

APPLICATION for: Miscellaneous Medical Malpractice Insurance
Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

1. Name of Applicant: _____

2. Physical Address: _____ Phone: _____

City: _____ County: _____ State: _____ Zip: _____

No. of Locations: _____ (If multiple names and locations, please attach list.)

3. a) Date Established: _____ Corporation Partnership Professional Assoc.
Individual For Profit Not for Profit

b) In what states is the Applicant registered and licensed to practice? _____

c) Please specify any professional societies or associations of which you are a member: _____

4. If the Applicant is an entity:

a) Is the entity engaged in, owned by, associated with, or controlled by any other business? Yes No

b) Is the entity owned by any physician? Yes No

c) Is the entity owned by any hospital or are any services hospital-based? Yes No

d) Have there been any changes in ownership of the business since the date the entity was established? Yes No

If "Yes", to any of the above, please provide details: _____

5. Professional Activities and Specialty: (Attach narrative description, if necessary,)

Check all that apply:

- | | |
|---|--|
| _____ Acupuncturist/Naturopathic Medicine | _____ Medical Spa (Please complete Medical Spa Supplemental) |
| _____ Alcohol/Drug/Psychiatric Rehabilitation | _____ Medical Testing/Laboratory |
| _____ Ambulance Services | _____ Nurse Registry |
| _____ Ambulatory Surgery Center | _____ Optometry |
| _____ Diagnostic Imaging | _____ Out-Patient Medical Clinic |
| _____ Dialysis Center | _____ Out-Patient Mental Health Clinic |
| _____ Health/Fitness Center | _____ Pharmacy (Please complete Pharmacy Supplemental) |
| _____ Home Healthcare Agency | _____ Residential Facility |
| _____ Hospice | _____ Speech Therapy |
| _____ Other (Specify): _____ | |

6. State approximate division of Applicant's patients among:

- | | | | |
|-------------------------------|------|-----------------------------|------|
| a) Alcoholics | (%) | k) Obstetrical | (%) |
| b) Counseling/Family Planning | (%) | l) Pediatric | (%) |
| c) Communicable Disease | (%) | m) Prisoners | (%) |
| d) Dental | (%) | n) Psychiatric | (%) |
| e) Drug Addicts | (%) | o) Research or Experimental | (%) |
| f) General | (%) | p) Senile or Aged | (%) |
| g) Hemodialysis | (%) | q) Stress Testing | (%) |
| h) Holistic Medicine | (%) | r) Surgical | (%) |
| i) Medical | (%) | s) Tubercular | (%) |
| j) Mentally Retarded | (%) | t) Other: _____ | (%) |

7. a. List the number and type of Applicant's employees and volunteers below: If "None", state None. _____

<u>Number</u>	<u>Type of Profession</u>	<u>Number</u>	<u>Type of Profession</u>
i) _____	Acupuncturist	xv) _____	Opticians
ii) _____	Counselor	xvi) _____	Optometrist
iii) _____	Chiropractor	xvii) _____	Paramedics
iv) _____	Dentist	xviii) _____	Perfusionist
v) _____	Dental Assistant	xix) _____	Pharmacist
vi) _____	EMT	xx) _____	Pharmacist Tech
vii) _____	Home Health Aide	xxi) _____	Physician Assistant
viii) _____	Inhalation Therapist	xxii) _____	Physician/Surgeon
ix) _____	Laboratory Technician	xxiii) _____	Physiotherapist
x) _____	Licensed Practical, Nurse	xxiv) _____	Psychologist
xi) _____	Massage Therapist	xxv) _____	Registered Nurse
xii) _____	Medical Director	xxvi) _____	Social Worker
xiii) _____	Nurse Anesthetist	xxvii) _____	Speech Therapist
xiv) _____	Nurse Practitioner	xxviii) _____	Other _____

b. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet, if necessary. If "None", state None. _____

- c. Are all of the individuals listed in questions 7.a. and 7.b. licensed in accordance with applicable state and federal regulations? Yes No
If "No", attach explanation.
- d. Are all employed/contracted physicians board-certified in their specialty? Yes No N/A
- e. Do all physicians, surgeons and dentists who provide professional services on behalf of the Applicant maintain their own Med Mal coverage with limits of at least \$1million/\$3million? Yes No N/A
- f. 1) Are criminal background checks conducted on all employees, volunteers and independent contractors? Yes No
If "No", attach explanation.

