SPG SPECIALTY PROGRAM GROUP

AMBULATORY SURGERY CENTERS PROFESSIONAL LIABILITY APPLICATION

(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – INTRODUCTION

1) Full Name of Applicant:

2) List all Subsidiaries:

3) Mailing and Location Address:

(If multiple addresses, include an attachment with a complete schedule of all locations)

4) Website address:

5) Date Established: (mm/dd/yy)

6) Type of Entity: Corporation Partnership Individual Other(specify):

7) Is this entity owned by, associated with, or controlled by, any other entity? Yes No

If yes, provide details:

8) Limits Requested:

Each Claim:$

Aggregate: $

9) Deductible Requested:

$5,000 $10,000

$15,000 $20,000

Other(specify):

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

(Note: Independent contractors are not covered by the policy unless endorsed)

	Employee	Independent Contractor	Insured on Own Med Mal Policy	Insured Limits
Physician/Surgeon's Assistants			Yes No	
Nurse Practitioners			Yes No	
Surgical Technicians			Yes No	
Nurse (RN/LPN/LVN)			Yes No	
X-Ray Technicians			Yes No	
Medical Assistants			Yes No	
Optometrists			Yes No	
Pharmacists			Yes No	
Students			Yes No	
Other:			Yes No	

11) Are all of the above individuals licensed in accordance with applicable State and Federal regulations? Yes No
If no, provide details:

12) Who is your Medical Director?

Medical Specialty:

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 the Medical Director required to carry?

13) Please provide the number of Privileged Practitioners and whether or not they carry their own individual medical malpractice coverage.

(Note: Privileged Practitioners are not covered by policy unless endorsed)

	Privileged Practitioners	Insured on Own Med Mal Policy	Insured Limits
Physician/Surgeons		Yes No	
Podiatrists		Yes No	
Chiropractors		Yes No	
CRNA's		Yes No	
Interns/Residents		Yes No	
Other:		Yes No	

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

15) Are all practitioners which 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, provide details:

16) Are practitioners allowed to post bonds or letters of credit instead of insurance? Yes No
If yes, how is this verified?

17) Are employees/contractors references contacted prior to hiring? Yes No

How are references checked? Written Verbal Both
If verbal only, provide details:

Do you verify certification and/or professional licensure status of employees/contractors? Yes No

Do you question prospective employees/contractors as to any criminal record? Yes No

Are employees/contractors screened to rule out drug, alcohol and/or sexual abuse? Yes No

18) Is credentialing, which includes primary source of verification and reference checks, performed on all providers? Yes No
If no, provide details:

19) Has the applicant or any of the above employees, independent contractors and/or privileged practitioners:

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.

20) Surgical Category/Pain Management Category – Annual Number of PATIENTS

	NUMBER OF PATIENTS			NUMBER OF PATIENTS	
SURGICAL CATEGORY (other than Pain Management)	Actual Last 12 Months	Estimated Next 12 Months	**PAIN MANAGEMENT CATEGORY**	Actual Last 12 Months	Estimated Next 12 Months
Abortions			**CATEGORY A**		
Bariatric (lap band only)			Acupuncture		
Bariatric (all other)			Boxtox Injections		
Cardiology					
Chiropractic			**CATEGORY B**		
Cosmetic Injectable			Facet Joint Blocks		
Dental, Oral & Maxillofacial			Lesioning (Radio Frequency)		
Dermatology – Non-Cosmetic			Peripheral Nerve Block		
ENT/Otorhinolaryngology – Non- Cosmetic			Radiofrequency Nerve Ablation		
Endoscopy/Colonoscopy			Selective Nerve Root Block		
Gastroenterology			Sympathetic Blocks		
General			Trigger Point Injections		
Gynecology					
Invitro Fertilization			**CATEGORY C**		
Liposuction			Percutaneous Discectomy		
Neurology			Percutaneous Endoscopy Nerve Root Decompression		
Obstetrics			Dorsal Column Stimulator Implants/Reprogramming		
Ophthalmology			Epidural or Spinal Catheters		
Orthopedic – No Spine			Intradiscal Electrthermal Therapy		
Orthopedic – Spine			Peripheral Nerve Stimulation – Percutaneous Spinal		
Plastic – Cosmetic or Reconstructive			Manipulation Under General Anethesia Kyphoplasty		
Podiatry			Vertebroplasty		
Rheumatology					
Thoracic			**CATEGORY D**		
Urology – no penile implants			Peripheral Nerve Stimulation – Open		
Urology – penile implants			Spinal Infusion Implants/Pumps		
Vascular			Discectomy – Open		
Other			Other		
			TOTALS:		

21) Does your practice include Pain Management? Yes No

If yes, specify the percentage of your practice derived from Prescription Only Pain Management. %

22) Does your practice include prescribing of opioids? Yes No

If yes, provide the following details:

a. Specify the percentage of your practice derived from opioid prescriptions: %

b. Do you fully comply with the CDC Guideline for Prescribing Opioids? Yes No
https://www.cdc.gov/drugoverdose/prescribing/guideline.html

c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? Yes No

d. Do you also dispense the opioids? Yes No

23) Gross Revenue:

Projected	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior
$	$	$	$	$

24) Patient Selection:

a. Based on the ASA Physical Status Classification System, what percentage of patients are accepted annually.

P1 A normal healthy patient	%
P2 A patient with mild systemic disease	%
P3 A patient with severe systematic disease	%
P4 A patient with severe systematic disease that is a constant threat to life	%

b. Indicate percentage of pediatric surgical procedures performed at your facility: %

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?

a.

