SUPPLEMENTAL APPLICATION

AMBULATORY SURGERY CENTER
MISCELLANEOUS HEALTHCARE FACILITIES

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

NOTE: Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

NOTICE OF POSSIBLE REDUCTION OF LIMITS OF INSURANCE

IF COVERAGE IS ISSUED BY THE COMPANY TO THIS FACILITY, BE AWARE OF THE POLICY PROVISION THAT WARRANTS THAT ANY PHYSICIAN UTILIZING YOUR FACILITY CARRY INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE WITH LIMITS EQUAL TO OR GREATER THAN THE LIMITS OF INSURANCE PROVIDED UNDER THE FACILITY'S POLICY.WE THEREFORE ENCOURGAGE YOU TO REVIEW THE FACILITY'S MEDICAL STAFF BYLAWS AND THE EFFECT THEY MAY HAVE ON ANY CLAIMS REPORTED UNDER THE PROPOSED POLICY.

The following additional information is required. Delay in providing this information will impede the company's decision to provide requested coverage:

1. Patient Informed Consent forms
2. Continuing Education Course Certificates
3. Copy of your Curriculum Vitae
4. Copy of your current professional liability insurance Declarations Page
5. Brochures, pamphlets, advertisements, or other descriptive literature of operations and services
6. Company loss runs for the past seven (7) years, valued within the last 90 days

I. GENERAL INFORMATION

1 Applicant/Entity Name:

Provide a list of all owners including their percentage of Ownership: Ownership

____________________ ______%
____________________ ______%
____________________ ______%
____________________ ______%

Must total 100%

May any qualified physician apply for privileges at this facility? ☐Yes ☐No

II. OPERATIONS

1. Hours of operation:
2. How man shifts are maintained?
3. Type of Procedures and Number of Annual Visits:

Name/Type of Procedure (provide details)
(Please attach separate page if more space is needed.)

	Projected	Current Year	Prior Year

© 2013 General Star, Stamford, CT

	Are patients screened prior to surgery to determine that they are low risk and able to undergo outpatient surgery? ☐ M.D. ☐ CRNA ☐ Other: (identify)	☐ Yes ☐ No
	Are written post-operative orders submitted and signed by the surgeons?	☐ Yes ☐ No
	Are nursing charts maintained, including patient's condition at time of discharge?	☐ Yes ☐ No
	Are patients contacted within 24 hours of discharge to determine if there are any complications?	☐ Yes ☐ No
	How long are orders, consent forms, and charts maintained?	

COSMETIC SURGERY

1.	Is cosmetic surgery (other than breast implant or liposuction) being performed?	☐ Yes ☐ No ☐N/A
2.	If yes, what is the percentage of cosmetic surgery(other than breast implant or liposuction) with respect to the overall procedures being performed? %	☐ Yes ☐ No ☐N/A
3.	Are only American Board Certified Surgeons credentialed to perform surgery at the facility?	☐ Yes ☐ No ☐N/A
4.	Are surgeons permitted to perform procedures that are outside their area of expertise as defined by their respective American Specialty Boards?	☐ Yes ☐ No ☐N/A

BREAST IMPLANT SURGERY

1.	Is cosmetic breast implant surgery being performed?	☐ Yes ☐ No ☐N/A
2.	What is the percentage of breast implant surgery with respect to the overall procedures being performed?	☐ Yes ☐ No ☐N/A
3.	Is breast implant surgery only performed by American Board Certified Plastic Surgeons and General Surgeons? If no, describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform that procedure.	☐ Yes ☐ No ☐N/A
4.	Advise the name(s) of the manufacturer(s) of all breast implants being used and measures taken to protect these implants prior to implantation surgery.	☐ Yes ☐ No ☐N/A

LIPOSUCTION

1.	Is liposuction being performed?	☐ Yes ☐ No ☐N/A
2.	If yes, what is the percentage of liposuction with respect to the overall procedures being performed? %	
3.	Is liposuction performed only by American Board Certified Plastic Surgeons and General Surgeons?	☐ Yes ☐ No ☐N/A
4.	If no, please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform that procedure.	
5.	Are surgeons permitted to perform procedures that are outside their area of expertise as defined by their respective American Specialty Board?	☐ Yes ☐ No ☐N/A
6.	How many "cc's" of fluid are injected prior to surgery and how many "cc's" are removed during surgery? cc's injected prior to surgery cc's removed during surgery	
7.	Is liposuction performed "incidental" to other surgical procedures	☐ Yes ☐ No ☐N/A

LASIK, PRK OR OTHER VISION-ENHANCING SURGERY

1.	Is LASIK, PRK or other vision-enhancing surgery performed?	☐ Yes ☐ No ☐N/A
2.	If yes, what is the percentage of LASIK, PRK or other vision-enhancing surgery with	

© 2013 General Star, Stamford, CT

	respect to the overall procedures being performed? %	
3.	Is LASIK, PRK or other vision-enhancing surgery performed only by American Board Certified Ophthalmic Surgeons?	☐ Yes ☐ No ☐N/A
4.	If no, describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform that procedure.	
5.	Describe the documentation you require when determining whether a surgeon will be approved for any of these procedures. Also, describe the minimum number of surgeries a surgeon must have previously performed in order to be credentialed for this process:	
6.	Advise the name(s) of the manufacturer(s) of the laser device being used:	
7.	Describe the training the surgeons must complete with respect to this equipment:	
8.	Describe who calibrates and maintains this equipment and how often this is done	

BARIATRIC SURGERY

1.	Is bariatric surgery performed?	☐ Yes ☐ No
2.	If yes, what is the percentage of bariatric surgery with respect to the overall procedures performed? %	
3.	Is bariatric surgery only performed by American Board Certified General Surgeons?	☐ Yes ☐ No
4.	If no, describe those other surgical specialists performing these procedures and the reason(s) why they have been granted privileges to perform those procedures.	
5.	Describe all types of bariatric surgical procedures being performed and the percentage of the total of all weight loss procedures:	

ADDITIONAL INFORMATION

Please use the space provided below to provide additional information as required by individual questions in this application. Use additional sheet(s) if necessary.

Section # and Question #	Comments

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Signature of Owner, Officer or Partner:	Print or Type Name and Title	Date:

© 2013 General Star, Stamford, CT