








NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641
800-548-4301 • www.neee.com

REQUESTED COVERAGE - AMBULATORY SURGERY CENTER APPLICATION

☐ **Requesting Professional Liability:**

Requested Retro Date: _____

Professional Liability Limits

☐ $100,000 / $300,000
☐ $200,000 / $600,000
☐ $250,000 / $750,000
☐ $500,000 / $1,500,000
☐ $1,000,000 / $1,000,000
☐ $1,000,000 / $2,000,000
☐ $1,000,000 / $3,000,000
☐ Other: _____

Professional Liability Deductible

☐ $2,500
☐ $5,000
☐ $7,500
☐ $10,000
☐ $15,000
☐ $20,000
☐ $25,000
☐ Other: _____

☐ **Requesting General Liability:**

Requested Retro Date: _____ or ☐ Occurrence Based Coverage

General Liability Limits

☐ $100,000 / $300,000
☐ $200,000 / $600,000
☐ $250,000 / $750,000
☐ $500,000 / $1,500,000
☐ $1,000,000 / $1,000,000
☐ $1,000,000 / $2,000,000
☐ $1,000,000 / $3,000,000
☐ Other: _____

General Liability Deductible

☐ $2,500
☐ $5,000
☐ $7,500
☐ $10,000
☐ $15,000
☐ $20,000
☐ $25,000
☐ Other: _____

☐ **Requesting Employee Benefits Liability (supplement required):**

Requested Retro Date: _____

Employee Benefits Liability Limits

☐ $100,000 / $300,000
☐ $200,000 / $600,000
☐ $250,000 / $750,000
☐ $500,000 / $1,500,000
☐ $1,000,000 / $1,000,000
☐ $1,000,000 / $2,000,000
☐ $1,000,000 / $3,000,000
☐ Other: _____

Employee Benefits Liability Deductible

☐ $1,000
☐ $2,500
☐ $5,000
☐ $7,500
☐ $10,000
☐ $15,000
☐ $20,000
☐ $25,000

☐ **Requesting Non-Owned Auto Liability (supplement required):**

Non-Owned Auto Liability Limits

☐ $100,000
☐ $200,000
☐ $250,000
☐ $500,000
☐ $1,000,000
☐ Other: _____

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.

AMBULATORY SURGERY CENTER APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) _____

2. Mailing Address:_____
   STREET CITY COUNTY STATE ZIP

3. Location Address(es): Check here if same as mailing: ☐

   (1) _____
   STREET CITY COUNTY STATE ZIP

   (2) _____
   STREET CITY COUNTY STATE ZIP

   (3) _____
   STREET CITY COUNTY STATE ZIP

   (4) _____
   STREET CITY COUNTY STATE ZIP

   Attach Additional Pages as Needed

4. Website Address: **www.** _____ 5. Telephone: _____

6. Inspection/Risk Management Contact Name: _____

7. Inspection/Risk Management Contact E-mail: _____

8. Date Established _____ Years under current management _____

9. Applicant is a:

   ☐ Individual
   ☐ Corporation
   ☐ LLC
   ☐ Other:_____
   ☐ Professional Associations
   ☐ Partnership
   ☐ Joint Venture

10. Enterprise is: ☐ For Profit ☐ Not For Profit
11. Is this entity owned by, associated with or controlled by any other entity? Yes ☐ No ☐

If yes, please provide details:

_____

_____

_____

APPLICANT'S PRACTICE

11. What are the facility days and hours of operation? _____

12. Is the applicant accredited by or a member of any professional organization or association? Yes ☐ No ☐
If yes, please name: _____

13. Estimated annual gross revenues in the next 12 months? $_____

Annual gross revenues in the past 12 months? $_____

14. Does applicant maintain beds for overnight occupancy? Yes ☐ No ☐
If yes, how many? _____ Also attach a copy of license and an explanation including protocols for onsite 24 hour staffing.

15. Please provide number of procedures for the following:

TYPE OF PROCEDURE	NUMBER PAST 12 MONTHS	ESTIMATED NUMBER NEXT 12 MONTHS
Abortions		
Bariatric Surgery		
Cosmetic Surgery		
Dental/ Oral Surgery		
Endoscopy/ Colonoscopy		
General Surgery		
Gynecological Surgery		
Manipulation under Anesthesia		
Obstetric		
Ophthalmology - Cataract		
Ophthalmology – Lasik / Refractive		
Orthopedic Surgery		
Orthopedic Surgery – Including Spine		
Otorhinolaryngology with Plastic		
Otorhinolaryngology no Plastic		
Pain Management		
Plastic/ Reconstructive Surgery		
Podiatry		

Radiological/ Nuclear/ Chemotherapy		
Other: (describe)		
Other: (describe)		

16. Any other services (other than surgery) not listed above? (i.e. Lab, Imaging, Office Visits, etc.) Yes ☐ No ☐
If yes, please list type and amount.

_____ _____
_____ _____
_____ _____
_____ _____

17. **IF ABORTIONS** are indicated please complete the following otherwise skip to question 18.

