APPLICATION FOR ALLIED HEALTHCARE PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

NOTICE: THE COVERAGE APPLIED FOR PROVIDES CLAIMS-MADE COVERAGE WHICH PROVIDES LIABILITY COVERAGE ONLY IF A CLAIM IS MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

If space is insufficient to answer any question fully, attach a separate sheet.

APPLICANT INFORMATION

1. Applicant (include professional degree if applicant is an individual): _____

   _____

2. Formal business, corporate or partnership name (s) : _____

3. Principal business premise address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   Please attach a list of additional office addresses.

4. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____

5. Business Phone: (___) _____

6. Square feet of total office space (all locations): _____

7. Your practice:

   ☐ Solo practitioner (unincorporated) ☐ Professional corporation (for profit)
   ☐ Solo practitioner (incorporated) ☐ Professional corporation (non-profit)
   ☐ Partnership ☐ Employee of _____
   ☐ Professional Association (Give name of employer)
   ☐ Other (please describe)_____

   Please list the names of all partners or members of your professional association/corporation who provide professional services: _____

   _____

8. Please attach a copy of your letterhead.

9. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No

   If yes, has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No

EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

(i) Where have you practiced your profession during the last ten years?

In _____ From _____ To _____
In _____ From _____ To _____
In _____ From _____ To _____

(ii) Have you ever failed any professional licensing or specialty organization examination? ..... ☐ Yes ☐ No

If yes, please attach a detailed explanation including the dates and location.

APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

_____

Please indicate all of your professional staff's specialty. Use additional sheets if necessary.

Professional Specialty	No. of Staff
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

. Please indicate the sources and amounts of actual and projected revenue:

	Source	Amount This Fiscal Year	Amount Next Fiscal Year
(i)	Charitable Contributions:	$_____	$_____
(ii)	Government Funding:	$_____	$_____
(iii)	Fee for Services:	$_____	$_____
(iv)	Other:_____	$_____	$_____
	TOTAL GROSS REVENUE	**$**_____	**$**_____

. Please provide the number of patient or client visits:

Type of Visit	Number of Visits Last 12 Months	Number of Visits Next 12 Months
Clinic	_____	_____
Laboratory	_____	_____
Other (specify)_____	_____	_____
TOTAL NUMBER OF VISITS	_____	_____

. Please specify any professional societies or associations in which you are a member: _____

_____

. Are you associated with or do you work for a physician or surgeon? ..... ☐ Yes ☐ No
If yes, please give the name and the specialty of the physician: _____

. Please give the approximate percentage of time spent in the following work locations:

_____% Administrative Office	_____% Laboratory	_____% Hospital Ward (specify)
_____% Classroom	_____% Operating Room	_____
_____% Emergency Dept of Hospital	_____% Outpatient Clinic	_____% Professional Office (specify profession)
_____% Nursing Home	_____% Patient's Home	_____
_____% Other (specify) _____		

. Please indicate the approximate division of your patients or clients among:

_____% Hemodialysis	_____% Psychiatric	
_____% Holistic Medicine	_____% Drug Addicts	_____% Physical Rehabilitation
_____% Surgical	_____% Alcoholics	_____% Disability Evaluation
_____% Stress Testing	_____% Obstetrical	_____% Research or Experimental
_____% Communicable	_____% Dental	_____% _____
_____% Family Planning	_____% Pediatric	_____% _____

. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

Type of Profession	No.	Type of Profession	No.
Counselors	_____	Opticians	_____
Laboratory Technicians	_____	Optometrists	_____
Nurse Anesthetists	_____	Perfusionists	_____
Nurses, Licensed Practical	_____	Pharmacists	_____
Nurse Practitioner	_____	Physiotherapists	_____
Nurses, Registered	_____	Social Workers	_____
Speech Therapists	_____	Other (please specify)	_____

. Are all of the above individuals licensed in accordance with applicable state and federal regulations?..... ☐ Yes ☐ No
If no, please attach an explanation.

APPLICANT PROCEDURES

Description of Professional Services	**Percent of Time Supervised**	**Qualifications of Supervisor**
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____

. Do you render professional services that do not involve contact with a patient? ☐ Yes ☐ No.
If yes, please describe these services in detail. _____

_____

. (i) Do you perform or assist in any surgical procedures? ☐ Yes ☐ No

(ii) Please list ALL surgical procedures performed (including minor surgery): _____

_____

_____

(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ☐ Yes ☐ No. If yes, please attach a detailed explanation.

(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ☐ Yes ☐ No. If yes, please attach a detailed explanation.

Do you perform radiation therapy? ..... ☐ Yes ☐ No

. Do you perform psychiatric shock therapy? ..... ☐ Yes ☐ No

. Do you compound in bulk, manufacture or wholesale medicine? ..... ☐ Yes ☐ No
If yes, please provide a detailed explanation. _____

. (i) Do you perform veterinary services? ..... ☐ Yes ☐ No
If yes, please indicate the approximate division of your work among the following categories.

_____ % Greyhounds _____ % Thoroughbreds

_____ % Animals valued over $5,000.

Please attach an explanation including the frequency and the type(s) of animals treated.

. Do you administer artificial insemination? ..... ☐ Yes ☐ No
If yes, please answer the following questions:
What type(s) of animals are involved? _____

(ii) Are you responsible for the storage of the semen? ..... ☐ Yes ☐ No
If yes, please explain. _____

_____

(iii) What percent of your practice is involved with artificial insemination? _____ %

Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action?
☐ Yes ☐ No If yes, please attach a detailed explanation.

PERSONNEL

Please list the number and type of independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.

No.	Type of Profession	No.	Type of Profession	No.	Type of Profession
_____	Inhalation Therapists	_____	Laboratory Technicians	_____	Nurse Anesthetists
_____	Nurses, Licensed Practical	_____	Nurse Practitioner	_____	Nurse, Registered
_____	Opticians	_____	Optometrists	_____	Perfusionists
_____	Pharmacists	_____	Physiotherapists	_____	Social Workers
_____	Speech Therapists	_____	Other (specify)_____		

. Do you supervise any individuals who are not your own employees? ☐ Yes ☐ No.

If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

Please indicate by profession the number of individuals you supervise.

No.	Type of Profession	No.	Type of Profession
____	Physicians	____	Laboratory technicians
____	X-ray technicians	____	Other (please specify):_____

APPLICANT AFFILIATIONS

Do you own or operate any business other than that shown in Question 1(a) above? ..... ☐ Yes ☐ No
If yes, please give details on a separate sheet.

Are you employed by any individual or entity other than that shown in Question 1(a) above? ..... ☐ Yes ☐ No
If yes, please attach an explanation describing details of your responsibilities.

. Are you under contract to any individual or entity other than that shown in Question 1(a) above? ..... ☐ Yes ☐ No
If yes, please attach an explanation describing details of your responsibilities. If your contract contains a hold-harmless agreement, a copy of the contract must be attached.

. Are you employed by or under contract to any government entity? ..... ☐ Yes ☐ No
If yes, please attach an explanation including the details of your responsibilities.

. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? ..... ☐ Yes ☐ No
If yes, please attach a copy of ALL of your advertisements.

. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? ..... ☐ Yes ☐ No
If yes, please attach a detailed explanation and a copy of ALL of your advertisements.

. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered? ..... ☐ Yes ☐ No
If yes, please give details including the name, location, size and number of beds.

_____

_____

If you have a training school, please complete the following. Attach a separate sheet if needed.

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 Faculty	Qualifications of Faculty (e.g. MD, RN, PhD, etc.)

. (i) Do you use a collection agency? ..... ☐ Yes ☐ No
If yes, please state the name of the agency

(ii) Does the agency have the authority to file a collection suit at its discretion? ☐ Yes ☐ No

APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

Have you or any of your employees:

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

(ii) Ever been convicted for 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, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? ☐ Yes ☐ No

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

Previous Professional Liability Insurance:

Policy Period	Insurer	Indicate whether Claims Made or Occurrence policy	Limits of Liability	Deductible	Retro Date	Premium

Does the Applicant carry General Liability Insurance? Yes ☐ No ☐

If Yes, provide: Insurer: _____

Limits: _____

Does coverage include Products/Completed Operations Hazards? Yes ☐ No ☐

Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? ☐ Yes ☐ No

Has any claim or suit been brought against you and/or any of your employees? ☐ Yes ☐ No

If yes, a Supplemental Claim Information Form must be completed for each claim or suit.

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

If yes, please give details on a separate sheet.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a claim or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or entity(ies) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there be knowledge of any such fact, circumstance or situation, any claim subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a claims made basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the extended reporting period option is exercised in accordance with the terms of the policy. The policy has specific provisions detailing claim reporting requirements.

The underwriting manager, Insurer and/or affiliates thereof are authorized to make any inquiry in connection with this application. Information regarding the applicant, or any person(s) or entity(ies) proposed for this insurance, received, found or developed by us and not part of the application, shall be used solely at our discretion, who shall not have any liability for the use or failure to use such information. Any such independently developed information shall not be attached to any subsequently issued policy or be considered part of the application.

Signing this application does not bind the Insurer to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The underwriting manager, Company and/or affiliates thereof, reserve the right to amend or withdraw terms upon review of the above additional information. In the event of any material change in underwriting information before coverage is bound, terms may be modified or withdrawn.

WARRANTY

I/We warrant to the Insurer, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to the underwriting manager, Insurer and/or affiliates thereof.

The statements in the Declarations are accurate and complete.

That the statements made in the application and attachments and any other materials submitted are true and are the basis of this Coverage Part and are considered as incorporated into and constituting a part of this policy

That the statements made in the application and attachments and any other materials submitted are representations and that such representations are deemed material to the acceptance of the risk or the hazard assumed by us under this Coverage Part and that this Coverage Part is issued in reliance upon the truth of such representations

That in the event that the application, including attachments and any other materials submitted, contains misrepresentations which materially affect either the acceptance of the risk or the hazard assumed by us, this Coverage Part in its entirety shall be void and of no effect

Must be signed within 60 days of the proposed effective date.

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects the person to criminal and civil penalties.