year**,** ground-up and unlimited, including all self insured, insured, and uninsured losses. Full details of allegations on all losses paid or outstanding in excess of $50,000.
   - Current audited financial statement.
   - Brochures, pamphlets or other advertising material utilized by your facility.
   - Copies of any inspection reports/surveys conducted by outside organizations within the past 3 years.
   - For Excess coverage please provide copies of all underlying policies.
   - For Umbrella coverage please provide copies of Primary Declaration pages or COI for all applicable coverages (auto, Employers Liability, etc.). Copy of underlying automobile carrier's loss run for the past 5 years including the following information: carrier, date of loss, report date, total incurred, status (open or closed), and narrative of claim. Date of loss valuation must be within past ninety days.
   - Start-Up Facility – (1) Business Plan, (2) Curriculum Vitae (CV) of all physicians involved, (3) inspection application(s), (4) loss history (10 years) for each physician involved.

   If you have multiple operations that are not ambulatory surgery centers, please complete Lexington Insurance Company's general applicant for healthcare facilities.

GENERAL INFORMATION

Producer Name: _____

Address: _____
Street City State Zip

Telephone Number: _____
(Area Code) Number

Applicant's Name: _____

Business Address: _____
Street City State Zip

Mailing Address: _____

Website address (if available): _____

Applicant key contact person: _____ Telephone No: _____

State and date of incorporation: _____ Date _____

Historical (past 5 years) annual gross revenues: *Gross Revenues* *Year*

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Current year annual gross revenues: _____ _____
Projected 12 months annual gross revenues: _____ _____

Requested policy effective date: _____

Insurance Coverage Desired:

Primary	Effective Date	Occ. or Claims Made	Retro Date	Limits of Liability (Per Claim/Aggregate)*	Ded ☐ or SIR ☐
Professional Liab PL					
General Liab GL					
Employee Benefits					
Excess/Umbrella					
Underlying PL					
Underlying GL					
Auto Liab.					
Employers' Liab.					
Employee Benefits					
Other:					

**Professional Liability and General Liability Limits must be the same, but limits apply separately*.

Applicant is a (check all that apply):

☐ Corporation ☐ Partnership ☐ Partnership Association
☐ Sole Proprietorship ☐ Joint Venture ☐ Physician Owned
☐ Hospital Owned ☐ Corporate Chain ☐ Other (*Please Explain)* _____

Applicant operates: ☐ For Profit ☐ Not for Profit ☐ Governmental entity

Deductible (*applies separately to Professional Liability and General Liability*)

☐ None ☐ $5,000 ☐ $10,000
☐ $25,000 ☐ $50,000 ☐ Other_____

Self-Insured Retention – SIR (if applicable please complete our SIR questionnaire)

List below all subsidiary, controlled entity or LLC that are desired to be added as additional named insured. For each facility/entity, provide date acquired, description of operations, ownership in percentages and retroactive date.

Subsidiaries	Date Acquired	Description of Operations	% Ownership	Retroactive date

How many locations do you have? _____

State Location Exposures – please specify the number of visits by state. “Visits” are defined as the number of times each patient enters your facility for healthcare related services.

By State (for all locations):	**Specify # of Visits By State**	
	Current Year _____	**Projected 12 Months** _____
TOTAL		

Acquisitions and Divestitures - If none, initial here: _____

List all acquisitions or divestitures during the past 3 years: _____

_____

_____

_____

Are there any other operations not described above? ☐ Yes ☐ No If yes, then describe.

_____

_____

_____

PROFESSIONAL LIABILITY INFORMATION

1. Type of Facility: □ Multi-Specialty □ Single Specialty – list type here: _____

2. Surgical services provided – Indicate the type of procedures and number of outpatient visits for each procedure. "Visits" are defined as the number of times each patient enters your facility for healthcare related services.

Type of Surgery/Procedures by Specialty: (specify year __/__/__; if □ Fiscal □ Calendar) (if none or zero then indicate "none" or "0") (attach additional page(s) if necessary)	**Number of Outpatient Visits (OPVs)**		
	Prior Year _____	**Current** _____	**Projected 12 Months**
Bariatric Surgery			
Laparoscopic Banding			
Roux-en Y gastric bypass			
BilioPancreatic Diversion with a Duodenal Switch (BPDDS)			
Other Bariatric procedures - please specify:			
ENT			
Gastrointestinal Endoscopies			
General Surgery			
Gynecology Surgery			
Ophthalmology			
Cataract			
LASIK			
Other Ophthalmic procedures - please Specify:			
Orthopedic Surgery			
Pain Management			
Plastic Surgery			
reconstructive			
Cosmetic			
Podiatry			
Urology			
Other Procedures:			
Any other services (other than surgery) not listed above? (i.e. Lab, Office Visits, etc…) □ Yes □ No If yes, list type and amount:			
TOTAL			