	0-13 Weeks Gestation	13-16 Weeks Gestation	16-20 Weeks Gestation	20+ Weeks Gestation	Total
# of Surgical Abortions					
# of Medical Abortions					

a. Does the applicant perform ultrasounds prior to **any** abortions? Yes ☐ No ☐
b. Please specify method(s) used for both Medical and Surgical Abortions:

_____
_____
_____

18. **IF BARIATRIC SURGERY** is indicated please complete the following otherwise skip to question 19.
a. Please list all procedures and **attach** protocols for selecting and monitoring patients.

_____
_____

b. Is Bariatric surgery **only** performed by American Board Certified General Surgeons? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure ..... Yes ☐ No ☐
c. Is this center a Bariatric Surgery Center of Excellence? ..... Yes ☐ No ☐

19. **IF PLASTIC OR COSMETIC SURGERY** is indicated please list all cosmetic procedures performed including botox or other injectables otherwise skip to question 20.

_____
_____
_____

a. If liposuction (any form or type) is indicated as being performed is it **only** performed by an American Board Certified Plastic Surgeon or General Surgeon? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure. .....Yes ☐ No ☐

20. **IF PAIN MANAGEMENT** is indicated please list all Pain Management procedures performed otherwise skip to question 21.

_____
_____

POLICIES AND PROCEDURES

21. Policies and Procedures – Pre-operative:

Are written consent forms used for each type of procedure performed? If yes, Is the surgeon also required to sign the consent form? Yes ☐ No ☐	Yes ☐ No ☐
Is the physician required to discuss the procedure and consent with the patient prior to performing the procedure?	Yes ☐ No ☐
Is there written documentation of a pre-operative anesthesia evaluation and airway assessment per ASA guidelines?	Yes ☐ No ☐
Preoperative history and physical examination in the medical record by the day of surgery?	Yes ☐ No ☐
Is there a formal process in place which includes **pre-operative verification of the patient**?	Yes ☐ No ☐
Is there a formal process in place which includes **pre-operative verification of the surgical site**?	Yes ☐ No ☐
Is there a formal process in place to which includes **marking of the operative site**?	Yes ☐ No ☐
Is there a "time out" immediately before starting the procedure?	Yes ☐ No ☐

22. Policies and Procedures – Intra and post-operative:

Is there documentation and signing of all intra-operative orders?	Yes ☐ No ☐
Is there written documentation of all medications and intravenous fluids given?	Yes ☐ No ☐
Are written post-operative instructions provided to all patients?	Yes ☐ No ☐
Is there documentation and signing of all post-operative orders and timely dictation of operative notes?	Yes ☐ No ☐
Is there a formal discharge policy requiring that a patient meet specific criteria prior to being discharged?	Yes ☐ No ☐

23. Does the applicant have a preventative maintenance program for all biomedical equipment including anesthesia and critical emergency equipment that includes:
    a. Proper training of all equipment users? Yes ☐ No ☐
    b. Repairs by qualified personnel? Yes ☐ No ☐
    c. Documentation of all activities (preventive maintenance, repairs, education)? Yes ☐ No ☐

24. Anesthesia Delivery and Monitoring:
    a. 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
        ☐ Level C – Levels listed above plus and/or surgical procedures with epidural anesthesia, endotracheal or laryngeal mask intubation or inhalation anesthesia, spinal or epidural
    b. Does the applicant permit professionals other than licensed Nurse Anesthetists and Anesthesiologists to administer and/or monitor sedation or general anesthesia? Yes ☐ No ☐
    c. Are non-Anesthesiologists administering Propofol or deep sedation? Yes ☐ No ☐
25. Is there a documented protocol for handling in house emergencies? Yes ☐ No ☐
26. Is there an agreement with a local hospital for emergency transfers? Yes ☐ No ☐

27. What is the distance from the applicant to the nearest acute care hospital? _____

STAFF / CREDENTIALED PROVIDERS

28. Please provide the name and specialty of the applicant's Medical Director

_____

29. Does the applicant's Medical Director have direct patient care? Yes ☐ No ☐

30. Is the applicant's Medical Director ☐ full-time or ☐ part-time?

31. Please complete the staff / credentialed provider table below **AND** provide a staff listing by name for all credentialed physicians:

