CapSpecialty®
Capitol Specialty Insurance Corporation
A Stock Company
P. O. Box 5900
Madison, WI 53705-0900

# Ambulatory Surgical Centers Supplemental Application

## I. APPLICANT INFORMATION

| | | |
|---|---|---|
| 1.1 | Applicant Name: | |
| 1.2 | Website(s): | |

## II. CRITICAL UNDERWRITING QUESTIONS

| | | |
|---|---|---|
| 2.1 | Do you provide any other medical services besides outpatient surgeries? | ☐ Yes ☐ No |
| | If yes, please provide details: | |
| 2.2 | Do you have a formalized employee verification program including background checks? | ☐ Yes ☐ No |
| 2.3 | Do you maintain a current license in accordance with applicable state and federal regulations? | ☐ Yes ☐ No |
| 2.4 | Are all surgeons credentialed every two years by your organization or an accredited third party credentialing verification organization? | ☐ Yes ☐ No |
| 2.5 | Do you have a written emergency transport policy? | ☐ Yes ☐ No |
| 2.6 | Do you perform any abortions? | ☐ Yes ☐ No |
| 2.7 | During the past five (5) years, has any claim that is within the scope of the proposed insurance been made against the applicant or against any entity or individual whom this proposed insurance is for? | ☐ Yes ☐ No |

**If answer to 2.7 is yes, please provide loss runs from the previous carrier.**

## III. RATING INFORMATION FOR MEDICAL PROFESSIONALS

The following information affects our pricing model and is critical for an accurate assessment of your exposure.

3.1 Please state the number of surgeries by type for the next projected policy period and the current one:

| Type of Surgery | # of Surgeries on an Annual Basis | |
|---|---|---|
| | Projected Policy Period | Current Policy Period |
| Bariatric (including lap banding) | | |
| Cardiovascular | | |
| Colon and Rectal | | |
| ENT | | |
| Endoscopies / Colonoscopies | | |
| General Surgery | | |
| Gynecological | | |
| Neuro Surgery / Spine | | |
| Ophthalmology – Laser | | |
| Ophthalmology – all other | | |
| Orthopedic | | |
| Pain Management | | |
| Plastic – Cosmetic | | |
| Plastic – Reconstructive | | |
| Podiatry | | |
| Urological | | |
| Vascular | | |
| Other, describe: _____ | | |

| | | | |
|---|---|---|---|
| 3.2 | Please provide any past or current accreditations for your organization: | | |
| | ☐ AAAHC ☐ JCAHO ☐ Other: _____ | | |
| 3.3 | If you are a member of either a state or national organization, please provide the name: | | |
| 3.4 | Please provide the required limits of liability of contacted surgeons to have privileges: | $ | $ |
| 3.5 | Is the applicant or any entity aware of any fact, circumstance, situation, transaction, event, act, error or omission which they have reason to believe may or could reasonably be assumed to give rise to a claim that may fall within the scope of the proposed insurance? | | ☐ Yes ☐ No |
| | If yes, please provide details in writing to us. | | |

**IMPORTANT NOTICE**

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I DECLARE THAT THE STATEMENTS MADE IN THIS APPLICATION ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AFTER REASONABLE INQUIRY.

Any person who knowingly and with intent to defraud any insurance company or another person submits an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information containing any material fact thereto, commits a fraudulent act that is subject to criminal and substantial civil penalties. **I agree that any intentional concealment or misrepresentation of a material fact concerning this insurance or the subject thereof may void any policy issued.**

(As part of our underwriting procedures, a routine inquiry may be made to obtain applicable information concerning character, general reputation, and credit history. Upon your written request, additional information as to the nature and scope of the report, if one is made, will be provided.)

| | |
|---|---|
| **Signature of authorized representative of Applicant** | **Title** |
| **Type / Print name of authorized representative** | **Date** |
| **Producer Signature** | **Date** |