Hull & Company
Lic. #0F60641

Southern California
P: (949) 477-5030
F: (949) 477-5040

Northern California
P: (209) 474-9100
F: (866) 217-1815

Pacific Islands
P: (808) 840-1980
F: (866) 859-8302

APPLICATION FOR AMBULATORY SURGERY CENTERS

1. Full Name of Applicant: (Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. Mailing and Location Address: (If multiple addresses include an attachment with a complete schedule of all locations)

3. Website Address (if applicable)

4. Date Established:

5. Type of Entity: ◯ Corporation ◯ Partnership ◯ Individual ◯ Other (Specify):

6. Is this entity owned by, associated with or controlled by any other entity? ◯YES ◯NO
   If Yes, please give details:

7. 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: E-mail:

8. Limits Requested: Each Claim: $ Aggregate: $

9. Deductible Requested: ◯ $5,000 ◯ $10,000 ◯ $15,000 ◯ $20,000 ◯ Other (Specify):

10. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ◯YES ◯NO
    If Yes, (a) Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ◯YES ◯NO
    (b) Provide the name and title of the applicant's privacy officer:

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

	Employee or Volunteer	Independent Contractor	Insured On Own Med Mal Policy	Insured Limits
Physicians/Surgeons			◯ YES ◯ NO	
Physician/Surgeon Assistants			◯ YES ◯ NO	
Surgical Technicians			◯ YES ◯ NO	
Chiropractors			◯ YES ◯ NO	
CRNA'S			◯ YES ◯ NO	
Nurse Practitioners			◯ YES ◯ NO	
Podiatrists			◯ YES ◯ NO	
Registered Nurses			◯ YES ◯ NO	
LPN's or LVN's			◯ YES ◯ NO	
X-Ray Technicians			◯ YES ◯ NO	
Medical Assistants			◯ YES ◯ NO	
Optometrists			◯ YES ◯ NO	
Pharmacists			◯ YES ◯ NO	

12. If you have a Medical Director, provide name, speciality and C.V.:

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 Medical Director required to carry?

13. Are all of the above individuals licensed in accordance with applicable State and Federal regulations? ◯ YES ◯ NO

If No, please provide a detailed explanation.

14. Is credentialing which includes primary source verification performed on all providers? ◯ YES ◯ NO

If No, explain:

15. Are references checked for all providers? ◯ YES ◯ NO

If No, explain:

16. Has the applicant or any of the above employees and/or independent contractors:

a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or 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.

17. Surgical category and estimated number of procedures (please provide totals at bottom):

Type of Procedure	Number of Procedures: Last Year	Current Year	Estimated Next Year	Type of Procedure	Number of Procedures: Last Year	Current Year	Estimated Next Year
Abortions				Ophthalmology			
Bariatric (lap band only)				Oral/Non-Cosmetic			
Bariatric (all other)				Oral/Cosmetic			
Botox Injections - Cosmetic				Orthopaedic/Incl. Hand/No Spine			
Cardiology				Orthopaedic/Incl. Spine			
Chiropractic				Otorhinolaryngology/Non-Cosmetic			
Cosmetic Injectable				Otorhinolaryngology/Cosmetic			
Dermatology/Non-Cosmetic				Plastic/Cosmetic			
Dermatology/Cosmetic				Plastic/Reconstructive			
Endoscopy/Colonoscopy				Pain Management			
Gastroenterology				Podiatry			
General				Rheumatology			
Gynecology				Thoracic			
Liposuction				Urology - no penile implants			
Neurology				Urology - penile implants			
Obstetrics				Other			
				Total			

18. Please indicate percent of pediatric surgical procedures performed at your facility:

19.

Applicant's Gross Revenue	Last 12 months	Estimate for next 12 months
Medicare/Medicaid	$	$
Fee for service	$	$
Other	$	$
Total Gross Revenues:	$	$

20. Is the facility Licensed by state? ◯YES ◯NO
Medicare Certified? ◯YES ◯NO
Accredited? ◯YES ◯NO
If Accredited: By JCAHO ◯YES ◯NO
By AAAHC ◯YES ◯NO

21. 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

22. 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, please explain:

23. Is there a written policy in place for:

Patient Identification	◯YES	◯NO
Surgical site verification	◯YES	◯NO
Patient positioning	◯YES	◯NO
Laser/electrical safety	◯YES	◯NO
Continuous physiological monitoring	◯YES	◯NO
Documentation of all intra-operative orders	◯YES	◯NO
Disposition of all pathology and other specimens	◯YES	◯NO
Verification of sponge, needle, and instrument counts	◯YES	◯NO
Documentation of patient condition, mode of transportation for hospital transfers:	◯YES	◯NO
Completion and signing of operative reports which includes a written, immediate post surgical report	◯YES	◯NO

PROVIDE EXPLANATION FOR ALL "NO" ANSWERS BELOW:

24. Prior to 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 EXPLANATION FOR ALL "NO" ANSWERS BELOW:

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?

28. Is "overnight" stay permitted at the facility? ◯YES ◯NO

If yes, provide explanation:

29. In the event of complications, what are the emergency handling procedures at the facility?

30. With what hospital(s) has the facility a "transfer agreement" for handling of emergency cases?

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

32. 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 and/or 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)?

If no, please explain:

33. Are all CRNA's with privileges at your facility required to carry their own professional liability coverage: ◯YES ◯NO

If Yes, at what limit:

Do you require proof of insurance ◯YES ◯NO

If no, please provide an explanation

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

35. Are all physicians with 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, please provide an explanation.

36. Do any physicians with privileges at your facility have medical malpractice coverage with a Risk Retention Group or Captive Insurance Company? ◯YES ◯NO If Yes, please provide the name of the physician (s) and their malpractice carrier.

37. Are providers allowed to post bonds or letters of credit instead of insurance? ◯YES ◯NO

If Yes, how is this verified?

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

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

39. Does the applicant carry General Liability insurance? ◯YES ◯NO

Are you interested in a quote for General Liability? ◯YES ◯NO

If Yes, please attach a completed GL Acord Application with a schedule of locations and the square footage of each location.

40. Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? ◯YES ◯NO

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

41. 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, please provide details including name of carrier and dates.

42. Has any claim ever been made against the applicant or any of its employees? ◯YES ◯NO

If Yes, how many?

If Yes, please complete the Supplemental Claim Information Form with your submission of this application. Form Link

43. Is the applicant aware of any circumstances which may result in any claim against them or their employees? ◯YES ◯NO

Is Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.

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

☐ I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. 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 nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

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 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:

Current Date 09/29/2010

Title

If you prefer not to return application with an electronic signature, please print and sign below:

Signature of Applicant or Authorized Representative

Current Date:

Title

Type or print your name & title

Type or print your phone number

Type or print your e-mail address