3. Do you have any beds for overnight stay? ☐ Yes ☐ No If yes, give number: _____

4. Does your facility perform any abortions? ☐ Yes ☐ No If yes, give number per year: _____

5. Does your facility perform any cosmetic/implant surgery? ☐ Yes ☐ No

If yes, list each type of cosmetic surgery performed and the corresponding number of surgeries per year:

_____

_____

_____

6. Are there any areas of surgery for which you are not currently engaged but plan to engage in the next 12 months? ☐ Yes ☐ No If yes, please explain: _____

_____

7. Please provide the total number of physicians and surgeons that work in your facility?

	Full-Time	Part-Time
Employed Physicians	_____	_____
Contracted Physicians	_____	_____

8. A proposed physician/surgeon would only be covered under the policy in his/her capacity as a medical director for activities relating to administration of the facility. If a more comprehensive physician/surgeon professional liability coverage is desired, please complete individual physician/ surgeon application.

Medical Director Name	Specialty	Current Insurance Carrier & Policy Number	Limits of liability	Effective date of the policy	Employee/ Contractor	Hours/Month

9. Other Health Care Professionals. Indicate the number in each category, full-time and part-time

	Employees Full Time – Part Time	Contractors Full Time – Part Time	Volunteers Full Time – Part Time
Dentists			
Emergency Medical Technicians			
Nurse Anesthetists			
Nurse Midwives			
Nurse Practitioners			
Occupational Therapists			
Oral Surgeons			
Pharmacists			
Physical Therapists			
Physician Assistants			
Psychologists			
RNs/LPNs/LVNs			

Social Workers			
Technicians			
Other (define)			

10. Are there any state licensing requirements for your facility? ☐ Yes ☐ No

11. If yes, has the state conducted an inspection of your facility? ☐ Yes ☐ No

12. Is the facility accredited by any of the following:

Joint Commission	☐ Yes ☐ No
AAAHC	☐ Yes ☐ No
AAAASF	☐ Yes ☐ No
CARF	☐ Yes ☐ No

If yes, please describe and include a copy of the accreditation report. _____

_____

Have ever been denied accreditation by any of the above organizations? ☐ Yes ☐ No
If yes, please explain. _____

_____

13. Do you have written requirements that the following providers carry Professional Liability Insurance? Please indicate the limits required.

	Yes	No	Limits
Physicians			
Surgeons			
Oral Surgeons			
Dentists			
Pharmacists			
Nurse Anesthetists			
Nurse Midwives			
Nurse Practitioners			
Physician Assistants			
Other (define)			

14. Do you require coverage for any Contracted Healthcare professionals? ☐ Yes ☐ No

If yes, list number and type: _____

_____

_____

COMMERCIAL GENERAL LIABILITY INFORMATION

1. Please provide physical facility information as requested:

Address/Occupancy	Square Footage	Age	Type of Construction	# of Floors	Type of Fire Protection*

* Fire Protection Key: AS = Automation Sprinkler, H = Heat Detector, S = Smoke Detector, A = Automatic Alarm

2. Please indicate any additional insureds to be included under your facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

3. Do you sell or lease any durable medical equipment or products to patients or others in connection with your operation? ☐ Yes ☐ No

   If yes, please complete the following information:

   Total Annual Sales: $ _____

   Total Annual Lease/Rental Receipts: $ _____

   Please provide product brochures and a list of items and their total annual sales and leases.

   _____

   Have any of the products that you distribute ever been recalled? ☐ Yes ☐ No

4. Do you provide preventive maintenance or repairs on medical equipment leased to others? ☐ Yes ☐ No
   If yes, please provide details: _____

EMPLOYER'S LIABILITY AND EMPLOYEE BENEFIT LIABILITY INFORMATION

1. Number of employees:
2. Are employee benefits self-administered? ☐ Yes ☐ No
   If not, are they administered by an outside vendor? ☐ Yes ☐ No
   If yes, what is the name of the vendor:

OTHER EXPOSURES

Are there any current or past professional or general liability exposures that are not listed under sections II and III of this application? ☐ Yes ☐ No

If yes, please explain: _____

RISK MANAGEMENT/LOSS CONTROL

Has an individual been designated to perform the function of risk management? ☐ Yes ☐ No

If yes, who coordinates your Risk Management Program?

Name: _____

Title: _____ Phone Number: _____

Section 1 – Accreditation

1.1 - Select the accreditation choice corresponding to your facility. Please select one.

