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

# APPLICATION FOR MEDICAL LABORATORIES, MEDICAL IMAGING CENTERS AND BLOOD PLASMAPHERESIS CENTERS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

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

## I. GENERAL INFORMATION

1. (a) Full name of Applicant: _____

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

   _____
   (City) (State) (Zip)

   (c) Secondary locations: _____

   _____

   _____

   (d) (i) Phone:_____ (ii) Fax:_____

   (iii) E-Mail Address:_____ (iv) Website Address: _____

2. Number of employees including principals: Full-time ____ Part-time ____ Seasonal _____ Total _____

3. Date organized (MM/DD/YYYY): _____

4. Total square feet occupied by Applicant (all locations): _____

5. Applicant is a(n):

   [ ] individual [ ] corporation [ ] limited liability company [ ] partnership

   [ ] other _____

6. Applicant laboratory or center is: [ ] Mobile [ ] Stationary

7. State(s) in which the Applicant is licensed to practice: _____

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

   If Yes,

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

   (b) 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.

## II. OPERATIONS

1. Provide a detailed description of the nature of operations, services and procedures provided: (Attach a copy of brochure, if available) _____

   _____

2. (a) Is the Applicant a Lab that is involved in drug testing? ..... [ ] Yes [ ] No

   If Yes, is the Applicant approved by National Institute on Drug Abuse (NIDA)? ..... [ ] Yes [ ] No

(b) Is the Applicant a Medical Laboratory? ..... [ ] Yes [ ] No
If Yes, is the Applicant CLIA approved? ..... [ ] Yes [ ] No

If No to either of the above, provide a detailed explanation. _____

3. (a) Annual gross receipts for the last twelve months: $_____

Estimated gross receipts for the next twelve month: $_____

(b) Number of tests performed last twelve months: _____

Estimated number of tests to be performed in the next twelve month: _____

(c) Number of patient contacts for the last twelve months: _____

Estimated number of patient contacts for the next twelve months: _____

4. Is the Applicant is a Medical Imaging Center? ..... [ ] Yes [ ] No
If Yes, provide the number of tests for each of the following categories:

| | Number of tests last 12 months | Anticipated number of tests for the next 12 months |
|---|---|---|
| Bone Density Scan | | |
| CAT / CT Scan | | |
| PET Scan | | |
| MRI | | |
| Mammograms | | |
| Ultrasound | | |
| X-Ray | | |
| Other (describe) | | |

5. Is the Applicant under contract to or in the employ of any federal governmental entity? ..... [ ] Yes [ ] No
If Yes, provide details. _____

_____

6. Is the Applicant licensed in accordance with all applicable state and federal laws? ..... [ ] Yes [ ] No
If No, provide details. _____

7. (a) Does the Applicant advertise its professional services in any manner other than a simple listing in a telephone directory? ..... [ ] Yes [ ] No

(b) Is the Applicant associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? ..... [ ] Yes [ ] No

If Yes to either of the above, provide details and a copy of all advertisements. _____

_____

## III. PROFESSIONAL ACTIVITIES AND SPECIALTY

1. Provide the percentage of services provided for:

Hospitals _____% Nursing Homes _____% Industrial Facilities _____% Vet Clinics _____%

Physicians' Offices _____% Other (describe) _____ _____%

2. Is the Applicant involved in:

(a) Services open to the public (health fairs, shopping mall exhibits, etc.) ..... [ ] Yes [ ] No
(b) Blood banking or cross matching ..... [ ] Yes [ ] No
(c) Medical, genetic, AIDS or drug research ..... [ ] Yes [ ] No
(d) Manufacturing, dispensing or testing pharmaceuticals ..... [ ] Yes [ ] No
(e) Use of injected or ingested materials ..... [ ] Yes [ ] No
If Yes, provide details. _____
(f) Use of any radioactive material other than used in x-ray equipment ..... [ ] Yes [ ] No
(g) Therapy or treatment procedures ..... [ ] Yes [ ] No
(h) Environmental analyses ..... [ ] Yes [ ] No

(i) Manufacturer and/or sell laboratory equipment or supplies, reagents or software ..... [ ] Yes [ ] No

(j) Intravenous transfusions of blood or in the procurement of blood or blood products ..... [ ] Yes [ ] No

(k) Drug testing..... [ ] Yes [ ] No

If Yes, provide the percentage of Applicants gross receipts that are from drug testing. _____%

(l) Testing for AIDS ..... [ ] Yes [ ] No

If Yes, provide the percentage of Applicants gross receipts that are from testing for AIDS. _____%

If Yes to any of the above provide a full description. _____

_____

3. (a) Provide percentage of specimens:

(i) Collected direct from patients by the Applicant: _____ %
(ii) Received by the Applicant from outside sources: _____%

(b) Describe the types of specimens collected: _____

4. Do the Applicant provide any services under contract?..... [ ] Yes [ ] No
If Yes, provide a details. _____

## IV. STAFF

1. (a) Total number of professional employees employed by the Applicant: _____

(b) Indicate by profession the number of individuals employed by the Applicant:

_____ Nurses _____ Physicians _____ X-Ray Technicians

_____ Phlebotomists _____ Technologies _____ Other Technician

_____Other (describe) _____

(c) If physicians are employed, is coverage being requested for employed physicians?..... [ ] Yes [ ] No
If Yes, submit an Application for Physicians & Surgeons Professional Liability Insurance for each physician requesting coverage.
If No, what Professional Liability Insurance limits of liability does the applicant request the physicians to carry? _____

2. (a) Total number of staff contracted by the Applicant: _____

(b) Indicate by profession the number of individuals contracted by the Applicant:

_____ Nurses _____ Physicians _____ X-Ray Technicians

_____ Phlebotomists _____ Technologies _____ Other Technician

_____Other (describe) _____

(c) If physicians are contracted, is coverage being requested for contracted physicians? ..... [ ] Yes [ ] No
If Yes, submit an Application for Physicians & Surgeons Professional Liability Insurance for each physician requesting coverage.
If No, what Professional Liability Insurance limits of liability does the applicant request the physicians to carry?

_____

3. (a) Name and qualifications of the Applicant's Medical Director*:_____

_____

(b) Name and qualifications of the Applicant's Medical Review Officer (MRO)*: _____

_____

* Attach a Curriculum Vitae (C.V.).

## V. CLAIMS AND HISTORY

1. Has the Applicant or any of its employees ever:

(a) Been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental 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

2. Has the Applicant or any person proposed for this insurance had any professional license refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license? ..... [ ] Yes [ ] No

3. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance? ..... [ ] Yes [ ] No
If Yes, how many? _____ Complete a copy of our Inc. Supplemental Claim form for each one.

4. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? ..... [ ] Yes [ ] No
If Yes, explain. _____.

5. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? .. [ ] Yes [ ] No
If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each one.

6. List prior Professional Liability Insurance for each of the last (5) years, including the current year:
If None, check here. [ ]

(a)

| Ins Company | Limits of Liability | Premium | Eff./Exp. Dates | Claims Made or Occurrence Form | Retroactive Date |
|---|---|---|---|---|---|
| (1) | | | | | |
| (2) | | | | | |
| (3) | | | | | |
| (4) | | | | | |
| (5) | | | | | |

Attach a copy of the Declarations page for the most recent coverage.

(b) Does the policy for the current year allow the reporting of any incidents or circumstances that are likely to result in a claim? ..... [ ] Yes [ ] No

**NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY**

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 Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company 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 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.

**WARRANTY**

I/We warrant to the Company, 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 and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

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

_____ _____
Name of Applicant Title

_____ _____

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.

## ADDITIONAL EXPLANATIONS

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: