ISMIE Mutual Insurance Company
The Physician-First Service Insurer

ATTN: UNDERWRITING DIVISION
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Processing Number _____

Application for Ambulatory Surgical Facility Professional Liability Insurance

Please choose your desired coverage option either claims-made or occurrence.

Claims-Made Coverage ☐

"A claims-made policy is limited to claims which are first made while the policy is in force and arise out of professional services provided on or after the retroactive date stated in the Declarations Page, and as defined in the policy."

Occurrence Coverage ☐

"An occurrence policy is limited to claims that arise out of professional services rendered during the policy period stated in the Declarations Page and as defined in the policy."

Instructions: It is essential that all statements be completed and all questions answered. If the answer to any question is "**no**", be certain to check **no** on the Application. **Please do not leave any question unanswered. If additional space is required to answer any question, use the "Remarks Addendum" section.**

INDICATE TYPE OF POLICY DESIRED:

A. ☐ **OPEN FACILITY** An open facility is utilized by independent physicians who **do not** maintain an employment relationship relationship with the physician owner or corporate entity.

B. ☐ **CLOSED FACILITY** A closed facility is solely utilized by physicians who maintain an employment relationship with the physician owner or entity.

C. ☐ **SEPARATE LIMITS**

D. ☐ **SHARED LIMITS (Not applicable in the states with a Patient Compensation Fund)**

Please submit 1 application for each Surgical Facility location.

1. Name of Facility:

2A. Name of Owner – physician or corporate entity:

2B. Indicate all states of practice where ISMIE Mutual coverage is desired:

3. Desired effective date of coverage (12:01 a.m. Standard Time):

____ / ____ / ____
Month Day Year

4. Desired retroactive date for Claims-Made Coverage. (12:01 a.m. Standard Time): Retroactive date is required to secure prior acts coverage (nose coverage). Only applicable for Claims-Made Coverage, leave blank if applying for Occurrence Coverage.

____ / ____ / ____
Month Day Year

Surgical Facility General Information

5. Mailing Address:
Note: This address is where all of your insurance documents and correspondence will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

6. Billing Address: **Same as #5** ☐
Note: This address is where all of your insurance premium invoices and notices will be sent.

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

7. Practice Location: **Same as #5** ☐

Address Line l:

Address Line 2:

City: **State:** **Zip Code:** **Telephone: ( ) -**

Fax: ( ) - **E-mail Address:**

8. Is the Ambulatory Surgical Facility free standing? Yes _____ No _____
If "no", is it physically located within a:

a) **Hospital (provide name): _____**
b) **Other (describe): _____**

9. Length of time this facility has been in operation: _____

10. Are there multiple locations? Yes _____ No _____
If "yes", please provide the address of each additional location and the name of the carrier that provides professional liability coverage for that location: _____
_____
_____
_____
_____

11. Name of Business Manager/Administrator: _____

12. Name of the Medical Director:_____

13. The legal entity applying for coverage is a:

- ☐ Partnership (Submit a copy of the partnership agreement)
- ☐ Limited Liability Company (Submit a copy of State Issued Organizational Documents)
- ☐ Multi-Shareholder Corporation (Submit a copy of State issued Organizational Documents)
- ☐ Sole Shareholder of Medical Corporation (Submit a copy of State Issued Organizational Documents)
- ☐ Other (Describe)
- ☐ Limited Liability Partnership (Submit a copy of State Issued Organizational Documents)

14. Federal Tax Identification Number: _____

14a. NPI Number: _____

15. Is the facility licensed by the State Department of Public Health? Yes _____ No_____
If "yes", indicate License Number and provide a copy of the License: _____

16. Is the facility accredited by the American Association for Accreditation of Ambulatory Surgery Facilities Inc. (AAAASF) or similar accrediting organization? Yes ____ No ____
If "yes", indicate name of organization and provide a copy of your accreditation certificate:
_____

17. Does the Surgical Facility operate under any other names (d.b.a. "doing business as")?
Yes _____ No_____

If "yes", please list all "doing business as" names of the Surgical Facility:

1. _____
2. _____
3. _____
4. _____

18. List all partners/shareholders of the entity and their occupation:

_____ _____
_____ _____
_____ _____

19. Limits of Liability (Please skip this section if your entity is domiciled in a state with a Patient's Compensation Fund.)

The offering of the following policy limits by ISMIE Mutual should not be deemed to express or imply that any particular policy limit is or is not adequate for an insured. It is the sole responsibility of each insured to select an appropriate limit of coverage.