"Accredited by the Joint Commission" means the organization is in compliance with all standards at the time of the on-site survey or has successfully addressed requirements for improvement in an Evidence of Standards Compliance (ESC) within 45 days following the survey.

The AAAHC awards accreditation for three years when it concludes that the organization is in substantial compliance with the standards.

The AAAASF Accreditation Program requires 100% compliance with each AAAASF Standard to become and remain accredited.

CARF accreditation for three years: The organization satisfies each of the CARF accreditation conditions and demonstrates substantial conformance to the standards. It is designed and operated to benefit the persons served. The organization demonstrates quality improvement from any previous periods of CARF accreditation.

☐ Accredited by the Joint Commission
☐ Accreditation for three years by AAAHC (Accreditation Association for Ambulatory Health Care)
☐ Accredited by AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities) requiring 100% compliance with AAAASF Standards
☐ Accreditation for three years by CARF (Commission on Accreditation of Rehabilitation Facilities)
☐ None of the above

Section 2 - Patient Safety

2.1 - Does your facility's formal processes implemented to minimize the risk of wrong patient, wrong procedure, wrong side, and wrong site surgery include the following (select all that apply)?

☐ Pre-operative verification of the patient.
☐ Pre-operative verification of the site.
☐ Marking of the operative site.
☐ A "time-out" immediately before starting the procedure.

2.2 - Does your facility's formal process implemented to ensure patients who undergo screening to de-select out high risk patients or procedures include the following (select all that apply)?

☐ ASA criteria or other formal anesthesia selection guidelines.
☐ Final decision by anesthesia based on medical status to de-selected patients.
☐ Formal list of acceptable/unacceptable procedures at this ASC.

2.3 — Does patient information obtained during the anesthesia screening process include the following (select all that apply)?

☐ History of malignant hyperthermia
☐ Wakefulness during surgery
☐ History of sleep apnea

2.4 — Does your facility's emergency response policy include the following (select all that apply)?

☐ Written policies for patient transfer to the nearest available emergency department.
☐ Immediate activation of the EMS system.
☐ Current Advanced Cardiac Life Support (ACLS) certification for all Post-Anesthesia Care Unit staff.

2.5 — Does your facility's preventive maintenance program for biomedical equipment include the following (select all that apply)?

☐ Program includes preventive maintenance for anesthesia and critical emergency equipment.
☐ Proper training of all equipment users.
☐ Repairs by qualified personnel.
☐ Documentation of preventive maintenance, repairs, and education.

2.6 — Does the preventive maintenance program include controls over physician owned equipment, if applicable?

☐ Yes
☐ No
☐ Not Applicable

2.7 — Does the preventive maintenance program include policies and procedures for borrowing, lending, selling, or donating equipment, if applicable?

☐ Yes
☐ No
☐ Not Applicable

2.8 — With regard to their use to prevent infection, are antibiotics (select all that apply)?

☐ Infused completely prior to incision but no longer than one hour prior to surgery.
☐ Dose adjusted for patient weight.
☐ Redosed for surgeries greater than four hours.

2.9 — Are clippers used for all pre-operative hair removal?

☐ Yes
☐ No

Section 3 — Surgical Fire Prevention

3.1 — With respect to compliance with surgical fire prevention methods, which of the following do you routinely monitor (select all that apply)?

☐ Delay draping patients until all flammable preps have fully dried.
☐ Questioning the need for 100% O2 for open delivery to the face (e.g. when using a nasal cannula)—use air or +/- 30% O2 for open delivery consistent with patient needs.

3.2 - During oropharyngeal surgery, is compliance monitored with the following surgical fire prevention method:

Wet any gauze or sponges used with uncuffed tracheal tubes to minimize leakage of gases into the

oropharynx, and keep them wet.

If oropharyngeal surgical services are not offered, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

3.3 - During electrosurgery, is compliance monitored with the following surgical fire prevention method:

Place the electrosurgical pencil in a holster when it is not in active use.

If electrosurgical services are not offered, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

3.4 - During laser surgery, is compliance monitored with the following surgical fire prevention method:

Place the laser in standby mode whenever it is not in active use.

If laser surgical services are not offered, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

3.5 - Special drills and training include the following (select all that apply).

- ☐ Proper use of fire-fighting equipment.
- ☐ Proper methods for rescue and escape.
- ☐ Identification and location of medical gas/ventilation/electrical systems and controls including when/where/how to shut off these systems.
- ☐ Use of the hospital alarm system and system for contacting the local fire department.

