



**HUDSON SPECIALTY INSURANCE COMPANY
SURGERY CENTER SUPPLEMENTAL APPLICATION**

SECTION 1: APPLICANT INFORMATION

Surgery Center Full Legal Name, Include Any DBA: _____
 Address: _____
 City: _____ State: _____ Zip: _____ County: _____
 Website Address (No Website): _____

SECTION 2: PERSONNEL

1. Complete the following table for Employed or Independent Contractor (IC) staff working at the Surgery Center:

Professional License/Status * Must be scheduled on policy to be covered.	Number Employed Staff	Number IC/1099 Staff	Exclude <u>Any</u> Employed Staff from this Policy?	Do You Confirm Excluded Employees & ICs Have Own Policy?
1) Physician/Surgeon (MD/DO)*			<input type="checkbox"/> Y** <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
2) Nurse Anesthetist (CRNA)*			<input type="checkbox"/> Y** <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3) Nurse Practitioner (NP)*			<input type="checkbox"/> Y** <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4) Physician Assistant (PA)*			<input type="checkbox"/> Y** <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
5) Other:			<input type="checkbox"/> Y** <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

2. Answer the following for staff working at the Surgery Center:

a) Do the medical practitioners carry their own insurance coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Are ALL physicians performing Plastic/Cosmetic procedures Board Certified Plastic Surgeons? If No, list in all physicians that are not Board Certified Plastic Surgeons by name, specialty and surgical procedures performed.	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) What are the <u>minimum</u> required limits of the center's medical staff?	<input type="checkbox"/> No minimum, or <input type="checkbox"/> \$ _____ per claim/ \$ _____ aggregate
d) Do you confirm that <u>all</u> practitioners working at the center have current hospital privileges?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3: GENERAL INFORMATION

1. Tell us about the surgery center.

a) Is the center staffed by an ACLS provider until <u>all</u> patients are discharged?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Does the center have any pediatric patient <u>minimum</u> age restrictions?	<input type="checkbox"/> N/A, No Pediatric Cases <input type="checkbox"/> No Age Restriction (any age okay) <input type="checkbox"/> > 6 mos. <input type="checkbox"/> > 1 yr. <input type="checkbox"/> > 2 yrs. <input type="checkbox"/> > 6 yrs. <input type="checkbox"/> > 12 yrs.
c) Are you a member of any industry association? (FASA, AAASC. etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No Name of Association: _____
d) Is the center accredited? If yes, by whom? (check all that apply)	<input type="checkbox"/> No Accreditation <input type="checkbox"/> AAAHC <input type="checkbox"/> JCAHO <input type="checkbox"/> AAAASF/SPF <input type="checkbox"/> Other: _____
e) What is the distance between the hospital above and the center, in miles and minutes?	<input type="checkbox"/> On Hospital Grounds <input type="checkbox"/> <1/2 <input type="checkbox"/> <1 <input type="checkbox"/> <3 <input type="checkbox"/> <5 <input type="checkbox"/> <10 <input type="checkbox"/> 11+ If over 11 miles, how many? _____ <input type="checkbox"/> Minutes? _____
f) Is there a transfer agreement in place with a local hospital allowing patients to be directly admitted to the hospital in an emergency situation?	<input type="checkbox"/> Yes (please list hospital): _____ <input type="checkbox"/> No (please explain in the remarks section)
g) What is the <u>maximum</u> scheduled length (in hours) of surgical cases?	<input type="checkbox"/> <1 <input type="checkbox"/> <2 <input type="checkbox"/> <3 <input type="checkbox"/> <4 <input type="checkbox"/> <5 <input type="checkbox"/> 6+ If more than 6 hours, how many? _____
h) What % of each ASA patient level is treated at the center?	ASA I: _____ ASA II: _____ ASA III*: _____ ASA IV*: _____ ASA V*: _____ * please list procedures done for these patients in the remarks section
i) Estimate the % of patients receiving anesthesia by type? (total must equal 100%)	_____ Local _____ Regional Block _____ IV/Con. Sedation _____ MAC _____ Epidural _____ General

SECTION 4: PROCEDURE/TREATMENT INFORMATION

1. For each procedure shown below, please provide the number of procedures for the current policy year and the projected number for the upcoming policy term.

Procedure	Projected Year: 201__	Current Year:201__	Procedure	Projected Year: 201__	Current Year:201__
Chiropractic/Physical/Rehab Therapy			Ophthalmology (including Laser/Lasik Surgeries)		
Dental			Orthopedic		
Ear, Nose, & Throat			Pain Management		
Endoscopic/Colonoscopy			Podiatric		
Gastroenterology			Plastic/Cosmetic		
General			Pulmonary		
Gynecological/Obstetrical			Urology		
Laparoscopic Banding			Other:_____		
Neurology			Other:_____		

2. Does your organization maintain beds for overnight occupancy? Yes No. If yes, please complete below.

Occupancy: The daily average number of occupied beds shall be the sum of the annual occupancy divided by 365. Acute Care Beds are defined as: All beds licensed by the state, including but not limited to, all beds designated for burn, coronary, intensive care, medical, surgical, pediatrics, or other acute care patients.

Type of Bed

	<u>No. Licensed Beds</u>			<u>Average Annual Occupied Beds</u>		
	Current Year	1 st Prior	2 nd Prior	Current Year	1 st Prior	2 nd Prior
Other Specify: _____						
Other Specify: _____						

3. What equipment is available at the center? (please check all that apply)

Anesthesia Machine:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suction Machine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pulse Oximeter:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Medicine & Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No
EKG Monitor:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Positive Pressure Ventilation Sources	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure Monitor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back up Oxygen Supplies & Regulators	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Remarks Section: _____

NOTICE

To All Prospective Insureds: 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia and Louisiana: “Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”

Florida and Oklahoma: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: An act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and/or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

New York: 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 fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Pennsylvania: 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 purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

This application is for insurance to be placed on a surplus lines basis with Hudson Specialty Insurance Company.

Applicant's Signature

Print Name

Date