Limits of Liability:

☐ $500,000/$1,500,000* "each person"/ "aggregate"
☐ $1,000,000/$3,000,000 "each person"/ "aggregate"
☐ $2,000,000/$4,000,000 "each person"/ "aggregate"

***NOTE: These limits are only available in Illinois for claims-made coverage**

20. Does the Facility currently maintain medical professional liability insurance? Yes _____ No _____

If "yes", please provide a current Declarations Page and all applicable endorsements from your most recent carrier.
If "no", how does the Facility handle any claims reported? Provide a detailed narrative describing this arrangement.

Carrier Name *	Policy Period	Limits	Claims-Made	Occurrence
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

***It is necessary that you obtain a current Loss History from each carrier listed above.**

21. Please provide total facility premiums paid, by year, for the last ten years.
Please indicate the most recent first.

Year	Annual Premium
1. Current Year	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$
9.	$
10.	$

22. Have any medical professional liability claims or suits been brought against this Surgical Facility within the Past five (5) years?

☐ Yes ☐ No

If "Yes", please provide the following:

- A detailed narrative of each claim (Completed Claim Information Supplement on page 13 of this application)
- Reserves on pending claims (both indemnity and expense)
- Payments on any closed claim/suit (both indemnity and expense)
- Complete copies of all office/hospital medical records, Summons and Complaint.

23. Please provide a comprehensive list of all procedures for which physicians /other healthcare providers are credentialed to perform at this Surgical Facility. (Copies of your credentialing forms are acceptable).

24. Please indicate the total number of procedures performed at this facility within the most recent 12 months. _____

25. Please provide name(s) and title(s) of individuals administering anesthesia:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

26. Profile Questions. Include details to each question in the space provided. If additional space is needed, please utilize the "Remarks Addendum" section.

	YES	NO	
A.	☐	☐	**Has the surgical facility's professional liability insurance ever been canceled for non-payment of premium?** If "yes", indicate dates(s) of such cancellation. **(Not Applicable in Missouri)** _____
B.	☐	☐	**Has the surgical facility's professional liability insurance ever been declined, canceled, non-renewed or issued on special terms?** (Including but not limited to: restrictive endorsements, surcharged premium, etc.)**(Not Applicable in Missouri)**_____ _____
C.	☐	☐	**Has the surgical facility owned and operated, participated in or directed any entrepreneurial medical business?** If "yes," indicate name(s), address(es) and type(s) of business(es):_____ _____ _____
D.	☐	☐	**Does the surgical facility, treat or intend to treat or intend to treat any patient by means of therapeutics which could be considered unconventional, experimental, investigational or clinical research that is not within the scope of research protocols approved by the Food and Drug Administration (FDA) or an institutional review board (IRB) (also known as an independent ethics committee (IEC), an ethical review board (ERB) or a research ethics board (REB))? If "Yes," utilize the "Remarks Addendum" on page 14 to identify physician(s) in the clinic who participate in this activity and provide a full written narrative indicating treatment(s), and provide name(s) and address(es) of sponsoring institution(s) or entity(ies) if applicable.**
E.	☐	☐	**Does the surgical facility contract to any governmental facility? If "Yes," please provide a copy of any contract you have executed.**
F.	☐	☐	**Has the surgical facility's State license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered? If "Yes," please provide details in "Remarks" section.**

27. Are complete medical histories taken and physical examination conducted (including necessary pathological tests) prior to all procedures performed at the facility? Yes _____ No _____

28. Is the patient's written authorization for the specific surgical procedure(s) and patient's written "informed consent" obtained prior to surgery? Yes _____ No _____
If "yes", please provide a copy of your current consent form.
If "no", please clarify _____

29. With respect to questions 27 and 28, are these items made a part of the patient's clinical records and maintained at the facility? Yes _____ No _____

30. Please provide a copy of your most recent brochure.

31. In the event of complications,

A. Are there written emergency procedures in place? Yes ___ No ___
If "yes", please provide a copy of your procedures.
If "no", please attach a detailed narrative explaining how emergency procedures are handled.

B. Does your facility have a transfer agreement in place? Yes ___ No ___
If "yes", please provide a fully executed copy of your transfer agreement.
If "no", please provide written verification that your facility is able to ensure the availability of follow-up care at a licensed hospital.

32. Please indicate the distance from your facility to the nearest licensed hospital.
Miles _____ Minutes _____

33. Indicate equipment in the facility to handle emergency situations:

_____

34. Are non-spontaneous induced abortions of over 14 weeks (beginning from onset of last menstrual period) performed at the facility? Yes _____ No _____

A. Is ultrasound used in establishing gestation age? Yes ____ No ____

B. What method is used for non-spontaneous abortions performed over 14 weeks gestation?
_____

35. Is any person other than a licensed physician/surgeon (M.D./D.O.) allowed to perform cosmetic procedures - including, but not limited to - cosmetic fillers & injectables, laser treatments, skin rejuvenation including microdermabrasion, etc? Yes ____ No ____

If "yes", please provide the number of non-M.D.'s/D.O.'s performing these procedures, their medical certification and your criteria for credentialing and supervising these individuals.

36. Please provide a detailed narrative of the facility's process for credentialing its physician and non-physician affiliates.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Surgical Facility Census

37. Indicate the names of all physicians who currently have privileges to perform procedures at the facility and their medical specialty by completing the grid below or attaching a separate census.

If additional space is required to complete this question, use "Remarks Addendum" section.

Physician Name	Specialty	Insurance Carrier	Limits of Liability
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			
11)			
12)			
13)			
14)			
15)			
16)			
17)			
18)			
19)			
20)			

38. Allied Health Personnel

Please provide the names of all credentialed Allied Health Personnel on the census provided on the following page.

Only separate limits are available in States with a Patient Compensation Fund.

Coverage for the following Allied Health Personnel are offered on either a Shared or Separate Limit basis for an additional charge. A separate Non-Physician application is required, and is available on our website- www.ismie.com.

		Total			Total
A .	**Certified Registered Nurse Anesthetist**	____	**E.**	**Physician Assistant**	____
B.	**Certified Clinical Nurse Specialist**	____	**F.**	**Psychologist**	____
C.	**Certified Nurse Practitioner**	____	**G.**	**Other (Specify Below)**	____
D.	**Certified Nurse-Midwife**	____			

Coverage for the following Health Care Professionals is only offered on Separate Limit basis for an additional charge. A separate Individual Physician application is required for Chiropractors and Podiatrists, and a Non-Physician application is required for Dentists, Optometrists and Pharmacists. Applications are available on our website- www.ismie.com.

		Total			Total
H.	**Chiropractor**	_____	**K.**	**Podiatrist**	_____
I.	**Dentist**	_____	**L.**	**Pharmacist**	_____
J.	**Optometrist**	_____			

Note: Coverage for all Health Care Professionals is limited to the scope of employment and services rendered on behalf of the ISMIE Mutual insured Physician or Corporation.

Non-Physician Census

39. Indicate the names of all non-physicians (M.D./D.O.) that currently have privileges to work at the facility and their medical license/certification. This should include all Allied Health Personnel and Non-Physician Health Professionals as listed on the previous page under question #38.

If additional space is required to complete this question, use "Remarks Addendum" section.

Codes: 01-Employee 02-Independent Contractor 03 – Leased

Code	Allied Health Personnel / Non-Physician Name	Medical Certification	Insurance Carrier	Limits of Liability
	1)			
	2)			
	3)			
	4)			
	5)			
	6)			
	7)			
	8)			
	9)			
	10)			
	11)			
	12)			
	13)			
	14)			
	15)			
	16)			
	17)			
	18)			
	19)			
	20)			

40. Name and title of the person who directs and supervises the Allied Health Personnel/Non-Physicians:

_____

41. Does your facility accommodate overnight stays? Yes _____ No _____
If "yes", please indicate the number of beds available. _____
If "yes", please provide statistics on the extent of overnight stays and to which procedures they relate
_____
_____
If "yes", please indicate the maximum length of stay. _____

42. Indicate the number of operating rooms in the facility _____

43. Indicate the number of beds in the recovery room _____

Certificate(s) of Insurance

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED.

44. If your insurance request is accepted, as a service to its insureds ISMIE Mutual can provide evidence of your coverage on an automated basis by issuing a Certificate of Insurance. If you wish to have a Certificate of Insurance issued to a hospital or other health care institution on your behalf, complete the following:

A. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

B. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

C. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

D. Certificate of Insurance

Name of Certificate Holder

Street Address

Suite/Room Number

City State Zip Fax

If the above is a hospital, please check one:

☐ Medical Director ☐ Administrator
☐ Medical Staff Office ☐ Other _____

Specific Policy Limits will be printed on Certificate.

Applicant's Representation, Authorization and Release

(Please read carefully)

ELECTRONIC SIGNATURES ARE PERMISSIBLE PURSUANT TO THE ELECTRONIC COMMERCE SECURITY ACT (5 ILCS 175)

PROXY

By applying for and receiving coverage from ISMIE Mutual Insurance Company, the policyholder/member agrees to grant, assign, and give a proxy to the Board of Directors of ISMIE Mutual Insurance Company or their designee, for purpose of casting a vote at any and all meetings or in any and all instances in which a vote of the policyholders/members is required. It is understood that in the absence of any further action by the policyholder/member, this proxy shall remain valid and binding for the length of time which the policyholder/member shall continue to be a policyholder/member of ISMIE Mutual Insurance Company. It is further understood that on any given issue as to which policyholders/members shall have a right to vote the policyholder/member may, by indicating in writing his, her, or its desire, revoke this proxy for purposes of the issue or matter then pending a vote. In the instance in which the policyholder/member revokes this proxy, he, she, or it may then vote in person or by written proxy at any meeting called for the casting of said vote. At the conclusion of said vote, this proxy, given to the ISMIE Mutual Board of Directors or its designee, shall return to full force and effect and shall continue in full force and effect unless and until the policyholder/member elects to revoke this proxy for purposes of a future issue which may arise.

