

Surgical Outpatient Facility Application for Claims-Made Professional Liability Insurance

Check one of the following:

- New Application
 Renewal Application (Existing MIEC Policyholder)

Policy Number: _____

- Answer all questions. Indicate N/A if not applicable
- Have Officer/Director sign and date pages 8 and 9

IMPORTANT NOTICE

You are applying for coverage under MIEC's claims-made policy. If your application is accepted by MIEC, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to MIEC either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

FACILITY INFORMATION / REQUESTED COVERAGE / LIMITS

ANSWER 1-3

1. FACILITY INFORMATION

Name of Facility

Mailing Address

City

State

Zip Code

Telephone Number

Fax Number

Website Address

Administrator

Medical Director

Contact Person (if other than Administrator)

Contact Person's E-mail

2. REQUESTED COVERAGE EFFECTIVE DATE

Date (mm/dd/yyyy)

I request that this insurance commence at 12:01 A.M. on the above date. I understand that all MIEC policies have an annual expiration date of February 1. In light of this, I understand that my initial policy period may be for a term of less than one year, and that my premiums will be pro-rated accordingly.

3. REQUESTED LIABILITY LIMITS

Check one. Limit Per Claim / Annual Aggregate

NOTE: Higher annual aggregates are available. Contact MIEC.

\$500,000 / \$1,500,000

\$2,000,000 / \$4,000,000

\$4,000,000 / \$6,000,000

\$1,000,000 / \$3,000,000

\$3,000,000 / \$5,000,000

\$5,000,000 / \$7,000,000

Coverage and actual effective date are subject to the approval of MIEC's Underwriting Department

4. OWNERSHIP

Please describe the ownership of the facility (in detail), i.e., sole proprietor, partnership, corporation. Provide names of owners, partners or shareholders.

5. LOCATIONS

Location(s) of Facility. If you wish to be covered for Professional Premises Liability as outlined under Part III of MIEC's policy, please indicate below.

A. _____ Premises Liability Yes No
 Name of Building

_____ Address _____ City _____ State _____ Zip Code

B. _____ Premises Liability Yes No
 Name of Building

_____ Address _____ City _____ State _____ Zip Code

C. _____ Premises Liability Yes No
 Name of Building

_____ Address _____ City _____ State _____ Zip Code

Do you carry separate Comprehensive General Liability Insurance on each of the above locations? Yes No

If yes, provide the name(s) of the carrier(s) and limits of liability.

_____ Name of Carrier _____ Limits of Liability

_____ Name of Carrier _____ Limits of Liability

6. HOURS

What are your hours of operation? _____

7. ESTABLISHED

How long has the facility been in business? _____ How long at the present location? _____

8. PROCEDURES

List types and numbers of surgical or diagnostic/medical procedures performed at the facility. List each separately.

SURGICAL (i.e., cosmetic surgery, gyn). Use separate sheet if necessary.

Type of Procedure Performed in the Past 12 Months	Number	Type of Procedure Expected to be Performed in the Next 12 Months	Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. PROCEDURES, cont'd.

DIAGNOSTIC/MEDICAL (i.e., IVP's, biopsies, CT scans, angiograms). Use separate sheet if necessary.

Type of Procedure Performed in the Past 12 Months	Number	Type of Procedure Expected to be Performed in the Next 12 Months	Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ANESTHESIA

ANSWER 9

9. ANESTHESIA

A. Which and what percentage of the procedures performed at the facility will require the administration of general and/or regional anesthesia?

B. Who will administer anesthesia? An anesthesiologist/CRNA, etc.? (Please provide names and professional licensure, including license numbers.)

C. What resuscitative equipment is kept at the facility?

D. What means of monitoring are in place pre-operatively, during surgery and post-operatively?

E. Have the anesthesiologists warranted to you that they follow ASA (American Society of Anesthesiologists) guidelines? Yes No

10. X-RAY

Does the facility provide laboratory, x-ray or diagnostic imaging services? Yes No If yes, please answer the following.

- A. Who takes the x-rays? _____
- B. Who reads them? _____
- C. What type of services are provided by the laboratory? _____
- D. Are laboratory and x-ray services limited to the physicians who utilize the facility? Yes No
If not, what are the gross annual receipts for outside services? _____
- E. Under what name are the patients billed? _____

11. DIAGNOSTIC OR SURGICAL SERVICES

What other medical diagnostic, or surgical services are provided or planned for the facility? _____

12. EMERGENCY SERVICES

Does the facility provide emergency medical services? Yes No. If yes, provide details, including number of annual emergency visits.

