Commonwealth Underwriters Ltd.
P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
Fax: 888-359-6994
www.commund.com

APPLICATION FOR CLINICS (MEDICAL, DENTAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER) 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 practice address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) Location: Stand alone _____ Hospital _____ School _____ Correctional Facility _____ Other _____

   (d) (i) Phone: _____

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

   (e) Date Established: _____
   Attached a proforma business plan if the Applicant is newly established.

2. Applicant is a:

   [ ] professional corporation [ ] joint venture

   [ ] limited liability company [ ] professional association

   [ ] other _____ [ ] partnership

3. Name(s) of all partners or members of the clinic who provide professional services: _____

   _____

4. Does any owner, partner or director operate or administer, wholly or in part, any hospital, nursing home or other institution where medical services are rendered? ..... [ ] Yes [ ] No
   If Yes, provide details, including name, location, size and number of beds. _____

   _____

5. 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. Days/hours of operation: _____

2. (a) Provide the name and specialty of the Applicant's Medical Director: _____
   (b) Does the Applicant's Medical Director have direct patient contact? ..... [ ] Yes [ ] No
   (c) Is the Applicant's Medical Director full-time or part-time? _____

3. Applicant's professional specialty: _____

4. Provide the percentage of patients/clients:

Bariatrics	____%	Holistic medicine	____%	Sleep Disorders	____%
Communicable Disease	____%	Obstetrical	____%	Stress Testing	____%
Correctional Medicine	____%	Oncology	____%	Students	____%
Dental	____%	Pain Management	____%	Substance Abuse	____%
Disability Evaluation	____%	Pediatric	____%	Surgical	____%
Family Planning	____%	Physical Rehabilitation	____%	Urgent Care	____%
Free Clinic	____%	Psychiatric	____%		
Hemodialysis	____%	Research or Experimental ____%			

5. List all Locations where Applicant is registered and licensed to operate:

   Location 1: _____

   Location 2: _____

   Location 3: _____

   Location 4: _____

6. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: _____
   _____

7. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered?..... [ ] Yes [ ] No
   If Yes, provide details._____

8. List all accreditations and association memberships held by Applicant's facility and include a copy of the most recent report:_____

9. Does the Applicant participate in any state patient compensation fund? ..... [ ] Yes [ ] No

10. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")? ..... [ ] Yes [ ] No
    If Yes, what percentage of services are provided under the FTCA? _____

11. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.? ..... [ ] Yes [ ] No

12. Applicant's Gross Revenues:

	Last Twelve Months	Next Twelve Months
Fee for Service	$_____	$_____
Medicare/Medicaid Funds	$_____	$_____
Research	$_____	$_____
Other (describe)	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

13. Number of outpatient/client visits:

	Last Twelve Months	Next Twelve Months
Clinics	_____	_____
Laboratory	_____	_____
X-ray/Imaging	_____	_____
Pharmacy	_____	_____
TOTAL VISITS:	_____	_____

    NOTE: If Applicant provided services for correctional facilities, provide number of inmates: _____

14. Does the Applicant maintain any beds for overnight occupancy:

    (a) On the Applicant's premises?..... [ ] Yes [ ] No
    If Yes,
    (i) No. of beds: ____
    (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

(b) Off the Applicant's premises? ..... [ ] Yes [ ] No
If Yes,
(i) No. of beds: ____
(ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

III. STAFF

1. Indicate the number of professional employees, independent contractors and volunteers. If None, state None.

	Employees		Independent Contractors		Volunteers	
	Full-Time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures						
Physicians: Minor surgery or obstetrical procedures not constituting major surgery						
Anesthesiologists						
Obstetrics-Gynecologists						
Oncologists						
Ophthalmologists						
Urologists						
Dentists						
Chiropractors						
Nurse Anesthetists						
Nurse Practitioners						
Optometrists						
Pharmacists						
Physician Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Other(describe):						

NOTE: If the Applicant requires any of the above to be Insureds, submit a separate application for each such individual.

2. Are all of the above persons licensed in accordance with applicable state and federal regulation? ..... [ ] Yes [ ] No
If No, attach explanation.

3. Do all professional staff maintain a Professional Liability Insurance Policy? ..... [ ] Yes [ ] No
If Yes, what are the minimum limits of liability that the Applicant requires?
$_____each claim / $_____ aggregate

IV. PROFESSIONAL SERVICES

1. Does the Applicant's employees or independent contractors:
(a) Perform any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? ..... [ ] Yes [ ] No
If Yes, list all minor/invasive procedures _____

_____

(b) Perform any anti-aging procedures, including Botox or other injectables? ..... [ ] Yes [ ] No
If Yes, complete a Supplement for Medical Spa/Anti-Aging Clinics (SM31001).

(c) Perform abortions and/or menstrual extractions? ..... [ ] Yes [ ] No
If the Applicant provides pregnancy termination complete a Supplement for Abortion Centers (SM31002)

(d) Perform any experimental procedures or research testing? ..... [ ] Yes [ ] No
If Yes, are they FDA approved? ..... [ ] Yes [ ] No
If No, attach a description.

