

AMERICAN INTERNATIONAL COMPANIES®
ASC APPLICATION

The Applicant represents and declares that all statements and facts set forth herein are true and no material facts have been suppressed or misstated. Any material misstatements and/or omissions may result in coverage being rescinded. The Applicant agrees that if the information supplied on this Application changes between the date of this Application and the effective date, then the Applicant will immediately notify the company of such changes. The Applicant acknowledges that the company is relying on the information contained in the Application, and it is agreed that this Application shall be the basis of the contract and shall be incorporated by reference into the policy should a policy be issued. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

INSTRUCTIONS

- 1) Please type or print clearly.
- 2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Appropriate).
- 3) If you need more space for your responses, continue on a separate sheet of paper and indicate question number.

INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED

- LOSS HISTORY – Submit company produced 10 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss greater than \$50,000.
- Copies of all marketing materials.
- Most current year-end financial statements – Audited or CPA prepared.
- Copies of most recent accreditation and inspection reports within the past three years.
- Start-Up Facility - submit (1) business plan, (2) resumes of all physicians involved, (3) inspection application(s), and (4) loss history (10 years) for each physician involved.

GENERAL INFORMATION

Applicant's Name: _____

Business Address: _____

Mailing Address: _____

Website: _____

Years In Business: _____ Employer Federal Tax I.D. No.: _____ Telephone No: _____

Requested effective date: _____

Current Form Of Insurance: Retro Date
 Professional Liability Claims-made _____ Occurrence
 Commercial General Liability Claims-made _____ Occurrence

Requested Coverage: Retro Date
 Professional Liability Claims-made _____ Occurrence
 Commercial General Liability Claims-made _____ Occurrence

Requested Limits of Liability – Primary*
 \$1,000,000/\$3,000,000 Other _____

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

Deductible (applies separately to Professional Liability and General Liability)
 \$10,000 \$25,000 \$50,000 \$100,000 Other _____

Requested Limits of Liability – Excess Coverage Requested Yes No
 \$1,000,000/\$1,000,000 \$3,000,000/\$3,000,000
 \$5,000,000/\$5,000,000 Other _____

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

10. Breakdown of Total Number of Healthcare Professionals – Indicate the number of Employees and Contractors split between the number of Full Time (FT) and Part Time (PT). Provide minimum PL limits required to work at the facility. Note - If you are requesting coverage for any physicians under this policy then please complete a separate Physician and Surgeons application.

	<u>Employees</u>		<u>Contractors</u>		<u>Minimum PL Limits Required</u>
	FT	PT	FT	PT	
Anesthesiologists					
Surgeons					
Oral Surgeons					
Emergency Medical Technicians					
Nurse Anesthetists					
Nurse Practitioners/Clinicians					
Occupational Therapists					
Physical Therapists					
Physician Assistants					
RNs/LPNs/LVNs					
Technicians					
Other (define)					

11. Do you require coverage for the doctors? Yes No

If yes, provide separate application for each physician.

If yes, provide the total number of doctors: _____

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

If yes, list number and type: _____

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24. Do all of your locations have a formal laser safety and surgical fire prevention program in place including at least:
- (a) Written policies and procedures for laser safety and surgical fire prevention programs? Yes No
- (b) A formal laser safety committee? Yes No N/A
- (c) Formal laser safety and surgical fire prevention education and competency validation for all staff at least annually? Yes No
25. Please indicate the **number** of ASC facilities accredited based on type of accreditation decision:

JCAHO	AAAHC	AAAASF
Accredited:	Three Years:	Accreditation:
Provisional:	One Year:	Provisional:
Conditional:	Six Months:	Denial:
Preliminary:	Deferred:	
Preliminary Denial:	Denial/Revocation:	
Denial:		
<u>If last complete survey before January 1, 2004</u>		
(a) JCAHO Accreditation with commendation or with full standards compliance:		
(a) JCAHO Accreditation with requirements for improvement:		
Number of Facilities NOT Accredited by JCAHO, AAAHC or AAAASF:		

26. Do all of the ASC locations have formal policies which require documentation of all preoperative care including:
- (a) Preoperative history and physical examination in the medical record by the day of surgery? Yes No
- (b) Preoperative laboratory and ECG review by surgeon and anesthesia provider when applicable? Yes No
- (c) Preoperative nursing assessments? Yes No
- (d) Preoperative anesthesia evaluation and airway assessment per ASA guidelines? Yes No
- (e) Documentation of informed consent for surgery and anesthesia prior to the administration of preoperative medication? Yes No
27. Do all of the ASC locations 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) Controls over physician owned equipment? Yes No N/A
- (c) Repairs by qualified personnel? Yes No
- (d) Policies and procedures for borrowing, lending, selling or donating equipment? Yes No N/A
- (e) Documentation of all activities (preventive maintenance, repairs, education)? Yes No
28. Do all of the ASC locations have a formal emergency response policy which includes at least:
- (a) Written policies for patient transfer to the nearest available emergency department? Yes No
- (b) Immediate activation of the EMS system? Yes No
- (c) Current Advanced Cardiac Life Support (ACLS) certification for all Post Anesthesia Care Unit (PACU) staff? Yes No

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29. Do all ASC locations have a formal policy which requires documentation of all intra and post operative care including:
- (a) Patient identification, procedure, site, side re-verification? Yes No
 - (b) Positioning, electrical and laser safety precautions? Yes No
 - (c) Anesthesia assessment and continuous physiologic monitoring? Yes No
 - (d) Documentation and signing of all intraoperative orders? Yes No
 - (e) All medications and intravenous fluids? Yes No
 - (f) Disposition of all specimens sent to pathology? Yes No
 - (g) Validation of sponge, needle and instrument counts, actions taken if count is not correct? Yes No
 - (h) Condition, mode of transport and clinical status of patient, transfer report upon completion of procedure and transfer to post-anesthesia care area? Yes No
 - (i) Signing of all postoperative orders and timely dictation of operative notes? Yes No
30. Do all of the ASC locations have a formal discharge policy which requires that patients:
- (a) Meet specific clinical discharge criteria? Yes No
 - (b) Be examined by a licensed independent provider or anesthesia provider prior to discharge? Yes No
 - (c) Receive written, individualized discharge instructions which detail emergency care procedures? Yes No
 - (d) Prevent patients from driving themselves home or taking public transportation post procedure? Yes No
 - (e) Receive a documented status "call-back" phone call from the ASC in 24 hours of discharge? Yes No
31. Does the ASC have a parent organization? Yes No
- If yes, does the corporate entity:
- (a) Mandate standardized clinical and administrative policies and procedures for all facilities? Yes No
 - (b) Have uniform quality and risk management programs implemented for all facilities? Yes No
 - (c) 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: _____

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COMMERCIAL GENERAL LIABILITY INFORMATION

32. Please provide physical plant information as requested (use additional sheet if necessary):

Address/Occupancy	Square Footage	Age	Type of Construction	# of Floors	Type of Fire Protection*
Patient Care Buildings					
Other Buildings					

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

Please indicate any <u>additional insureds</u> to be included under your facility's General Liability Coverage, including explanation of their interest.	Address	Interest
Name of Additional Insured		

33. Was the facility designed for patients test subjects to stay overnight? Yes No
34. Are the electrical, heating and plumbing systems up to code and regularly inspected? Yes No
35. Is the building completely sprinklered? Yes No
If partially sprinklered, identify those areas that are sprinklered. _____
36. Are the fire alarms connected to a local fire station? Yes No

UMBRELLA LIABILITY

37. List all Automobile Liability and Workers Compensation\Employer's Liability policies if you are applying for excess/umbrella coverage:

Type of Insurance	Insurer	Policy Number	Effective Date	Expiration Date	Limits	Premium
Auto						
Workers Compensation						
Other						
Other						
Other						

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38. Submit company produced 5 year Auto Liability loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).

35(a). **If no auto claims have been reported, initial here:** _____

35(b). If there are any large loss auto claims greater than \$50,000, then initial here _____ and provide detailed description of each loss.

39. Please indicate the number of vehicles that you own or lease. If none, indicate "none."

If yes, indicate number of:

(a) Cars	
(b) Light Trucks	
(c) Vans/Buses	
(d) Other (describe):	

40. Does your auto liability policy include liability coverage for hired and non-owned autos? Yes No

If yes, please quantify: _____

If applying for excess auto coverage, do you have any vehicles garaged in any of the following states? Yes No

(a) Ohio		
(b) Florida		
(c) Louisiana		
(d) Indiana		
(e) Vermont		
(f) New Hampshire		

41. Do you reject uninsured/underinsured motorist coverage in the above states? Yes No

If yes, then provide a copy of the formal rejection required form.

HISTORICAL CARRIER INFORMATION

42. Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

PRIMARY	Policy Period	Insurer	Premium	Limits	Attachment	CM (w/ Retro) Or Occurrence
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						
<input type="checkbox"/> Professional Liability <input type="checkbox"/> Commercial GL						
<input type="checkbox"/> Excess						

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LOSS HISTORY

43. Please provide currently valued carrier produced loss runs for the past 10 years.

44. **If no claims have been reported to you, then initial here:** _____

45. Large Loss Description – On a separate sheet of paper list any liability or auto claims or suits made or brought against your facility during the past 10 years for amounts incurred greater than \$50,000.

If no claims or suits greater than \$50,000 then check the box:

- Submitted on Separate Sheet of Paper
- None Greater than \$50,000 also initial here: _____

46. Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? Yes No

If yes, give dates, allegations and disposition of each claim or suit. _____

THE UNDERSIGNED DECLARES THAT ALL STATEMENTS SET FORTH HEREIN ARE TRUE. ANY MATERIAL MISSTATEMENTS AND/OR OMISSIONS MAY RESULT IN RESCINDED COVERAGE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT THE APPLICANT ACKNOWLEDGES THAT THE COMPANY IS RELYING ON THE INFORMATION CONTAINED IN THE APPLICATION, AND IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT AND SHALL BE INCORPORATED BY REFERENCE INTO THE POLICY SHOULD A POLICY BE ISSUED.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

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

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____

Brokerage Firm Name: _____

Producer Name: _____

Address: _____

Telephone: _____

Fax: _____