2) Does the Applicant conduct pre-employment screenings and background investigations prior to hiring all employees, volunteers and independent contractors? Yes No
If "No", attach explanation.

g. Has the Applicant or any of the individuals listed in questions 7.a. and 7.b:

i) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? Yes No

ii) Ever been convicted of an act committed in violation of any law or ordinance other than traffic offenses? Yes No

iii) Ever been treated for alcoholism or drug addiction? Yes No

iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, non-renewed or accepted only on special terms, or ever voluntarily surrendered same? Yes No

If "Yes" to any of the above, attach explanation.

8. a) Does the Applicant have a written/formalized risk management/quality assurance program? Yes No

b) Does the Applicant have a written credentialing process for all staff? Yes No

c) Does the Applicant have written procedures for reporting all incidents? Yes No

If "No" to any of the above, attach explanation.

9. State approximate division of services being provided among the following settings:

a) Assisted Living Facilities (%) e) Nursing Homes (%)

b) Clinics (%) f) Physician Offices (%)

c) ER/ICU/Labor, Delivery (%) g) Private Homes (%)

d) Hospitals (%) h) Other _____ (%)

10. If the Applicant provides AMBULANCE/TRANSPORT SERVICES, answer the following:

Number of Ground Ambulances _____ Number of Emergency Calls (per year) _____

Number of Non-Emergency Calls (per year) _____

Number of Air Ambulances _____ Number of Transport Calls (per year) _____

Number of Body Transports (per year) _____

Radius of Services _____ Is the Applicant part of a Fire Department? Yes No

11. For AMBULATORY SURGERY CENTERS, answer the following:

Number of Surgical Procedures in the next 12 months _____

Percentage of procedures using general anesthesia _____

12. Do you perform obstetric surgeries, bariatric surgeries or abortions? Yes No

13. For DIALYSIS CENTERS, answer the following:

Number of hemodialysis treatments in the next 12 months _____

Number of peritoneal treatments in the next 12 months _____

Hours of service in the next 12 months for in-home treatments _____

Number of stations _____

14. For ALCOHOL/DRUG/PSYCHIATRIC REHABILITATION CENTERS, answer the following:

Number of total licensed beds _____

Do you provide off-site counseling services? Yes No

Are all counselors licensed? Yes No

Number of intern counselors? _____

15. For HEALTH/FITNESS CENTERS, answer the following:

- Is there a pool? Yes No
Are there tanning beds? Yes No

16. Does the Applicant perform: **(Attach detailed explanation for any "Yes" answers to the following)**

- a. Acupuncture or acupuncture anesthesia? Yes No
- b. Angiography/Arteriography/Venography? Yes No
- c. Cardiac catheterization? Yes No
- d. Catheterization (other than cardiac, urinary or umbilical)? Yes No
- e. Closed reduction of compound fractures? Yes No
- f. Normal deliveries? Yes No
- g. Microdermabrasion? Yes No
- h. Injection of radioisotopes and/or use of irradiated substances? Yes No
- i. IV/Infusion Therapy? Yes No
- j. AIDS therapy? Yes No
- k. Radiation therapy and/or chemotherapy? Yes No
- l. Psychiatric shock therapy? Yes No
- m. Silicone injections? Yes No
- n. Spinal anesthesia (other than saddle blocks or caudals)? Yes No
- o. Botox injections? Yes No
- p. Chelaton therapy? Yes No
- q. DNA testing? Yes No
- r. Genetic testing? Yes No
- s. Environmental testing? Yes No
- t. Pharmaceutical testing? Yes No
- u. Testing of any weapons? Yes No
- v. Blood banking? Yes No
- w. Clinical trials or research using animal or human test subjects? Yes No
- x. Teleradiology? Yes No
- y. Telemedicine? Yes No

17. Does the Applicant perform any: **(Attach detailed explanation for any "Yes" answers to the following)**

- a. Surgery other than incision of superficial boils or suturing superficial fascia? Yes No
- b. Circumcisions? Yes No
- c. Dilation and curettage? Yes No
- d. Insertion of temporary pacemakers? Yes No
- e. Tonsillectomies and/or adenoidectomies? Yes No
- f. Caesarean sections? Yes No
- g. Cosmetic plastic Surgery? Yes No
- h. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? Yes No
- i. Hysterectomies? Yes No
- j. Open reduction of fractures? Yes No
- k. Surgery for weight reduction of patients? Yes No
- l. Abortions and/or menstrual extractions? (If "Yes", include trimester, method and number of abortions performed per month in description.) Yes No

- m. Silicone implants? Yes No
- n. Sterilization procedures? Yes No
- o. Biopsies and/or endoscopies? Yes No
- p. Therapeutic optometry (implantation of prosthetic ocular devices)? Yes No
- q. Sex change operations? (If "Yes", please advise the number performed per year.) Yes No
- r. Other surgery: _____ Yes No

18. Does the Applicant perform hospital emergency room care:
- a. For its own patients? Yes No
 - b. For patients of other providers? Yes No
 - c. If answer to (b) is "Yes", please specify: the percentage of its time devoted to this work = _____%, the number of hours per month devoted to this work = _____ hours.

