Commonwealth Underwriters Ltd.
P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
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www.commund.com

APPLICATION FOR PUBLIC ACCESS DEFIBRILLATION PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full name of Applicant _____

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

_____
(City) (State) (Zip)

(Please attach a list of additional office addresses)

c. Business Phone: (____)_____ Fax : (_____)_____

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

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

2. AUTOMATED EXTERNAL DEVICE SCHEDULE

PAD Location, type of occupancy, City & State	Number of PAD'S	Mfg. & Model Number Automatic (A) Semiautomatic (S)	Number of Employees at this location certified to use AED

b. How many AED's do you expect to add during the next 12 months? _____

c. Where is /are the AED (s) stored?

d. What agency trains your employees in the use of the AED?

e. How often are the trained employees re-certified?

f. Has an owned AED been used in an emergency situation within the past year? [ ] Yes [ ] No. How many times? __

g. Who operates the AED? Employee [ ] Other trained individual [ ]

h. Have any claims for the use of Public Access Defibrillators (PAD's) been made against you in the past 5 years? [ ] Yes [ ] No. If Yes, provide details, including the status of the claim (s), amounts demanded or paid, date of claim, and action taken to prevent a claim of similar nature from occurring in the future.

i. Are you aware of any incidents which might give rise to a professional liability claim against you? [ ] Yes [ ] No. If "yes", provide details, including the status of the claim (s), amounts demanded or paid, date of claim, and action taken to prevent a claim of similar nature from occurring in the future.

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, 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.

WARRANTY: I/We warrant to the Insurer, that I 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 of insurance 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, Company and/or affiliates thereof.**

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

Commonwealth Underwriters Ltd.

BROKER RISK SUMMARY

(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip

States of Licensure

New or Renewal for us

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: