



# MARKEL INSURANCE COMPANY

4600 Cox Road, Glen Allen, VA 23060  
(800) 431-1270 Fax (804) 527-7966

## Healthcare Facility Supplement

(To be attached to ACORD applications)

1. Applicant Facility Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Physical Address: \_\_\_\_\_  
Street Address City State Zip County

Mailing Address: \_\_\_\_\_  
Street Address City State Zip County

### 2. Names and Descriptions of all legal entities

Name	Description	Entity Type (Individual/Partnership/Corporation/Organization/Etc.)	To Be Insured? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prior Acts Date (If Prior Acts Coverage is required)
a.			<input type="checkbox"/> Yes <input type="checkbox"/> No	
b.			<input type="checkbox"/> Yes <input type="checkbox"/> No	
c.			<input type="checkbox"/> Yes <input type="checkbox"/> No	

3. a. Does the applicant own property, which is leased to other entities?  Yes  No

b. What date was the applicant entity established? \_\_\_\_\_

c. How long has the applicant been at the main location? \_\_\_\_\_

4. In what states is the applicant registered and licensed to practice? \_\_\_\_\_

5. Indicate the applicant's professional specialty: \_\_\_\_\_

6. Does the applicant maintain any beds for overnight occupancy?  Yes  No

### 7. State the approximate division of the applicant's patients or clients among:

a. Alcoholics	%	g. Family Planning	%	m. Psychiatric	%
b. Bariatrics	%	h. Hemodialysis	%	n. Research or Experimental	%
c. Communicable	%	i. Holistic Medicine	%	o. Stress Testing	%
d. Dental	%	j. Obstetrical	%	p. Surgical	%
e. Disability Evaluation	%	k. Pediatric	%	q.	%
f. Drug Addicts	%	l. Physical Rehabilitation	%	r.	%

8. Does the applicant use a collection agency?  Yes  No

If yes, what is the name of the agency? \_\_\_\_\_

Has the agency authority to file a collection suit at its discretion?  Yes  No

9. Does the application own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?  Yes  No

10. Is the applicant a member of any professional societies or associations?  Yes  No

If yes, what professional societies or associations: \_\_\_\_\_

11. Does the applicant perform any of the following:

- a. Acupuncture or acupuncture anesthesia?  Yes  No
- b. Angiography/Arteriography/Venography?  Yes  No
- c. Catheterization (other than urinary)?  Yes  No
- d. Closed reduction or compound fractures?  
and/or Normal Dermabrasion?  Yes  No  
or Normal Deliveries?  Yes  No
- e. Experimental procedures or research testing?  Yes  No
- f. Hypnosis?  Yes  No
- g. Injection of radioisotopes and/or use of irradiated substances?  Yes  No
- h. Laser Treatment?  Yes  No
- i. Psychiatric Shock Therapy?  Yes  No
- j. Radiation Therapy and/or Chemotherapy?  Yes  No
- k. Silicone Injections?  Yes  No
- l. Spinal Anesthesia (other than saddle blocks or caudals)?  Yes  No

If yes to any of the above, explain: \_\_\_\_\_

12. Does the applicant perform any of the following:

- a. Surgery other than incision of superficial boils or suturing superficial fascia?  Yes  No
- b. Circumcisions?  Yes  No  
or Dilation and curettage?  Yes  No  
or Insertion of temporary pacemakers?  Yes  No
- c. Tonsillectomies?  Yes  No  
or Adenoidectomies?  Yes  No  
or Caesarian Sections?  Yes  No
- d. Cosmetic Plastic Surgery?  Yes  No
- e. Excision of large cysts and/or I & D or deep-seated boils or carbuncles?  Yes  No
- f. Hysterectomies?  Yes  No
- g. Open reduction of fractures?  Yes  No
- h. Surgery for weight reduction of patients?  Yes  No
- i. Abortions and/or menstrual extractions?  Yes  No
- j. Cryosurgery (other than use on benign or pre-malignant dermatological lesions)?  Yes  No
- k. Silicone Implants?  Yes  No
- l. Sterilization Procedures?  Yes  No
- m. Biopsies and/or endoscopies?  Yes  No
- n. Sex change operations?  Yes  No

o. Experimental surgery or surgical research?  Yes  No

p. Other Surgery?  Yes  No

13. a. Does the applicant perform or engage in any surgical procedure(s) in their professional office or similar non-hospital facility?  Yes  No

b. List ALL surgical procedures performed (including minor surgery): \_\_\_\_\_  
\_\_\_\_\_

c. Is anesthesia (other than topical or by means of local infiltration) administered by either the applicant or others?  
If yes, explain in detail on separate sheet.  Yes  No

14. Does the applicant perform hospital emergency room care for patients not its own?  Yes  No

If yes, explain in detail on separate sheet and include number of "patient contact" hours MONTHLY by applicants:

a. Emergency Room Physicians	hours	c. Nurses	hours
b. Paramedics	hours	d.	hours

15. Has the applicant at any time used drugs for weight reduction of patients?  Yes  No

If yes, explain on separate sheet and include percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantify dispensed by applicant.

16. Does the applicant administer any methadone treatment?  Yes  No

If yes, explain on separate sheet and include the treatment and controls used and indicate number of treatments during:

Last 12 months: \_\_\_\_\_ Next 12 Months: \_\_\_\_\_

17. Number of annual x-ray exposures for:

Exposures: \_\_\_\_\_ Treatment: \_\_\_\_\_

If x-ray treatment is given, what qualifications are required of the staff? \_\_\_\_\_

18. Does the applicant participate in any activity whereby professional advice is offered to the public (Newspaper columns, broadcasts, etc.)?  Yes  No

19. Does the applicant own or operate any business other than that shown in question 1?  Yes  No  
If yes, explain in detail on separate sheet.

20. Indicate the number of professional employees, volunteers and independent contractors (if none, state "none"):

Type	Number of Employees & Volunteers	Number of Independent Contractors
a. Anesthesiologists, Thoracic Surgeons, Vascular Surgeons Neurosurgeons, and Orthopedic Surgeons.		
b. Chiropractors		
c. Dentist ( no oral surgery)		
d. General Surgeons, Cardiac Surgeons and Otolaryngologists doing plastic surgery		
e. Nurse Anesthetists		
f. Nurse Midwives		
g. Obstetric-Gynecologists, Plastic Surgeons and Otolaryngologists doing plastic surgery		
h. Optometrists, Opticians		
i. Oral Surgeons		
j. Orthodontists		
k. Physicians: No surgery other than incision of boils, suturing of skin or obstetrical procedures		
l. Physicians: Minor surgery or obstetrical procedures not constituting major surgery		
m. Podiatrists		
n. Proctologists, Ophthalmologists and Urologists		

Indicate the number of professional employees, volunteers and independent contractors (if none, state "none"):

**NOTE:** If you require any of the below to be insured parties, please submit a separate application for each individual.

Type	Number of Employees & Volunteers	Number of Independent Contractors
o. Laboratory Technicians		
p. Pharmacists		
q. Perfusionists		
r. Physician's & Surgeon's Assistants, Nurse Practitioners		
s. RN's, LPN's		
t. Unlicensed interns		
u. X-ray Technicians		

21. Are all of the above individuals licensed in accordance with applicable state and federal regulations?  Yes  No

If no, explain: \_\_\_\_\_

22. Have you or any of your employees, volunteers or independent contractors ever:

- Been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?  Yes  No
- Been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No
- Been treated for alcoholism?  Yes  No
- Had any state professional license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms or voluntarily surrendered?  Yes  No
- Had their malpractice insurance canceled, decline, refused renewal or accepted only on special terms?  Yes  No

23. Does the applicant supervise any individuals other than your own employees?  Yes  No

If yes, provide a detailed explanation of responsibilities and relationship to the entity, which employs these individuals. Also indicate by profession the number of individuals.

