GeneralStar™

SUPPLEMENTAL APPLICATION FOR AMBULATORY SURGERY CENTERS

MISCELLANEOUS HEALTHCARE FACILITIES PROGRAM

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 WHICH STATES IN ESSENCE THAT, IF A PHYSICIAN WHO UTILIZES YOUR FACILITY DOES NOT CARRY INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE WITH LIMITS EQUAL TO OR GREATER THAN THE LIMITS OF INSURANCE PROVIDED UNDER THE FACILITY'S POLICY, THEN THE LIMITS OF INSURANCE AVAILABLE TO THIS FACILITY FOR ANY CLAIM UNDER THIS POLICY SHALL NOT EXCEED THE LOWEST LIMIT MAINTAINED BY THE INDIVIDUAL PHYSICIAN.

WE, THEREFORE, ENCOURAGE THIS FACILITY TO REVIEW ITS MEDICAL STAFF BYLAWS ONCE AGAIN AND THEIR EFFECT THEY MAY HAVE ON ANY CLAIMS REPORTED TO THE COMPANY AT A LATER DATE.

Instructions to the Applicant.

A. Please answer **all** the questions on this supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
C. The application must be signed and dated by an owner, partner, officer or director of your facility.

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

A. Patient-informed Consent forms
B. Brochures, pamphlets, advertisements, or other descriptive literature of operations and services
C. Credentialing guidelines

I. GENERAL INFORMATION

Applicant's / Entity's Name:_____

1. Provide a list of all owners including their percentage of ownership:

Name	% Ownership
	%
	%
	%

Must total 100%

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

II. OPERATIONS

1. Hours of operation:_____ How many shifts are maintained?_____

2. Type of Procedures and Number of Annual Visits:

Name/Type of Procedure (provide details) Please attach separate page if more space is needed.	Annual Visits		
	Projected	Current	Past Year

3. Are patients screened prior to surgery to determine that they are low risk and able to undergo outpatient surgery? ☐ Yes ☐ No

4. Who administers anesthesia?
   - ☐ M.D.
   - ☐ CRNA
   - ☐ Other: (identify) _____

5. Are written post-operative orders submitted and signed by the surgeons? ☐ Yes ☐ No

6. Are nursing charts maintained, including patient's condition at time of discharge? ☐ Yes ☐ No

7. Are patients contacted within 24 hours of discharge to determine if there are any complications? ☐ Yes ☐ No

8. How long are orders, consent forms, and charts maintained? _____

9. Complete this question as applicable:

COSMETIC SURGERY

A. Is Cosmetic Surgery (other than Breast Implant or Liposuction) being performed? ☐ Yes ☐ No

B. If yes, what is the percentage of Cosmetic Surgery(other than Breast Implant or Liposuction) with respect to the overall procedures being performed? ☐ N/A ____%

C. Are only American Board Certified Surgeons credentialed to perform surgery in the facility? ☐ N/A ☐ Yes ☐ No

D. Are surgeons permitted to perform procedures that are outside their "area of expertise" as defined by their respective American Boards? ☐ N/A ☐ Yes ☐ No

BREAST IMPLANT SURGERY

A. Is Breast Implant Surgery being performed? ☐ Yes ☐ No

B. If yes, what is the percentage of Breast Implant Surgery with respect to the overall procedures being performed? ☐ N/A ____%

C. Is Breast Implant Surgery only performed by American Board Certified Plastic Surgeons and General Surgeons? ☐ N/A ☐ Yes ☐ No

D. If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure. ☐ N/A

E. Please advise the name(s) of the manufacturer(s) of the breast implants being used and what measures are taken to protect these implants prior to implantation surgery. ☐ N/A

_____

_____

_____

LIPOSUCTION

A. Is Liposuction being performed? ☐ Yes ☐ No

B. If yes, what is the percentage of Liposuction with respect to the overall procedures being performed? ☐ N/A ____%

C. Is Liposuction performed only by American Board Certified Plastic Surgeons and General Surgeons? ☐ N/A ☐ Yes ☐ No

D. If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure. ☐ N/A

E. Are surgeons permitted to perform procedures that are outside their "area of expertise" as defined by their respective American Board? ☐ N/A ☐ Yes ☐ No

F. How many "cc's" of fluid are injected prior to surgery and how many "cc's" are removed during surgery? ☐ N/A
_____ cc's injected prior to surgery
_____ cc's removed during surgery

G. Is Liposuction performed "incidental" to other surgical procedures? ☐ N/A ☐ Yes ☐ No

LASIK, PRK OR OTHER VISION-ENHANCING SURGERY

A. Is LASIK, PRK or other vision-enhancing surgery performed ? ☐ Yes ☐ No

B. If yes, what is the percentage of LASIK, PRK or other vision-enhancing surgery with respect to the overall procedures being performed? ☐ N/A ____%

C. Is LASIK, PRK or other vision-enhancing surgery performed only by American Board Certified Ophthalmic Surgeons? ☐ N/A ☐ Yes ☐ No

D. If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure. ☐ N/A

E. On a separate page please describe the documentation you require when determining whether a surgeon will be approved for any of these procedures. Also, please describe the minimum number of surgeries a surgeon must have previously performed in order to be credentialed for this process. ☐ N/A

F. On a separate page, please advise the name(s) of the manufacturer(s) of the Laser being used. ☐ N/A

G. On a separate page, please describe the training the surgeons must complete with respect to this equipment. ☐ N/A

H. On a separate page, please describe who calibrates and maintains this equipment and how often this is done. ☐ N/A

BARIATRIC SURGERY

A. Is Bariatric surgery performed? ☐ Yes ☐ No

B. If yes, what is the percentage of Bariatric Surgery with respect to the overall procedures being performed? ☐ N/A ____%

C. Is Bariatric surgery only performed by American Board Certified General Surgeons? ☐ N/A ☐ Yes ☐ No

D. If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure. ☐ N/A

E. Describe which types of Bariatric surgical procedures are being performed. ☐ N/A

_____

_____

_____

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR FACILITY NOT SPECIFICALLY ADDRESSED HEREIN.

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 (month-day-year)

ADDITIONAL INFORMATION FORM

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

QUESTION #	COMMENTS
	_____ SIGNATURE: _____ DATE: