Rockbridge Underwriting, An RLI Company
3700 Buffalo Speedway, Suite 300
Houston, TX 77098
(713) 874-8800

SURGERY CENTER LIABILITY INSURANCE APPLICATION

Instructions: Please complete and sign. Attach additional sheets as needed.

I. IDENTIFYING INFORMATION

A. Full name of Facility and all subsidiaries or related entities for whom this insurance is desired:

_____

_____

B. Mailing Address:

_____

_____

C. Contact Person: _____

Title: _____

D. Telephone Number: _____

E. Web Site: _____

F. Administration

1. Name of Chief Executive Officer: _____
2. Name of Medical Director: _____
3. Name of Risk Manager: _____

II. LICENSURE/OWNERSHIP

A. ☐ Physician or privately owned

Percent of Physician ownership _____

B. ☐ Not-for-Profit
☐ For Profit (attach list of Stockholders/Partners)

III. COVERAGE REQUESTED

A. Deductible/SIR – Amount: _____

B. Effective Date: _____

C. Retroactive Date: _____

D. Limits of Liability:

- ☐ $100,000/$300,000
- ☐ $200,000/$600,000
- ☐ $500,000/$1,500,000
- ☐ $1,000,000/$3,000,000
- ☐ $1,000,000/$6,000,000
- ☐ $2,000,000/$4,000,000

IV. INSURANCE INFORMATION

A. Previous five year period:

	Current Year	Year 2	Year 3	Year 4	Year 5
Insurance Company(ies)					
Policy Number(s)					
Limits of Liability					
Deductible/SIR	☐ Deductible ☐ SIR Amount:	☐ Deductible ☐ SIR Amount:	☐ Deductible ☐ SIR Amount:	☐ Deductible ☐ SIR Amount:	☐ Deductible ☐ SIR Amount:
Coverage Form	☐Claims-Made Retro Date: ☐Occurrence	☐Claims-Made Retro Date: ☐Occurrence	☐Claims-Made Retro Date ☐Occurrence	☐Claims-Made Retro Date: ☐Occurrence	☐Claims-Made Retro Date: ☐Occurrence
Policy Period					
From:					
To:					
Premium:	$	$	$	$	$

B. Has any insurance company canceled or refused to renew your Professional Liability insurance policy(ies)? ☐ Yes ☐ No

If "Yes", please explain: _____

C. Does the applicant own, operate, manage or have an interest in a hospital, nursing home, outpatient clinic, pharmacy, laboratory, dispensary, transportation service, or other health care-related organization not listed in question 1 of this application? ☐ Yes ☐ No

If "Yes", please explain: _____

V. PATIENT ACTIVITY

Census data for past five years:

	Current Year	Year 2	Year 3	Year 4	Year 5
Surgeries-					
Local Anesthesia					
General Anesthesia					

VI. PROPERTY INFORMATION

A. Are all areas equipped with:

Smoke Alarms	☐ Yes	☐ No
Self-closing fire doors	☐ Yes	☐ No
Clearly marked emergency exits	☐ Yes	☐ No
Sprinkler systems	☐ Yes	☐ No

B. Is there a written disaster/evacuation plan? ☐ Yes ☐ No

C. Are all general contractors and subcontractors required to provide certificates of insurance to the facility? ☐ Yes ☐ No

VII. PATIENT MIX

Medicare _____ Managed Care/Insurance _____

Medicaid _____ Other Private Pay _____

Charitable _____

VIII. EMPLOYMENT DATA

Total number of Employees _____ Laboratory Technicians _____

CRNAs _____ X-Ray Technicians _____

Nurse Practitioners _____ Surgical Assistants _____

Physicians
(attach list with specialty) _____ Nurses (RN & LPN/LVN) _____

IX. ACCREDITATION

☐ JCAHO, Expiration Date:
- ☐ Full
- ☐ Contingent (attach copy of report)

☐ Medicare/Medicaid Approval

☐ AAAHC, Expiration Date:
- ☐ Other
- ☐ None

Have you ever been denied accreditation? ☐ Yes ☐ No

If "Yes", for what reason? _____

X. MEDICAL STAFF

A. Is there a written policy requiring all medical staff members to carry professional liability insurance? ☐ Yes ☐ No

If "Yes," minimum limits required _____

If "Yes," is this policy strictly enforced? ☐ Yes ☐ No

B. Are Certificates of Insurance maintained on file? ☐ Yes ☐ No

C. Are there established procedures to utilize the National Practitioner Data Bank during the credentialling and reappointment process? ☐ Yes ☐ No

D. Are court records checked to verify suits against Applicants or Reappointees: ☐ Yes ☐ No

E. Is Board Certification a requirement for active medical staff privileges? ☐ Yes ☐ No

If not, what percentage of your medical staff is:

Board Certified _____ Board Eligible _____

XI. RISK MANAGEMENT/QUALITY ASSURANCE

A. Is there a written statement by the Board of Directors endorsing risk management? ☐ Yes ☐ No

B. Is there a written Quality Assurance Plan organized and implemented on a departmental basis? ☐ Yes ☐ No

C. Does applicant edit or sell publications, video tapes or other media? ☐ Yes ☐ No

If "Yes," please explain. _____

_____

D. Are all Nursing Personnel oriented and trained before serving in surgery areas? ☐ Yes ☐ No

E. Are there written agreements with other health care facilities and internal protocols guiding the transfer of any patient? ☐ Yes ☐ No

F. Is there a policy requiring all Anesthetists to remain with patients during the entire time of surgery? ☐ Yes ☐ No

G. Is there a policy requiring pre-operative evaluations of all patients by anesthesiologists? ☐ Yes ☐ No

XII. TO COMPLETE THIS APPLICATION, PLEASE ATTACH:

A. Articles of Incorporation for all entities listed in question I.

B. A list of all premises owned, occupied, rented or leased by the applicant in which patient care is rendered. Please provide age, construction, number of stories, fire protection, and type of usage for each location.

C. Corporate organization chart illustrating relationships among all affiliates.

D. A loss experience report from present and past insurers listing all open or closed claims for past five years, including reserve or payment amounts, defense costs and current status. If not available, please explain.

E. Most recent audited annual report.

F. State inspection report, if not JCAHO accredited, or JCAHO and AAAHC accreditation.

G. All contracts with the contracted physicians.

H. Medical staff bylaws.

I. Any policy or resolution indicating insurance requirements for medical staff members.

J. A written summary of the applicant's risk management and credentialing process.

XIII. LOSS INFORMATION

DATE OF INCIDENT	DATE OF CLAIM	ALLEGATION	STATUS*	AMOUNT RESERVED	AMOUNT PAID

* Status should be shown as (O)pen, (C)losed, (I)ncdent

XIV. SCHEDULE OF SURGICAL PROCEDURES

General Surgery Procedures	No. of Procedures Performed Annually	Eye Surgery Procedures	No. of Procedures Performed Annually

Plastic Surgery Procedures	No. of Procedures Performed Annually	Urology Surgery Procedures	No. of Procedures Performed Annually

XIV. SCHEDULE OF SURGICAL PROCEDURES (continued)

Ob/Gyn Procedures*	No. of Procedures Performed Annually	Orthopedic Surgery Procedures	No. of Procedures Performed Annually

* Termination of Pregnancy should be divided as follows:
TOP – 1st Trimester; TOP – 2nd Trimester; TOP – 3rd Trimester

Ear, Nose, Throat Procedures	No. of Procedures Performed Annually	Miscellaneous Surgical Procedures	No. of Procedures Performed Annually

XV. CONDITIONS OF APPLICATION

By applying for Medical Malpractice Insurance from Mt. Hawley Insurance Company, I hereby:

- consent to the inspection by Mt. Hawley Insurance Company or their agents of all documents that may be material to an evaluation of the group's qualifications and competence.

- release from liability Mt. Hawley Insurance Company, their agents and any other individuals for acts performed and statements made in good faith and without malice in connection with evaluating this application and the group's qualifications;

- release from liability any and all individuals and organizations who provide information to Mt. Hawley Insurance Company, in good faith and without malice concerning the group's professional competence, ethics, character and other qualifications;

All information requested in this application is considered material and important, and are made a part of any insurance policy issued by the Company. If Mt. Hawley Insurance Company agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, or attempt to defraud or lie to us about any matter contained in this application.

I understand that falsification or material inaccuracy of any part of the above information can result in the immediate cancellation of my policy, and that no claims shall be paid nor coverage provided in the event of such falsification or material inaccuracy.

I agree to be bound by the terms and conditions contained in the policy to be issued, in the event this application is approved.

I hereby certify that the above information is correct, and that I have no knowledge of any incidents, pending claims, or any other activities that might result in a claim other than those listed on this application. I authorize release and exchange of information involving underwriting or claims matters among insurance carriers. Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy written to provide coverage excess of this policy.

_____	X_____
Date	Applicant's Signature

Signing this application does not bind Mt. Hawley Insurance Company or any other insurance carrier to complete the insurance.