13. PHYSICIAN PROVIDERS

A. Provide list of names, license numbers and medical specialties of all physicians and other licensed health care providers who will utilize the facility. Use separate sheet if necessary.

_____	_____	_____
Name	License Number	Specialty
_____	_____	_____
Name	License Number	Specialty
_____	_____	_____
Name	License Number	Specialty
_____	_____	_____
Name	License Number	Specialty

B. Do you require each such physician to submit evidence of his/her individual professional liability insurance? Yes No

C. Minimum limits of liability required: _____

D. Do all of the physicians and/or others who utilize the facility have local active hospital privileges for all of the procedures they will perform at the facility? Yes No

If any of the physicians or others who utilize the facility do not have local hospital privileges, please list their names and explanation why they do not have such hospital privileges.

14. NON-PHYSICIAN HEALTHCARE PROVIDERS

- A. Does the facility employ persons in the following categories to render medical services? Yes No

If yes, indicate the number of hours employed per week.

	<u>Total Hours Per Week</u>
Nurses (RN, LVN or LPN)	
Medical Assistants (draw blood, give injections, etc.)	
Laboratory Technicians	
X-ray Technicians	
Other Technicians (describe) _____	

- B. Does the facility employ any health care personnel in the following categories? Yes No

If yes, indicate the number of hours employed per week in each category listed and attach a description or protocol of the type of services performed. Also, attach a copy of each practitioner's curriculum vitae.

	<u>Total Hours Per Week</u>
Nurses Practitioners	
Nurse Anesthetists	
Nurse Perfusionists	
Scrub Nurses	
Surgical Technicians	
Physician's Assistants	
Nurse Midwives	
Other (describe) _____	

- C. What arrangements does the facility have with support personnel such as surgical nurses, i.e., will they be employed by the facility? Will they act as independent contractors? Will the physicians utilize their own nurses?

- D. Are non-physician support personnel trained in CPR? Yes No

FACILITY PROCESSES

ANSWER 15-20

15. ACUTE-CARE HOSPITAL BACK-UP

- A. What arrangements have been made for acute-care hospital back-up? _____
- _____
- _____

- B. How close is the nearest acute-care hospital? _____ Miles _____ Minutes

Who would be able to admit patients? _____

15. ACUTE-CARE HOSPITAL BACK-UP, cont'd.

C. How many minutes are needed to arrange for the transfer of a patient from your facility to the nearest acute-care hospital which has agreed to accept emergency transfers from your facility?

_____ Minutes

_____ Hospital Name

_____ Address

16. SURGICAL SUITES AND RECOVERY ROOMS

How many surgical suites and recovery rooms are available at the facility? _____ Surgical Suites _____ Recovery Rooms

Any over-night beds? Yes No

17. STATE / FEDERAL REQUIREMENTS

Has the facility passed all state and/or federal requirements? Yes No

If yes, provide copies of certificate. If no, explain.

18. ACCREDITATION

Is the facility accredited? Yes No. If yes, by whom? _____

19. QUALITY ASSURANCE

Please describe in detail the quality control measures that have been initiated by the facility.

A. Does the facility have a credentialing committee? Yes No

B. Have credentialing procedures been established? Yes No

C. Is there a tissue committee? Yes No

D. Has the center established a quality assurance committee? Yes No

Who are its members? _____

E. Attach copies of staff bylaws, if any exist.

20. CONSENT FORMS

Submit copies of surgical consent forms utilized by the facility.

INSURANCE HISTORY/ CLAIMS

21. INSURANCE HISTORY

Give name(s), policy dates, policy numbers, and type of coverage (occurrence or claims-made) of all professional liability carriers who have insured the facility.

_____ Name of Carrier _____ Policy Dates (From / To) _____ Policy Number _____ Type

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22. INSURANCE

Has any insurance carrier ever denied, declined, canceled, refused to renew, restricted, or placed a surcharge on the premium of your professional liability insurance? Yes No

If yes, please provide full details including dates, actions taken, and reasons.

23. GOVERNMENTAL ACTION

Has the facility ever been investigated by any state or federal licensing agency? Yes No. If yes, provide details.

24. CLAIMS

Has the facility ever been notified of its involvement in a medical malpractice claim either directly or indirectly? Yes No

If yes, on your own letterhead, please provide us with full details of each, including:

- | | |
|--|---|
| A. Name, age and sex of patient | G. Insurance carrier |
| B. Description of treatment provided | H. Additional defendants |
| C. Injury | I. Location of incident |
| D. Allegation | J. Disposition of claim (i.e., verdict, settlement, dismissal, etc.), or if pending, current status |
| E. Date of accident | K. Amount of settlement or judgment |
| F. Was suit actually filed and served? | |

PRIOR ACTS

ANSWER 25

25. Prior Acts

If your most recent coverage was a claims-made policy, you must either purchase "tail" coverage from your former carrier, or apply for "Prior Acts" (also called "nose") coverage with MIEC. If MIEC approves you for Prior Acts coverage, MIEC premiums will be at the claims-made step rate based on the number of years you have been insured by your previous claims-made carrier. If you wish to apply, please contact MIEC for the special prior acts application. Coverage is provided only after review and underwriting approval by MIEC.

If you have purchased tail coverage from your former carrier, and do not need Prior Acts coverage from MIEC, please attach a copy of the tail coverage endorsement to this application.

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to Medical Insurance Exchange of California, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned hereby represents that the above statements and answers are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned has been advised that MIEC offers limits of liability at various levels and has voluntarily elected to choose the limits option checked on this application.

The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature Title Date

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my prior professional liability insurance carriers, or from my past and present medical association or society.

I further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

Signature Title Date

Print Name

Facility Name and Address City State Zip

SUBSCRIBER'S AGREEMENT – A LEGAL REQUIREMENT FOR INSURANCE WITH MIEC

For and in consideration of the benefits to be derived therefrom, the subscriber covenants and agrees with MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," and other subscribers thereto through their and each of their Attorney-in-Fact, MEDICAL UNDERWRITERS OF CALIFORNIA, herein called "MUC," to exchange with all other subscribers policies of insurance or reinsurance containing such terms and conditions therein as may be specified by said Attorney-in-Fact and approved by MIEC's Board of Governors or its Executive Committee for any loss insured against, and subscriber hereby designates, constitutes and appoints MUC to be Attorney-in-Fact for subscriber, granting to it power to substitute another in its place and in subscriber's name, place and stead to do all things which the subscriber or subscribers might or could do severally or jointly with reference to the operation and management of MIEC and the business of inter-insurance; subscriber further agrees that from subscriber's premiums there shall be paid to MUC as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MUC.

The remaining portion of the subscriber's premiums shall be applied to the payment of the losses and expenses and to the establishment of reserves and general surplus. Such reserves and surplus may be invested and reinvested by or under the supervision of a Board of Governors duly elected by and from subscribers, which Board or its Executive Committee or an agent or agency appointed by written authority of said Executive Committee shall have full powers to negotiate purchases, sales, trades, exchanges and transfers of investments, properties, titles and securities, together with full powers to execute all necessary instruments. The expenses above referred to shall include all reinsurance, taxes, government charges, allocable claims expense and attorneys' fees and legal expenses and charges, expenses of members and Board of Governors, meetings, and such other specified fees, dues and expenses as may be authorized by the Board of Governors. All other expenses incurred in connection with the conduct of MIEC and such of the above expenses as shall from time to time be agreed upon by and between MUC and the Board of Governors or its Executive Committee shall be borne by MUC.

The principal office of MIEC and its Attorney-in-Fact shall be maintained in the County of Alameda, State of California.

It is intended that by compliance with *Section 1399 and 1400 or 1401 or 1401.5 of the Insurance Code of the State of California* subscribers will have no contingent liability to assessment by reason of membership in the exchange. If because of non-compliance with said code sections a contingent liability arises it shall not be more than an amount equal to and in addition to the amount of the premium deposit provided in the policy or the annual premium earned thereon, whichever is greater.

This instrument can be signed upon any number of counterparts with the same effect as if the signatures of all subscribers were upon and one and the same instrument; shall remain in effect as to all policies or insurance hereafter issued and accepted by subscriber; and shall be binding upon the parties thereto, severally and ratably as provided in policies issued. Wherever the word "subscriber" is used the same shall mean members of MIEC, the subscriber thereto, and all other subscribers to this and any other like agreements.

Signature


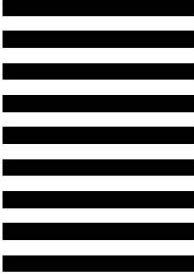

Title

Date

Print Name

You can send in your application by:

1. Mail- {Print PRE-PAID Mailing Label}
2. Fax- (510) 654-4634
3. E-mail- Underwriting@MIEC.com

	<p>NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES</p>
<p>BUSINESS REPLY MAIL FIRST CLASS PERMIT NO. 739 OAKLAND, CA</p>	
<p>POSTAGE WILL BE PAID BY ADDRESSEE</p>	
<p>Medical Insurance Exchange of California Attn: UNDERWRITING 6250 Claremont Avenue Oakland, CA 94618-9983</p>	
	

PRE PAID MAILING LABEL – PLEASE FIRMLY ATTACH TO YOUR ENVELOPE