(e) Perform any chelation therapy services? ..... [ ] Yes [ ] No
If Yes, explain: _____

(f) Administer anesthesia other than topical or local infiltration? ..... [ ] Yes [ ] No
If Yes, attach detailed explanation.

(g) Use drugs for weight reduction for patients? ..... [ ] Yes [ ] No
If Yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs and quantity dispensed.

(h) Administer any methadone treatment? ..... [ ] Yes [ ] No
If Yes,
(i) Provide the number of treatments during the:
Last 12 months _____ Next 12 months _____
(ii) Attach a description of treatment and controls used.

(i) Provide teleradiology services? ..... [ ] Yes [ ] No
If Yes, provide description of services and for whom services are provided. _____

(j) Offer professional advice to the public via the internet, newspapers or broadcasts? ..... [ ] Yes [ ] No
If Yes, provide details. _____

(k) Advertise professional services in any manner other than a simple listing in a telephone directory? ..... [ ] Yes [ ] No
If Yes, attach a copy of all advertisements.

2. Does the Applicant use a collection agency: ..... [ ] Yes [ ] No
If Yes,
(i) Name of agency: _____
(ii) Does the agency have authority to file a collection suit on behalf of the Applicant? ..... [ ] Yes [ ] No

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 a licensing, administrative or governmental agency? ..... [ ] Yes [ ] No
(b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses? ..... [ ] Yes [ ] No
If Yes, provide details. _____

(c) Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders? ..... [ ] Yes [ ] No
If Yes, provide details. _____

(d) Had any professional license or license to prescribe or dispense narcotics been denied, limited, 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
If Yes, provide details. _____

2. 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? _____

3. 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. _____

4. 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? _____

5. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years?..... Yes [ ] No [ ]
If Yes, attach a copy of such insurer's notice.

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

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

7. List prior General Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

VI. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					

2. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:
   (a) Complete Sprinkler System? ..... [ ] Yes [ ] No
   (b) At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
   (c) Self-closing fire doors on each floor? ..... [ ] Yes [ ] No

(d) Automatic fire alarm system connected to a local fire department? [ ] Yes [ ] No
(e) Smoke detectors? [ ] Yes [ ] No
(f) Emergency electrical system? [ ] Yes [ ] No
(g) Heat sensors? [ ] Yes [ ] No
(h) Fire escape(s)? [ ] Yes [ ] No
(i) Posted emergency evacuation procedures? [ ] Yes [ ] No
(j) Properly maintained fire extinguishers? [ ] Yes [ ] No

If any of the above are answered No, provide details by attachment.

4. Does the Applicant have a written safety program in place? [ ] Yes [ ] No
If Yes, attach a copy of the written safety program.

5. Does the Applicant have written procedures for incident reporting? [ ] Yes [ ] No

6. Do any of the Applicant's locations have any:
(a) Exposure to flammables, explosive, chemicals? [ ] Yes [ ] No
(b) Catastrophe exposure? [ ] Yes [ ] No
(c) Exposure to radioactive materials? [ ] Yes [ ] No

7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? [ ] Yes [ ] No

8. Does the Applicant sell or lease any medical equipment or products to patients/clients or others in connection with Applicant's operation? [ ] Yes [ ] No
If Yes, Total Annual Sales $_____
Total Annual/Lease Rental Receipts $_____

9. Does the Applicant:
(a) Loan or rent machinery or equipment to others? [ ] Yes [ ] No
(b) Own any elevators or escalators? [ ] Yes [ ] No
(c) Own or rent any parking facility? [ ] Yes [ ] No
(d) Provide any recreational facility? [ ] Yes [ ] No
(e) Have a swimming pool on the premises? [ ] Yes [ ] No
(f) Sponsor any sporting or social events? [ ] Yes [ ] No

10. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? [ ] Yes [ ] No
If Yes, answer the following:
Provide three year loss history for claims under $100,000 Loss and Expense and ten years for claims $100,000 and greater. Attach further sheets if needed.

Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved and Paid	Amount of Expenses Reserved and Paid	Open (O) or Closed (C)

11. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? [ ] Yes [ ] No
If Yes, provide details for each incident._____

VII. ADDITIONAL INFORMATION

As part of this Application attach the following:

1. A CV of Medical Director including specialty and board certification.
2. Five (5) years of currently valued Professional Liability Insurance and General Liability Insurance claim runs from current and prior insurers or complete a Supplemental Claim Information form (SM6236) for each claim.
3. A list of any activities or procedures performed that are not otherwise described in this Application.

4. Credentialing, Risk Management protocols.
5. Most recent annual financial statements, both a balance sheet and a revenue and expense statement. If the Applicant is newly established attached proforma financial statements.
6. Complete an Additional Insured Supplement for any additional insured that coverage is being requested for under General Liability Coverage.

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 Extended Reporting Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof are 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/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 Company 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.

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: