APPLICATION
PROFESSIONAL LIABILITY INSURANCE
MISCELLANEOUS MEDICAL (CLAIMS-MADE FORM)

1. NAME OF APPLICANT:____
   (If other than parent firm, supply full details of ownership entity)

2. a) MAILING ADDRESS:________________________________ Phone No.____________
   (If multiple name and locations, please attach list)
   b) Square feet of total office space (all locations)______________________________

3. a) DATE ESTABLISHED: _____ Corp. ________ Partnership ________ Prof. Assoc. ________ Individual __________
   b) In what state is the applicant registered and licensed to practice? ____________________
   c) Normal hours of operation: ______________________________________

4. Is the firm engaged in, owned by, associated with or controlled by any other business?______________
   If yes, give details____
   ____
   ____
   ____

5. PROFESSIONAL ACTIVITIES AND SPECIALTY (Attach narrative description if necessary) Check One:

   _____ Health Maintenance Organization
   _____ Home Healthcare Agency
   _____ Medical/Testing Laboratory
   _____ Nurse's Registry
   _____ Out-Patient Clinic
   _____ Services to nursing homes
   _____ Residential Healthcare Facility
   _____ Other (Specify)__________________________
   ____
   ____

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

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

7. a . List the number and type of applicant's employees and volunteers: If None, State None.

	NUMBER	Type of Profession		NUMBER	Type of Profession
(a)	_________	Inhalation Therapists	(e)	_________	Nurse Practitioner
(b)	_________	Laboratory Technicians	(f)	_________	Nurses Registered
(c)	_________	Nurse Anesthetists	(g)	_________	Opticians
(d)	_________	Nurses, Licensed Practical	(h)	_________	Optometrists

	NUMBER	Type of Profession		NUMBER	Type of Profession
(i)	_________	Perfusionists	(m)	_________	Physiotherapists
(j)	_________	Pharmacists	(n)	_________	Social Workers
(k)	_________	Physicians -- minor surgery	(o)	_________	Speech Therapists
(l)	_________	Physicians -- no surgery	(p)	_________	Other

b. List the number and type of independent contractors who provide professional services on behalf of the applicant. IF NONE, STATE NONE. ____
____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations? ___Yes ___No
If no, attach explanation.

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
(a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	(a) ____	____
(b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	(b) ____	____
(c) Ever been treated for alcoholism or drug addiction?	(c) ____	____
(d) Ever had any state professional license or license to prescribe or dispense narcotics refused, Suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	(d) ____	____

8. Does the applicant perform:	YES	NO
A. Acupuncture or acupuncture anesthesia? Explain: ____________	A. ____	____
B. Angiography/ Arteriography/ Venography? Describe: ____________	B. ____	____
C. Catheterization (other than urinary or umbilical)? Describe Procedure: ____________	C. ____	____
D. Closed Reduction of compound fractures and/or Normal Deliveries and/or Dermabrasion?	D. ____	____
E. Injection of radioisotopes and/or use of irradiated substances? Describe: ____________	E. ____	____
F. Radiation Therapy and/or Chemotherapy? Describe: ____________	F. ____	____
G. Psychiatric shock therapy?	G. ____	____
H. Silicone Injections? Describe: ____________	H. ____	____
I. Spinal Anesthesia (other than saddle blocks or caudals)?	I. ____	____
J. Laser treatment? Describe: ____________	J. ____	____

9. Does the applicant perform any:		
A. Surgery other than incision of superficial boils or suturing superficial fascia?	A. ____	____
B. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers?	B. ____	____
C. Tonsillectomies and/ or Adenoidectomies and/or Caesarean Sections?	C. ____	____
D. Cosmetic Plastic Surgery? Describe: ____________	D. ____	____
E. Excision of large cysts and/or I&D of deep-seated boils or carbuncles?	E. ____	____
F. Hysterectomies?	F. ____	____
G. Open reduction of fractures? Describe: ____________	G. ____	____
H. Surgery for weight reduction of patients?	H. ____	____
I. Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): ____________	I. ____	____
J. Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe:____________	J. ____	____
K. Silicon Implants? Describe: ____________	K. ____	____
L. Sterilization Procedures? Describe:____________	L. ____	____
M. Biopsies and/or endoscopies? List types performed: ____________	M. ____	____
N. Sex change operations? Describe and advise the number performed per year:____________ ____________	N. ____	____
O. Other Surgery? Describe: ____________	O. ____	____

10. Does the applicant perform hospital emergency room care?
(a) for its own regular patients? ____ Yes _____ No (b) for patients not its own? ____ Yes ____ No
(b) if the 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 = _____________ hrs.

11. Does the applicant use drugs for weight reduction of patients? ____ Yes ____ No If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant.

12. Does the applicant administer any methadone treatment? ____ Yes ____ No If yes, describe treatment and controls used and indicate number of treatments during last 12 months ___________ Next 12 months __________

13. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? ____ Yes ____ No If yes, attach detailed explanation.

14. Does the applicant maintain any beds for overnight occupant? ____ Yes ____ No If yes, total number: ____

15. State number of X – ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom treatment is given and number of procedures: ____
____
____

16. 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. ____

17. State sources and amounts of total revenue

	Source	Amount Last Policy Year	Est. Amount This Policy Year
A.	Charitable Contributions	$__________________________	$__________________________
B.	Government Funding	$__________________________	$__________________________
C.	Fee for Service	$__________________________	$__________________________
D.	_______________________	$__________________________	$__________________________
E.	_______________________	$__________________________	$__________________________
	TOTAL GROSS REVENUE:	$__________________________	$__________________________

18. Number of patient encounters last 12 Months _____ and/or patient tests carried out ______
(NOTE: “Patient encounters” refers to number of *visits* – not number of patients.)

19. Number of estimated patient encounters next 12 months ______ and/or patient tests carried out ______
(NOTE: “Patient encounters” refers to number of *visits* – not number of patients.)

20. If applicant has a training school, complete the following.

Specify profession for which students are being trained	**Max. No. of students per session**	**No. of sessions per year**	**% of Time involved in clinical setting**	**Number of students**	**Qualifications of faculty (e.g. MD, RN, PHD)**
________________	_________	______	_________	_______	_______________
________________	_________	______	_________	_______	_______________

21. Give Professional Liability coverage for last five years for the firm:

Carrier	**Limit**	**Deductible**	**Premium**	**Expiration** (Mo/Day/Yr)
_______________	___________	_____________	___________	____________________________
_______________	___________	_____________	___________	____________________________
_______________	___________	_____________	___________	____________________________
_______________	___________	_____________	___________	____________________________
_______________	___________	_____________	___________	____________________________

If expiring insurance is a claims-made policy, what is the retroactive date? _______________________________________

22. Is the Applicant currently insured under a Commercial General Liability Policy? Yes ____ No____ If yes, please give details:

Insurance Company	Type of Coverage	Limits BI	Limits PD	Effective From	Effective To
______________________	_____________	_________	_________	___________	____________

23. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? Yes ____ No ____
If yes, please give details: ____
____

24. Has any claim ever been made against the firm or any of its employees? Yes _____ No ______ If yes, please attach details stating: 1) date when claim was made; 2) date of 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.

25. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any present or past Partners or Officers? Yes ____ No _____ If yes, please give full details on the same basis as item 23.

26. Has any insurer cancelled or refused to renew any similar insurance during the past five years? ______________________
____

27. Limits of Liability requested ___________________________ Deductible ___________________________________

28. Desired term of policy: From __________________________________ To ___________________________________

29. The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy.

The applicant understands that and subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

____ ____
Date Signature of Applicant Title

Producer_____________________________________