# Healthcare Facility Application
# Surgery Center—Renewal

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

**Expiring Policy No.** ________

## 1. Introductory Information

Policyholder Name: ______________________

Address: ______________________

City: ____________ County: ____________ State: ______ ZIP: ____________

Telephone Number: ____________ Fax Number: ____________

Fiscal Year Begins: ____________

Contact Name: ____________ Contact Email: ____________

Website Address: ______________________

Instructions:

1. Please review and complete this renewal application.
2. When necessary, check all boxes that apply.
3. If you need more space for your responses, continue on a separate sheet indicating question number.

## 2. General Information

A. Has there been a change in facility ownership or management? ☐ Yes ☐ No
If *yes*, please explain: ______________________

______________________

B. Provide details of any new start-up services or any services discontinued during the past fiscal year.

C. Has the facility's license been revoked, suspended or restricted during the past fiscal year?
If *yes*, please provide details: ______________________

______________________

D. Has any accreditation program revoked, suspended or restricted the facility's accreditation status?
If *yes*, please provide details: ______________________

______________________

E. Please provide a copy of the facility's latest fiscal year-end audited financial statement.

F. Please provide an updated schedule of locations and insured entities.

## 3. General Exposure Data

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
If *yes*, what minimum limits are required: ____________ per claim ____________ aggregate

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

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


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

Surgery Center: ______________ No. Operating Rooms Hours of Operation: ____________________________

______________ No. Occupied overnight/24-hour Beds

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

F. Select each type of surgical service that applies and provide the 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 if new operation – Refer to Company*

G. Other services provided:

Medical Lab ___________________ Annual Receipts X-ray/Imaging Center ______________________ Annual Receipts

## 4. 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 |
|---|---|---|
| Aids or Orderlies | | |
| Anesthesiology Assistant | | |
| *Dentists | | |
| EEG or EKG Operators | | |
| Inhalation/Respiratory Therapists | | |
| Laboratory Technicians | | |
| LPNs | | |
| Medical Technicians | | |
| #Nurse Anesthetists - Are they supervised by an anesthesiologist? ☐ Yes ☐ No | | |
| #Nurse Practitioners | | |
| Occupational/Physical Therapists | | |
| Paramedics or EMTs | | |
| Pharmacists | | |
| #Physician Assistants | | |
| *Podiatrists | | |
| RNs | | |
| Scrub Nurses | | |
| #Surgical Assistants | | |
| X-ray or Radiology Technicians | | |
| X-ray or Radiology Therapists | | |
| Other (describe): | | |

**Separate Application Required – Refer to Company*
*#Separate Application Required for New Personnel if not Previously Submitted*

## 5. 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: ______________

**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: ______________________


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


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**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.


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