Overnight recovery beds	# of beds
Less than 24 hours	
More than 24 hours	

If overnight beds were listed, describe staffing levels, qualification and patient/staff ratio.

b. Is there a written policy in place for required staffing levels when patients are kept after normal working hours? Yes No
If no, provide details:

28) Is the facility licensed by the state? Yes No

Medicare Certified? Yes No

Accredited? Yes No

If accredited: By JCAHO Yes No

By AAAHC Yes No

Other: Yes No

29) 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:

30) 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: Email:

31) 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, provide details:

32) Is there a written policy for:

a. Patient identification ○ Yes ○ No
b. Surgical site verification ○ Yes ○ No
c. Patient positioning ○ Yes ○ No
d. Laser/electrical safety ○ Yes ○ No
e. Continuous physiological monitoring ○ Yes ○ No
f. Documentation of all intra-operative orders ○ Yes ○ No
g. Disposition of all pathology and other specimens ○ Yes ○ No
h. Verification of sponge, needle and instrument counts ○ Yes ○ No
i. Documentation of patient condition, mode of transportation for hospital transfers ○ Yes ○ No
j. Completion and signing of operative reports which includes a written, immediate post-surgical report ○ Yes ○ No

PROVIDE AN EXPLANATION FOR ALL "NO" ANSWERS BELOW:

33) Prior to the 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? Yes No

b. Active communication among all members of the surgical/procedure team? Yes 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? Yes No

PROVIDE AN EXPLANATION FOR ALL “NO’ ANSWERS BELOW:

34) In the event of complications, what are the emergency handling procedures at the facility?

35) With what hospital does the facility have a “transfer agreement’ for handling of emergency cases?

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

37) 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 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)? Yes No

If no, provide details:

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

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

39) 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, provide details including name of carrier and dates:

40) Has any claim ever been made against the applicant or any of its employees? ◯ Yes ◯ No
If yes, how many?
If yes, complete the Supplemental Claim Information Form for each and every claim.

41) Is the applicant aware of any circumstances which may or may not result in any claim against them or their employees? ◯ Yes ◯ No
If yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident:

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

Please attach a copy of the most recent state licensure or Medicare certification inspection report.

SECTION II – NETWORK SECURITY MEASURES AND PROCEDURES

1) Please describe your security measures utilized to protect:
   a. Your physical premises and facilities:
   b. Your computer network and systems:

2) Please describe security measures and procedures used to protect sensitive data in your care, custody and control.

3) Please describe security measure and procedures used to secure, protect monitor and track mobile hardware (laptops, communication device, etc.)

4) Do you have a formal documented security policy? ◯ Yes ◯ No
   Are all employees required to read, receive and understand the security policy? ◯ Yes ◯ No

5) Are you currently HIPAA / HITECH complaint? ◯ Yes ◯ No

6) Do you utilize encryption for data stored? ◯ Yes ◯ No

7) Do you utilize encryption for data transmitted between locations or systems? ◯ Yes ◯ No

8) Do you backup computer systems and data? ◯ Yes ◯ No
   If yes, how often are backups performed?
   If yes, are backups stored off site? ◯ Yes ◯ No

9) Are your computer systems and networks actively monitored? Yes No

If yes, by whom?

10) Have you experienced any security breaches or data loss event? Yes No

SECTION III – GL SECTION

1) Does the applicant carry General Liability Insurance? Yes No

Are you interested in a quote for General Liability? Yes No

If yes, complete the section below:

2) Complete the following for each of the applicant's facilities:

Location	Name of Facility	Address	Description of Facility	Does the Applicant Manage a Garage? (Y/N)	Is There an Adjacent Exposure? (Y/N)

3) Complete the following for each of the applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percent of Building Occupied by the Applicant	%	%	%	%
Other Occupants? (Yes/No)				

**Include square footage of parking facilities if owned or rented by the Applicant.*

4) Are all of the applicant's locations equipped with:

a. Complete sprinkler system? Yes No

b. At least two clearly marked exits on each floor? Yes No

c. Self-closing fire doors on each floor? Yes No

d. Automatic fire alarm system connected to a local fire department? Yes No

e. Smoke detectors? Yes No

f. Emergency electrical system? Yes No

g. Heat sensors? Yes No

h. Fire escape(s)? Yes No

i. Posted emergency evacuation procedures? Yes No

j. Properly maintained fire extinguishers? Yes No

If any of the above questions are answered **No**, provide details on a separate attachment.

5) Does the applicant have a written safety program in place? Yes No
If yes, attach a copy of the written safety program.

6) Does the applicant have written procedures for incident reporting? Yes No

7) Does the applicant's locations have any:

a. Exposure to flammables, explosives, chemicals? Yes No

b. Catastrophe exposure? Yes No

c. Exposure to radioactive materials? Yes No

Do any of the applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? Yes No

8) Does the applicant sell or lease any medical equipment or products to patients/clients or others in connection with the applicant's operations? Yes No

If yes, what are:

Total Annual Sales $

Total Annual/Lease Rental Receipts $

9) Does the applicant:

a. Loan or rent machinery or equipment to others? Yes No

b. Own or rent any parking facility? Yes No

c. Provide any recreational facility? Yes No

d. Have a swimming pool on the premises? Yes No

e. Sponsor any sporting or social events? Yes No

10) Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for the insurance? ○ Yes ○ No

If yes, answer the following:

Provide three years' loss history for claims under $100,000 Loss and Expense and ten years for claims $100,000 and greater. Attach further sheets if needed.

Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved and Paid	Amount of Expenses Reserved and Paid	Open (O) or Closed (C)

11) Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? ○ Yes ○ No

If yes, provide details for each incident:

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

Please attach the following information:

- Advertisements, brochures, descriptive literature
- Informed consent document

Please provide any additional details in the space provided:

RESET SAVE PRINT EMAIL

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: 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 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 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:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.