Number	Type of Profession	Number	Type of Profession
	Physicians		
	X-ray Technicians		
	Laboratory		
	Technicians		

24. Provide the number of outpatient visits:

Visit Type	Number of Visits in Last 12 Months	Number of Visits in Next 12 Months
Clinic		
Laboratory		
Emergency Room		

25. Does the applicant have a training school?  Yes  No

If yes, please complete the following (attach a separate schedule if needed).

Profession Being Trained	Max No. of Students per session	No. of sessions per year	% time involved in clinical setting	No. of Faculty	Qualifications of Faculty (e.g. MD, RN, PhD, etc.)

26. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)?

If yes, attach a copy of ALL of the advertisements.  Yes  No

27. Does your group attract patients because of reputation in any particular field of medicine?  Yes  No

If yes, please explain: \_\_\_\_\_

28. Does your group own, control, or staff one or more of the following:

a. Facilities for overnight patient monitoring/care	<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Emergency Vehicles	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Hospital	<input type="checkbox"/> Yes <input type="checkbox"/> No	j. Pharmacy	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Surgicent/Clinic Surgical Outpatient Unity	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Gross Sales	\$
d. Emergency Room	<input type="checkbox"/> Yes <input type="checkbox"/> No	k. Optical Goods Store	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Birthing Center	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Gross Sale	\$
f. Substance Abuse Programs	<input type="checkbox"/> Yes <input type="checkbox"/> No	l. Hearing Aid Store	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Annual Gross Sales	\$
h. Laboratory	<input type="checkbox"/> Yes <input type="checkbox"/> No		

IF THE ANSWER IS YES TO ANY QUESTIONS ABOVE, PLEASE DESCRIBE ON YOUR LETTERHEAD.

29. Specify hospitals at which the applicant's physicians hold staff or courtesy privileges.

Hospital Name	Hospital Type	JCAH Approved
a.	<input type="checkbox"/> General <input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	<input type="checkbox"/> General <input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	<input type="checkbox"/> General <input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	<input type="checkbox"/> General <input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No

30. LOSS PREVENTION

a. Does your group have an arbitration plan?  Yes  No

If yes, please describe: \_\_\_\_\_

b. Does a Peer Review Committee exist?  Yes  No

c. Please describe how fee-related complaints are handled: \_\_\_\_\_

d. Are any research or teaching programs conducted?  Yes  No

If yes, please describe on your letterhead.

e. Is there a credentialing committee?  Yes  No

f. Are informed consent forms used?  Yes  No

g. Is office surgery performed?  Yes  No

If yes, please explain on your letterhead the types of surgeries and emergency protocol..

31. NEW PHYSICIANS

a. Describe how the qualifications of new physicians are checked: \_\_\_\_\_

b. Are all prospective physicians required to be Board Certified or Board Eligible?  Yes  No

32. MEDICAL RECORDS PRODECURES (Check all that apply)

- a.  Progress Notes Written or Typed                       Medical Records Supervisor                       Medical Records Librarian  
 Drug Allergies Noted in Patient File     Medical Records Committee
- b. How are records keeping deficiencies handled? \_\_\_\_\_

33. ACCREDITATION

- a. Are you a member of a national organization?                       MGMA     AGPA     Other: \_\_\_\_\_
- b. Is the entity certified or accredited by any of the following?  AAAHC     ARC     JCAH     Other: \_\_\_\_\_

34. Has any claim or suit been brought against the applicant and/or any of its employees?                       Yes     No

35. Are you aware of any circumstances which may result in a malpractice claim or suite being made or brought against the applicant or any of its employees?                       Yes     No

36. List prior professional liability insurance carried for the past four years. If none, place state "none".

Insurance Carrier	Limits of Liability	Deductible (if any)	Premium	Inception MM/DD/YY	Expiration MM/DD/YY	Retroactive Date	Was this a claim made policy form?
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

37. Please complete the following:

Policy Limits	Desired	Alternate	Deductible Desired (if any)		
Each Claim	\$	\$	Claim	Each \$	\$
Annual Aggregate	\$	\$			

**ANY PERSON WHO KNOWING AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL TO CRIMINAL AND (NY: SUBSTANTIAL) CIVIL PENALTIES.**