	Number Employed?		**Number Privileged**		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Physicians: no surgery other than incision of boils and superficial abscesses; suturing of skin or superficial fascia					☐ YES ☐ NO	☐ YES ☐ NO
Anesthesiologists; Pain Management Specialists					☐ YES ☐ NO	☐ YES ☐ NO
Dermatologist; Cardiologists; Gastroenterologist; Proctologists; Ophthalmologists; Urologists, Internists;					☐ YES ☐ NO	☐ YES ☐ NO
General Surgeons; Cardiac Surgeons;					☐ YES ☐ NO	☐ YES ☐ NO
Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery					☐ YES ☐ NO	☐ YES ☐ NO
Thoracic Surgeons; Vascular Surgeons; Neurosurgeons; and Orthopedic Surgeons					☐ YES ☐ NO	☐ YES ☐ NO
Bariatric Surgeons					☐ YES ☐ NO	☐ YES ☐ NO
Podiatrists					☐ YES ☐ NO	☐ YES ☐ NO
Dentists; Oral Surgeons					☐ YES ☐ NO	☐ YES ☐ NO
Nurse Anesthetists					☐ YES ☐ NO	☐ YES ☐ NO
Physicians' and Surgeons' Assistants; Nurse Practitioners					☐ YES ☐ NO	☐ YES ☐ NO
Perfusionists					☐ YES ☐ NO	☐ YES ☐ NO
Pharmacists					☐ YES ☐ NO	☐ YES ☐ NO
Chiropractors					☐ YES ☐ NO	☐ YES ☐ NO
RNs, LPNs					☐ YES ☐ NO	☐ YES ☐ NO
X-Ray Technician; Lab Technician					☐ YES ☐ NO	☐ YES ☐ NO
Other (specify):						

32. Are all above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐

33. Do you require all employed, contracted, or privileged physicians or nurse anesthetists to carry their own professional liability insurance? If yes, what limits are they required to carry? Yes ☐ No ☐

_____

34. Does the Applicant have a formal credentialing and privileging process which includes primary source verification of professional credentials and privilege qualifications for all surgeons and anesthesia providers? Yes ☐ No ☐
If yes, does it include the following **AND attach copy of written credentialing protocols**:

    a. Review/approval of requested privileges by the center's medical director and/or credentials committee? Yes ☐ No ☐
    b. Continuous updates of new or deleted privileges for ambulatory surgery center staff either through an automated or manual system? Yes ☐ No ☐

35. Can the Applicant's staff refuse to schedule a surgery or procedure that is not:
    a. On an individual provider's list of approved privileges? Yes ☐ No ☐
    b. Authorized at the Applicant's surgical center? Yes ☐ No ☐

PREMISES INFORMATION – complete only if you are requesting General Liability Coverage

Building Description

	Buildings/Wings			
	#1	#2	#3	#4
Type of Construction:	_____	_____	_____	_____
No. of Stories:	_____	_____	_____	_____
Square Footage	_____	_____	_____	_____
Date Built:	_____	_____	_____	_____
Smoke detectors:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Local/Central station fire alarm:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Sprinkler System:	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial	☐ Yes ☐ No ☐ Partial

36. Do any of the Applicant's locations have any (explain any "yes" answers on page 8):
    a. Exposure to flammables, explosive, chemicals? ☐ YES ☐ NO
    b. Catastrophe exposure? ☐ YES ☐ NO
    c. Exposure to radioactive materials? ☐ YES ☐ NO

37. Has any claim for General Liability **ever** been made against any person(s) or entity(ies) proposed for this insurance? If Yes, answer complete a supplemental claims form for each. ☐ YES ☐ NO

38. 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? If Yes, complete a supplemental claims form for each. ☐ YES ☐ NO

COVERAGE HISTORY

39. Please list professional liability insurance carried for each of the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg	Deductible	Premium	Retroactive date

40. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg	Deductible	Premium	Occurrence or Claims – Made?

If the current expiring GL policy is claims- made what is the retroactive date? _____

CLAIMS AND HISTORY – Please explain or complete a supplemental claim for form for all "Yes" answers

41. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain on page 9 or attach additional pages as needed** ☐ YES ☐ NO

42. Has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain on page 9 or attach additional pages as needed** ☐ YES ☐ NO

43. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on page 9 or attach additional pages as needed** ☐ YES ☐ NO

44. Has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance? **How Many? _____ (Complete Supplemental Claims form for Each)** ☐ YES ☐ NO

45. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐ NO

46. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.** ☐ YES ☐ NO

SUPPLEMENTAL INFORMATION (reference question number if applicable)

FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MAINE APPLICANTS: 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, or denial of insurance benefits.

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.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud an 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 shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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 a 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 the person to criminal and civil penalties.

NOTICE TO TENNESSEE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

NOTICE TO VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.
The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: _____ Title: _____

FEIN #: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____

SUPPLEMENTAL CLAIM / INCIDENT INFORMATION

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient:_____ Age:_____ Sex:_____

Incident ☐ Claim ☐

Date reported to insurance company: _____

Name of insurance company: _____

Date of incident and your treatment: _____

Allegations / Circumstances: _____

_____

_____

_____

Additional Defendants: _____

What is the present condition of the patient?_____

_____

STATUS OF CLAIM

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in YOUR favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open
☐ Awaiting mediation
☐ Awaiting court action
Reserve amount:
$_____

☐ Suit settled out of court
a. Date claim paid: _____
b. Amount paid: $_____
c. Did you want to settle?
☐ Yes ☐ No

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Amount of loss payment:
$_____

Name and address of the attorney assigned to your case: _____

_____

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

_____

_____

_____

Signature: _____ Date:_____

Printed Name: _____