Healthcare Facility Application
Surgery Center—New Business

PROASSURANCE. Treated Fairly

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

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1. Introductory Information

Legal Entity Name: _____

Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Contact Name: _____

Contact Email: _____

Number of Years in Operation: _____

Telephone Number: _____ Fax Number: _____

Hospital Fiscal Year Begins: _____

Tax ID Number: _____ NPI Number: _____

Website Address: _____

2. Facility/Corporate Organization

Type of Entity: ☐ Government ☐ Non-Profit ☐ Profit ☐ Other _____
☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture

Type of Facility: _____

Do you have a Physician Medical Director? ☐ Yes ☐ No

Does the Medical Director provide any patient care as part of the Medical Director duties? ☐ Yes ☐ No

Please attach the following:

A. Carrier Loss History:

   i. **Ten years** of historical professional liability (PL) and general liability (GL) losses including current year, ground-up and unlimited, including all self-insured, insured and uninsured losses.

   ii. Date of loss valuation must be within the past 90 days.

   iii. Loss run must include carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL) and narrative of claim.

   iv. Full details of allegations on all losses paid or outstanding in excess of $100,000 even if greater than 10 years old.

B. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or, if accrediting agency reports are unavailable, please submit the state licensure report with recommendations and the institution's response to any contingencies.

C. CPA prepared and audited financial statement including balance sheet, income statement and cash flow.

D. Identity of each employed physician including name, specialty, date of hire, retro date, primary PL carrier, is primary coverage occurrence or claims-made and PL limits (if applicable).

E. Identity related entities or subsidiaries to be considered for coverage on the policy including a brief explanation of their relationship to the applicant, scope of operations and their retro date on Schedule A (if historically written on claims-made basis).

F. Complete schedule of locations owned, leased or operated including address, square footage and occupancy.

G. Copy of state license.

H. List of all stockholders and their percent of ownership and identify any medical designations held by any stockholder.

I. Copy of your facility accreditation.

3. Current Insurance/Claim Information

Type	Carrier or Self-Insured	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible	Premium
Primary Prof. Liability							
Primary General Liability							
Excess PL							
Umbrella GL							
Auto Liability							
Employers' Liability							
Helipad/Aviation							
Other:							

**Please specify by layer if more than one Retro Date applies.*

A. Do you participate in a Patient Compensation Fund or similar type program in the state in which you operate? ☐ Yes ☐ No

If *yes*, what limit do you carry? _____

B. Have any claims ever been made or suits brought against you or any of your employees in the last five years because of any alleged malpractice, error or mistake, or from any premise accident arising in any manner out of your operations? ☐ Yes ☐ No

If *yes*, attach a separate sheet listing date of occurrence, circumstances of claim and amount paid or amount reserved.

C. Do you have knowledge of any pending claims or activities that might give rise to a claim in the future? ☐ Yes ☐ No

If *yes*, please provide details:

4. Insurance Coverage Desired

Primary:	Effective Date	Claims-Made or Occurrence	*Retro Date	Limits	Deductible
Professional Liability (PL)					
General Liability (GL)					
#Limited Pollution Liability					
Excess/Umbrella:					
Excess PL					
Umbrella GL					

**Please specify by layer if more than one Retro Date applies.*
#Separate Application Required – Refer to Company

Include the following as underlying coverage on the Excess/Umbrella (if applicable). Policy information must be indicated in the "Current Insurance" section above. Provide policy declaration pages for all applicable coverage.

☐ Auto Liability ☐ Employers' Liability ☐ Helipad/Aviation ☐ Other: _____

For each Excess/Umbrella underlying line of insurance above, describe any claims in excess of $10,000.

5. General Exposure Data

A. Do you maintain any beds for overnight occupancy? ☐ Yes ☐ No

Surgery Center: _____ No. Operating Rooms Hours of Operation: _____

_____ No. Occupied overnight/24-hour Beds

B. Facility is licensed as: ☐ Ambulatory Surgical Center ☐ Surgical Hospital

C. Select each type of surgical service that applies to the applicant and provide the number of annual procedures. (If new business start-up, please provide estimated number of annual procedures.)

Type of Procedure	Annual No. Procedures for Last Fiscal Year	Type of Procedure	Annual No. Procedures for Last Fiscal Year
*Bariatric		Gastroenterology	
Obstetrics		Vascular	
Urology		Cardiac Catheterization	
Hand		Otolaryngology (ENT)	
Orthopedic		Thoracic	
Colon and Rectal		Plastic (reconstructive)	
Head and Neck		Endoscopy	
General		Pain Management	
Cosmetic		Gynecology	
Podiatry		Oral and Maxillofacial	
Neurology		Wound Care	
Ophthalmology (cataracts)		Other (describe):	
Ophthalmology (Lasik, PRK, TKP)			

**Separate Application Required – Refer to Company*

D. Other services provided:

Medical Lab _____ Annual Receipts X-ray/Imaging Center _____ Annual Receipts

6. Other General Information

A. Are anesthesia services provided by:

☐ Employed physicians ☐ Contract group ☐ Employed CRNA's

i. If under contract, name of group: _____

ii. If contract group, are certificates of insurance required? ☐ Yes ☐ No

iii. If *yes*, what minimum limits are required: _____ per claim _____ aggregate

B. Do you have the following equipment at the center:

i. Laboratory, with the following capabilities—CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine ☐ Yes ☐ No

ii. X-ray with on-premises processing ☐ Yes ☐ No

iii. EKG ☐ Yes ☐ No

iv. Monitor/defibrillator ☐ Yes ☐ No

v. Crash cart with full cardiac life support capabilities and necessary intravenous fluids ☐ Yes ☐ No

vi. Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage ☐ Yes ☐ No

vii. Oxygen ☐ Yes ☐ No

viii. Suction ☐ Yes ☐ No

ix. Pneumatic anti-shock trousers ☐ Yes ☐ No

x. Dedicated telephone lines to the closest appropriate hospital emergency department and/or two-way communication with EMS ☐ Yes ☐ No

C. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? ☐ Yes ☐ No

If *yes*, please attach detailed explanation of this activity.

D. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? ☐ Yes ☐ No

If *yes*, please attach a copy of *all* of the advertisements.

E. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? ☐ Yes ☐ No

If *yes*, please attach detailed explanation and a copy of *all* of the advertisements.

F. Do you maintain adequate medical records for each patient? ☐ Yes ☐ No

i. How often and by whom are the medical records reviewed? _____

_____

ii. What arrangements are made for transmitting medical records to other requesting physicians?

G. Is there an established procedure and agreement with a hospital to accept emergency cases? ☐ Yes ☐ No

i. Has time and distance from the center to the nearest appropriate hospital been determined and evaluated? ☐ Yes ☐ No

ii. Have procedures for Physician direction and supervision of personnel, facilities, and equipment for the provision of medical services under emergency conditions been evaluated? ☐ Yes ☐ No

iii. Is there an established procedure to secure sufficient blood supplies in emergency situations? ☐ Yes ☐ No

H. Does the facility have a procedure to screen for inappropriate procedures or patients at risk for an ambulatory surgery procedure? ☐ Yes ☐ No

I. Are any procedures performed on persons rendered unconscious through anesthesia? ☐ Yes ☐ No

If *yes*, give detailed description on a separate sheet of how anesthesia is provided, including minimum patient age and number of overnight beds on premises or affiliated.

7. Personnel

A. Physicians providing health care services at this entity:

Name	Specialty	Board Certified	Limits	C=Contracted E=Employed O=Owner	Current Insurance Carrier

Please attach additional sheets if necessary.

B. Do you require certification of Professional Liability Coverage? ☐ Yes ☐ No

If *yes*, how much? _____

C. Non-Physician Personnel

Non-Physician Personnel	No. Employed	No. Contracted
Anesthesiology Assistant		
*Dentists		
EEG or EKG Operators		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPN's		
Medical Technicians		
*Nurse Anesthetists - Are they supervised by an anesthesiologist? ☐ Yes ☐ No		
*Nurse Practitioners/Clinical Nurse Specialists		
Occupational/Physical Therapists		
Paramedics or EMT's		
Pharmacists		
*Physician Assistants		
*Podiatrists		
RNs		
Scrub Nurses		
*Surgical Assistants (Certified or Licensed)		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe):		

**Separate Application Required – Refer to Company*

8. Premises and Operations

A. Are there any construction plans for the next twelve months? ☐ Yes ☐ No
If *yes*, please provide cost of project: _____

B. Total square footage of parking lots or decks: _____

C. Total number of swimming pools: _____

D. Total number of lakes: _____

E. Total number of fountains: _____

F. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

G. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____

Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):			
Agent:		Phone:	
Agency:		Fax:	
Address:		Email:	
		License No.:	
Signature:			

Insured Entities and D/B/A's
Schedule A

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ______________________ Retroactive Date: ______________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ______________________ Retroactive Date: ______________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ______________________ Retroactive Date: ______________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Entity Name: ______________________________
Address: ______________________________
____
Tax ID No.: ______________________ Retroactive Date: ______________
Ownership and relationship to the policyholder: ______________________________
____
Description of all operations and activities: ______________________________
____

Please attach additional sheets if necessary.

HEALTH CARE FACILITY APPLICATION ADDENDUM

PCF SCHEDULE OF ENTITIES AND D/B/A'S

NOTE: In compliance with the Indiana Patient Compensation Fund Guidelines all eligible entities and business names (D/B/A's) operating under the hospital's license must be scheduled on the Patient Compensation Fund Certificate, and remit the applicable surcharge to be extended coverage by the Patient Compensation Fund. Rating exposures (including but not limited to outpatient visits, one day surgery procedures, home health visits, inpatient days, etc.) of scheduled entities and operations are to be included on the Health Care Facility Application.

Other hospital owned or controlled eligible entities and D/B/A's operating under separate licensure must make separate PCF application, pay applicable surcharge, and meet underlying primary coverage requirements. Failure of the hospital to comply with PCF requirements could result in a declination of coverage by the Patient Compensation Fund.

Name:	**Tax ID #**	**Health Dept License #**