Section 4 - Credentialing, privileging and Performance Improve

4.1 - Does your facility's credentialing and privileging process include the following (select all that apply)?

- ☐ Primary source verification of professional credentials and privilege qualifications for all surgeons and anesthesia providers.
- ☐ Review/approval of requested privileges by the center's medical director and/or credential committee.
- ☐ Continuous updates of new or deleted privileges for ASC staff.
- ☐ ASC staff can refuse to schedule surgeries or procedures not on an individual provider's list of approved privileges or a non-approved procedure.
- ☐ A formal process of assuring that physicians maintain required limits of professional liability insurance.

4.2 - Which of the following information regarding the practitioner's practice is utilized during the reappointment process (select all that apply)?

- ☐ Patterns of care, as demonstrated in findings of quality/utilization activities.
- ☐ Timely and accurate completion of medical records.
- ☐ Compliance with Medical Staff bylaws and all applicable policies, rules, regulations and procedures.
- ☐ Current National Practitioner Data Bank Report.

☐ Information from the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (Medicare and Medicaid).

4.3 - Which of the following performance measures do you routinely monitor and review within surgery and anesthesia (select all that apply)?

☐ Compliance with Joint Commission Universal Protocol for preventing wrong site/wrong procedure/wrong person surgery.

☐ Wrong implant precautions included in time-out checklist.

☐ Preventive maintenance of electrosurgical units and other OR equipment based on manufacturer specifications.

☐ Near misses for wrong site/wrong patient/wrong procedure surgery.

☐ Labeling of all medications - medication containers (e.g. syringes/medicine cups/basins) - other solutions on and off the sterile field in perioperative and other procedural settings to include anesthesia medications.

4.4 - Which of the following unexpected occurrences do you routinely monitor and review within surgery and anesthesia (select all that apply)?

☐ Hospital transfers

☐ OR/PAR deaths

☐ Deaths within 24 hours of anesthesia

☐ Cardiac arrests in OR or PAR

☐ Occurrences of wrong site/wrong patient/wrong procedure surgery

☐ Number of occurrences of unintentionally retained foreign body (e.g. instrument/sharps/sponges)

☐ Injuries from OR or anesthesia (see guidance)

☐ Injuries from equipment (e.g. burns/pressure ulcers)

4.5 - Which of the following provider-specific performance indicators are used in peer review in surgery and anesthesia (select all that apply)?

☐ Surgical complications

☐ Surgical deaths

☐ Surgical site infection rate

☐ Anesthesia complications or injuries

☐ Anesthesia deaths

4.6 - Please check if formal simulation training or drills are completed AT LEAST ANNUALLY for the following potential adverse events in the OR (select all that apply).

☐ Malignant hyperthermia

☐ Adult cardiac resuscitation

4.7 - Are formal simulation training or drills completed AT LEAST ANNUALLY for pediatric cardiac resuscitation? If your facility does not perform pediatric surgery, select not applicable.

☐ Yes

☐ No

☐ Not Applicable

Section 5 - Non-Physician Providers

5.1 - Do non-physician anesthesia providers conduct pre-anesthesia evaluations?

- ☐ Yes
- ☐ No

5.2 - If you answered yes to Q5.1, do physicians review and sign off on non-physician anesthesia provider pre-anesthesia evaluations? If you answered no to Q5.1, or your facility resides in a state where supervision of non-physician anesthesia providers is not mandated, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

5.3 - With respect to monitoring the quality of care of non-physician anesthesia providers, select all that apply.

- ☐ Non-physician provider scope of practice is clearly defined and in compliance with state law.
- ☐ There is peer review of non-physician provider practices including outcomes and quality data.
- ☐ Not Applicable

5.4 - Is the staff certified in PALS? If your facility does not perform pediatric surgery, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

POLICY AND LOSS INFORMATION

1. Please provide past policy information as requested. (expand the table with additional rows as needed, or attach separate page)

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	Ded ☐ or SIR ☐	Premium
Professional Liab PL							
General Liab GL							
Employee Benefits							
Excess/Umbrella							
Underlying PL							
Underlying GL							
Auto Liab.							
Employers' Liab.							
Employee Benefits							
Other:							

If claims-made, indicate retroactive date.

2. Are you aware of any circumstance, accident or loss which has occurred after the retroactive date, which may result in a claim under this insurance coverage that has not been reported to your current or prior insurer?
☐ Yes ☐ No
If yes, provide complete details. _____

3. Have any claims ever been made against the applicant or any person proposed for this insurance?
☐ Yes ☐ No

If yes, please give dates, allegations and disposition of each claim or suit in the comments section. _____

NOTICE TO 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 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.

THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.

APPLICANT

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____