|  |
| --- |
| Healthcare/Hospital Facilities Liability Application |
| Bariatric Surgery Supplement |
| * Ace American Insurance Company * Illinois Union Insurance Company * Westchester Surplus Lines Insurance Company |

# Instructions:

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use ⌧ Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued..

***Notice: This supplement is part of the main Healthcare/Hospital Facilities Liability Application and is subject to the same warranties, representations and conditions.* All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Coverage Requested, Loss Adjustment, Loss Experience, Exposures (prospective and historical Professional Liability, General Liability, Helipad Liability, Aircraft Liability, Automobile Liability, Watercraft Liability, Employee Benefits Liability, and Employer’s Liability), Staff Privileges, Medication Administration, Blood Bank Services, Day Care Services, Emergency Management and Health Care Facility Evacuation Plans, Risk Management, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

# Section A. – Applicant & Retroactive Dates

1. Legal name of the entity specializing in bariatric treatment and care to be insured exactly as it shall be shown on the policy. Include location information and requested retroactive date(s).

|  |  |
| --- | --- |
| First Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |
| Professional Liability Retroactive Date: | General Liability Retroactive Date: |
|  |  |

1. Parent entity:

|  |  |
| --- | --- |
| First Named Insured | Street Address |
|  |  |
| City, State, Zip Code | County |
|  |  |

# Section B. – Types Of Services Provided

1. Number of bariatric procedures performed in past 12 months:
2. Type and number of bariatric procedures performed:

|  |  |  |
| --- | --- | --- |
| Laparoscopic: | | |
| Roux-En-Y | Yes  No | Number Past 12 Months: |
| Gastric Banding | Yes  No | Number Past 12 Months: |
| Other (Describe) | | Number Past 12 Months: |

|  |  |  |
| --- | --- | --- |
| Open | | |
| Roux-En-Y | Yes  No | Number Past 12 Months: |
| Gastric Banding | Yes  No | Number Past 12 Months: |
| Other (Describe) | | Number Past 12 Months |

|  |  |
| --- | --- |
| 1. Complication rate for the past 12 months: % Administrator | % |
| 1. Readmission rate for the past 12 months: % | % |
| 1. Are bariatric procedures performed on persons under the age of 18? | Yes  No |
| 1. Are there written guidelines for selecting and screening appropriate candidates for bariatric surgery? | Yes  No |
| 1. Are the guidelines based on existing criteria from the National Institute of Health? | Yes  No |
| 1. As part of the pre-screening process, are all candidates required to undergo a complete and comprehensive medical and psychological evaluation? | Yes  No |
| 1. Are formal patient education programs established for potential bariatric candidates starting at the initial consultation through discharge and then through long term medical follow-up? | Yes  No |
| 1. Are patient education programs mandatory for patients considering bariatric surgery? | Yes  No |
| 1. Are there a multidisciplinary team and unit dedicated to the care and treatment of bariatric patients?   If Yes, describe the staff/members on the bariatric team: | Yes  No |
| 1. Are specialists in cardiology, pulmonary, rehabilitation and psychiatry available? |  |
| If No Explain |  |
| 1. Are there formal employee training programs to address the management of morbidly obese patients and their special physical challenges? | Yes  No |
| If Yes, does the employee training program include sensitivity training? | Yes  No |
| If Yes, does the employee training program include the importance of maintaining patient confidentiality? | Yes  No |
| 1. Have uniform credentialing criteria been established for surgeons seeking privileges to perform open and laparoscopic bariatric procedures? | Yes  No |
| 1. Are credentialing criteria in accordance with recommendations from the American College of Surgeons? | Yes  No |
| 1. Has the applicant established appropriate mechanisms for ensuring physician competence in performing bariatric procedures? | Yes  No |
| If Yes, is evidence of competency documented? | Yes  No |
| 1. Is there an established quality management program that monitors bariatric patient outcomes? | Yes  No |
| 1. Is Recovery Room staff experienced in difficult intubations and respiratory support? | Yes  No |
| 1. Does the operating room have tables and equipment to accommodate morbidly obese patients? | Yes  No |
| 1. Is special equipment, such as beds, stretchers, commodes, chairs and wheelchairs available that can accommodate the morbidly obese? | Yes  No |
| 1. Are radiology and other diagnostic equipment capable of handling morbidly obese patients available? | Yes  No |
| 1. Is there a formal informed consent process? 2. If Yes, describe: | Yes  No |

### **The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.**

### **The Applicant understands that this form is part of the main Healthcare/Hospital Facilities Liability Application and is subject to the same warranties, representations and conditions.**

|  |
| --- |
| Signature of Applicant |
| Title |
| Date |