19. Does the Applicant prescribe or dispense weight reduction drugs? Yes No
- If "Yes", list drugs used and indicate the percentage** of the Applicant's practice devoted to weight reduction; the frequency and duration of prescriptions for weight reduction drugs; and quantity dispensed by the Applicant:
- _____
- _____

20. Does the Applicant administer any methadone treatments? Yes No

21. Is anesthesia (other than topical or by means of local infiltration) administered by either the Applicant or others working on behalf of the Applicant? Yes No
- If "Yes", attach detailed explanation.**

22. Does the Applicant maintain any beds for overnight occupancy? Yes No
- If "Yes", provide number of licensed beds by location:** _____
- _____
- _____

23. State number of x-ray machines owned or operated by the Applicant and indicate whether they are used for diagnosis or treatment or both: _____
- _____
- _____

State by whom treatment is given and number of procedures: _____

24. 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
- If "Yes", give details, including name, location, size and number of beds:** _____
- _____
- _____

25. Does the Applicant sell or lease any equipment for use by any other persons or entities? Yes No
- If "Yes", give details, including name, location, size and number of beds:** _____
- _____
- _____

26. a) State sources and amounts of the Applicant's total revenue:

<u>Source</u>	<u>Amount Last Policy Year</u>	<u>Est. Amount This Policy Year</u>
1. Charitable Contributions:	\$ _____	\$ _____
2. Government Funding:	\$ _____	\$ _____
3. Fee for Services:	\$ _____	\$ _____
4. Product Sales: (attach a list of products)	\$ _____	\$ _____
5. Other: _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

b) For PHARMACIES, state sources and amounts of total revenue:

<u>Source</u>	<u>Amount Last Policy Year</u>	<u>Est. Amount This Policy Year</u>
1. Prescription Sales:	\$ _____	\$ _____
2. Non-Prescription Sales:	\$ _____	\$ _____
3. Other: _____	\$ _____	\$ _____

c) Are all drugs dispensed by the Applicant approved by the FDA? Yes No
If "No", attach explanation.

27. Number of estimated patient encounters in the last 12 months _____ and/or patient tests carried out _____ (Note: "patient encounters" refers to number of visits – not number of patients.)

28. Number of estimated patient encounters and patient tests in the next 12 months:
 (Note: "patient encounters" refers to number of visits – not number of patients.)

Patient encounters _____
 Patient Tests _____

29. Describe the Applicant's Professional Liability coverage for the last five years:

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration (Mo/Day/Yr)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If the expiring policy is claims-made, what is the retroactive date? _____

30. Has any insurer cancelled or refused to renew any similar insurance during the past five years? Yes No
If "Yes", please describe: _____

31. Is the Applicant currently insured under a Commercial General Liability Policy? Yes No
If "Yes", please give details:

<u>Insurance Company</u>	<u>Type of Coverage</u>	<u>Limits BI</u>	<u>Limits PD</u>	<u>From</u>	<u>To</u>
_____	_____	_____	_____	_____	_____

32. Has any application for Professional Liability or General Liability Insurance made on behalf of the Applicant, any predecessors in business, or present partners ever been declined, or has such insurance ever been cancelled or renewal refused? Yes No

If "Yes", please describe: _____

33. Has any claim ever been made against the Applicant or any of its employees? Yes No

If "Yes", please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

34. Is the Applicant aware of any circumstances which may result in any claim against the Applicant, predecessors in business, or any present or past partners and officers? Yes No

If "Yes", please give full details on the same basis as question 33.

Please answer, question 35 if the Applicant currently has Miscellaneous Medical Professional/General Liability through NAS Insurance Services, LLC

35. Has the Applicant notified NAS Insurance Services of all litigation, administrative proceedings, demand letters or formal or informal governmental investigations or inquiries which have occurred in the past 12 months? Yes No None to Report

If "Yes", please indicate number of events in the last 12 months: _____

If "No", please forward notice to NAS Insurance Services, LLC, on behalf of Underwriters, immediately.

36. Limits of Liability requested _____ Deductible _____

37. Desired term of policy: From _____ To _____

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENT A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

The undersigned declares that the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached to and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on file by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein prior to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

For Kentucky residents:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Name of Applicant: _____
Please print Title Date

Signature: _____
Name Date