Applicant's Name (please print)	Applicant's Signature	Date

REPRESENTATION

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of ISMIE Mutual in considering this application have been omitted. *I agree that this shall be the basis of the policy of insurance requested and that I will notify ISMIE Mutual of any changes contained herein.*

FRAUD NOTICE (applicable in Kentucky only)

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

HIPAA DISCLOSURE

ISMIE Mutual Insurance Company and its affiliates shall act as business associates of applicant(s) with respect to the receipt, use and disclosure of protected health information. The Business Associate Agreement is hereby incorporated by reference.

AUTHORIZATION

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, ISMIE Mutual or its duly authorized representative may conduct an inquiry or investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant for this insurance. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, my/their insurance agents or consultants, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physician, any prior insurance carriers and ISMIE Mutual, or its duly authorized representative. I hereby release and discharge the aforementioned providers of information, ISMIE Mutual, its duly authorized review committee from any and all legal liability which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by ISMIE Mutual or its duly authorized representative. I authorize ISMIE Mutual or its duly authorized representative to provide information regarding my professional liability history and to issue Certificates of Insurance to those hospitals, managed care entities or other organizations to which I am affiliated or have applied. I consent and agree to the exchange of information regarding my professional liability policy between my present/future employer and ISMIE Mutual or its duly authorized representative. In the event that my insurance premiums are paid by my present/future employer and the practice relationship between myself and my employer is severed at any time during the policy period for any reason, including but not limited to cancellation of my policy, it is agreed that any and all remaining insurance premiums, including any return premium due, as of the severance date of the practice relationship, shall be the property of the employer. Communication regulations require that certain entities, including ISMIE Mutual and its affiliates, obtain written consent to share or distribute policyholder information via regular mail, e-mail, and facsimile. By signing this consent and authorization, you are agreeing to receive promotional notices or solicitation of the availability of goods, services, membership, and opportunities related to the practice of medicine from ISMIE Mutual and its affiliates.

Signature of President/Partner or person authorized to make changes to this policy.

Surgical Facility Name (*please print*)	Signature of President/Partner or Authorized Person	Date

I understand that signature of this application does not bind ISMIE Mutual to complete processing of the application nor to offer insurance to the applicant. A photostatic, imaged or other electronic copy of this Representation, Authorization and Release shall be considered as effective and as valid as the original. PLEASE NOTE: Email transmission of a completed application or other document is unsecure. ISMIE Mutual is not responsible for any disclosure while the information is in transit. Email submissions may be made to underwriting@ismie.com

Insurance Agent/Producer/Broker (*please print*)	Signature	Date

Claim Information Supplement (please print). In addition to completing this form, please provide a typed, detailed narrative for each open claim, or any claim that has closed with an indemnity payment. Please photocopy this form for additional claims.

1. Patient/Claimant _____

Name **Age** **Sex**

2. Date(s) of treatment and/or surgery which led to the allegations against you _____

3. Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state when** ____ / ____

Month **Year**

4. Name of insurance carrier defending you: _____

5. Policy Number. _____

6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $**_____

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made.**

- Has carrier indicated desire to settle? **Indicate amount of settlement or award:**

☐ **Yes** ☐ **No**

a. Your policy $ _____ **Date** _____

b. Total (if additional defendants involved) $ _____

----------NEXT CLAIM----------

1.Patient/Claimant _____

Name **Age** **Sex**

2.Date(s) of treatment and/or surgery which led to the allegations against you _____

3.Was suit ever filed? ☐ **Yes** ☐ **No** **If "Yes", state when** ____ / ____

Month **Year**

4.Name of insurance carrier defending you: _____

5. Policy Number. _____

6. Names of other doctors and hospitals, if any, involved in claim or suit. _____

_____

7. Disposition or current status of claim or suit:

☐ **Open - Indicate case value established by carrier $** _____

☐ **Closed-With no payment made** **Date** _____

☐ **Closed-With payment made.**

- Has carrier indicated desire to settle? **Indicate amount of settlement or award:**

☐ **Yes** ☐ **No**

a. Your policy $ _____ **Date** _____

b. Total (if additional defendants involved) $_____

Remarks Addendum

PHOTOCOPY AND COMPLETE THIS FORM AS NEEDED, OR CONTINUE INFORMATION ON YOUR LETTERHEAD. PLEASE WRITE LEGIBLY

Question Number	Remarks