**Markel Insurance Company**
4600 Cox Road, Glen Allen, VA 23060
Telephone: (800) 431-1270 Fax: (804) 527-7966
Email applications to: mscsubmissions@markelcorp.com
Website: markelsocialservices.com

# Social services – Healthcare facility supplement

(To be attached to ACORD applications)

Markel agent number: _____

Business name: _____

Mailing address: _____

Submission or policy number: _____

## Section 1 - Facility information

1. Names and descriptions of all legal entities:

| Name | Description | Entity type (Individual/Partnership/ Corporation/Organization/etc.) | To be insured | Prior Acts date (If Prior Acts Coverage is required) |
|---|---|---|---|---|
| | | | ☐ Yes ☐ No | |
| | | | ☐ Yes ☐ No | |
| | | | ☐ Yes ☐ No | |

2. Does the applicant own property, which is leased to other entities? ☐ Yes ☐ No
3. What date was the applicant entity established? _____
4. How long has the applicant been at the main location? _____
5. In what states is the applicant registered and licensed to practice? _____
6. Indicate the applicant's professional specialty: _____
7. Does the applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No
8. State the approximate division of the applicant's patients or clients among:

| | | | | | |
|---|---|---|---|---|---|
| Alcoholics | ____% | Family planning | ____% | Psychiatric | ____% |
| Bariatrics | ____% | Hemodialysis | ____% | Research or experimental | ____% |
| Communicable diseases | ____% | Holistic medicine | ____% | Stress testing | ____% |
| Dental | ____% | Obstetrical | ____% | Surgical | ____% |
| Disability evaluation | ____% | Pediatric | ____% | | ____% |
| Drug addicts | ____% | Physical rehabilitation | ____% | | ____% |

9. Does the applicant use a collection agency? ☐ Yes ☐ No
   If yes, what is the name of the agency? _____
   Does the agency have authority to file a collection suit at its discretion? ☐ Yes ☐ No
10. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? ☐ Yes ☐ No
11. Is the applicant a member of any professional societies or associations? ☐ Yes ☐ No
    If yes, what professional societies or associations? _____

## Section 2 - Services information

1. Does the applicant perform any of the following:
   a. Acupuncture or acupuncture anesthesia? ☐ Yes ☐ No
   b. Angiography, arteriography or venography? ☐ Yes ☐ No

c. Catheterization (other than urinary)? ☐ Yes ☐ No

d. Closed reduction or compound fractures? ☐ 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. Normal dermabrasion? ☐ Yes ☐ No

j. Normal deliveries? ☐ Yes ☐ No

k. Psychiatric shock therapy? ☐ Yes ☐ No

l. Radiation therapy or chemotherapy? ☐ Yes ☐ No

m. Silicone injections? ☐ Yes ☐ No

n. Spinal anesthesia (other than saddle blocks or caudals)? ☐ Yes ☐ No

If yes to any of the above, explain: _____

_____

2. Does the applicant perform any of the following:

a. Abortions and/or menstrual extractions? ☐ Yes ☐ No

b. Adenoidectomies? ☐ Yes ☐ No

c. Biopsies or endoscopies? ☐ Yes ☐ No

d. Caesarian sections? ☐ Yes ☐ No

e. Circumcisions? ☐ Yes ☐ No

f. Cosmetic plastic surgery? ☐ Yes ☐ No

g. Cyrosurgery (other than use on benign or pre-malignant dermatological lesions)? ☐ Yes ☐ No

h. Dilation and curettage? ☐ Yes ☐ No

i. Excision of large cysts or I & D or deep-seated boils or carbuncles? ☐ Yes ☐ No

j. Experimental surgery or surgical research? ☐ Yes ☐ No

k. Hysterectomies? ☐ Yes ☐ No

l. Insertion of temporary pacemakers? ☐ Yes ☐ No

m. Open reduction of fractures? ☐ Yes ☐ No

n. Sex change operations? ☐ Yes ☐ No

o. Silicone implants? ☐ Yes ☐ No

p. Sterilization procedures? ☐ Yes ☐ No

q. Surgery for weight reduction of patients? ☐ Yes ☐ No

r. Surgery other than incision of superficial boils or suturing superficial fascia? ☐ Yes ☐ No

s. Tonsillectomies? ☐ Yes ☐ No

t. Other Surgery? ☐ Yes ☐ No

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

If yes, list all surgical procedures performed (including minor surgery): _____

_____

b. 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

4. 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:

| | | | |
|---|---|---|---|
| Emergency room physicians | hours | Nurses | hours |
| Paramedics | hours | Other: | hours |

5. 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 quantity dispensed by applicant.

6. 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: _____

7. Number of annual x-rays for:

Exposures: _____ Treatment: _____

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

_____

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

9. Does the applicant own or operate any business other than that shown as the business name shown at the beginning of this application? ☐ Yes ☐ No If yes, explain in detail on separate sheet.

## Section 3 - Employee, Volunteer and Contractor Information

1. Indicate the number of professional employees, volunteers and independent contractors (if none, state “none”):

| Type | Number of employees & volunteers | Number of independent contractors |
|---|---|---|
| Anesthesiologists, thoracic surgeons, vascular surgeons, neurosurgeons, and orthopedic surgeons | | |
| Chiropractors | | |
| Dentist (no oral surgery) | | |
| General surgeons, cardiac surgeons and otolaryngologists during plastic surgery | | |
| Nurse anesthetists | | |
| Nurse midwives | | |
| Obstetric-gynecologists, plastic surgeons and otolarynologoists doing plastic surgery | | |
| Optometrists, opticians | | |
| Oral surgeons | | |
| Orthodontists | | |
| Physicians: no surgery other than incision of boils, suturing of skin or obstetrical procedures | | |
| Physicians: minor surgery or obstetrical procedures not constituting major surgery | | |
| Podiatrists | | |

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

| | | |
|---|---|---|
| Proctologists, ophthalmologists and urologists | | |
| Laboratory technicians | | |
| Pharmacists | | |
| Perfusionists | | |
| Physician's & surgeon's assistants, nurse practitioners | | |
| Registered nurses, licensed practical nurses | | |
| Unlicensed interns | | |
| X-ray technicians | | |

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

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

   If no, explain: _____

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

   a. Been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No

   b. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

   c. Been treated for alcoholism? ☐ Yes ☐ No

   d. 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

   e. Had their malpractice insurance canceled, declined, refused renewal or accepted only on special terms? ☐ Yes ☐No

5. 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 | | |

6. 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 | | |
| | | |
| | | |

7. 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 number of students per session | Number of sessions per year | Percentage of time involved in clinical setting | Number of faculty | Qualifications of faculty (e.g. MD, RN, PhD, etc.) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

8. 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

   If yes, attach a copy of all of the advertisements.

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

   If yes, please explain: _____

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

| | | | |
|---|---|---|---|
| Birthing center | ☐ Yes ☐ No | Hearing aid store | ☐ Yes ☐ No |
| Emergency room | ☐ Yes ☐ No | Annual gross sales | $ |
| Emergency vehicles | ☐ Yes ☐ No | Optical goods store | ☐ Yes ☐ No |
| Facilities for overnight patient monitoring/care | ☐ Yes ☐ No | Annual gross sales | $ |
| Hospital | ☐ Yes ☐ No | Pharmacy | ☐ Yes ☐ No |
| Laboratory | ☐ Yes ☐ No | Annual gross sales | $ |
| Radiation therapy | ☐ Yes ☐ No | | |
| Substance abuse programs | ☐ Yes ☐ No | | |
| Surgicent/clinical surgical outpatient unit | ☐ Yes ☐ No | | |

   If the answer is yes to any questions above, please describe on your letterhead.

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

| Hospital name | Hospital type | JCAH approved |
|---|---|---|
| | ☐ General ☐ Child | ☐ Yes ☐ No |
| | ☐ General ☐ Child | ☐ Yes ☐ No |
| | ☐ General ☐ Child | ☐ Yes ☐ No |
| | ☐ General ☐ Child | ☐ Yes ☐ No |

## Section 4 - Risk management information

1. 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.

2. 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

3. MEDICAL RECORDS PROCEDURES (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? _____

_____

4. 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: _____

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

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

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

| Insurance carrier | Limits of liability | Deductible (if any) | Premium | Inception MM/DD/YY | Expiration MM/DD/YY | Retroactive date | Was this a claims-made policy form? |
|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |
| | | | | | | | ☐ Yes ☐ No |

8. Please complete the following:

| Policy limits | Desired | Alternate |
|---|---|---|
| Each claim | $ | $ |
| Annual aggregate | $ | $ |

| Deductible desired (if any) | | |
|---|---|---|
| Claim | Each $ | $ |

**NOTE:** This Supplement becomes part of your primary application and must be signed and dated. Coverage cannot be bound until the Company approves your completed application. The Company's receipt of premium does not bind coverage until a written quote has been issued. Before electronically signing this document, verify your information is correct. Electronically signing will disable further editing of your application.

Applicant's signature: _____ Date: _____

Agent's signature: _____ Date: _____

(Florida only) Agent license number: _____

**Thank you for choosing Markel!**