1-877-245-5887
Return application by fax or email
fax: (310) 796-9054
email: info@cbmalagains.com

CBMALAGA
Insurance Services LLC

Policy Number: ____________________
Company Use Only

BLOOD/ORGAN/TISSUE BANK LABORATORY APPLICATION

INSTRUCTIONS

1. PLEASE PRINT LEGIBLY. IF THE APPLICATION IS APPROVED, THE POLICY WILL BE BASED ON THE INFORMATION PROVIDED.
2. PLEASE ANSWER ALL QUESTIONS. IF A QUESTION IS NOT APPLICABLE, PRINT, "N/A".
3. IF ADDITIONAL SPACE IS NEEDED, PLEASE PROVIDE THE ADDITIONAL INFORMATION ON A BLANK SHEET OF PAPER AND ATTACH TO THIS APPLICATION.

I. ORGANIZATION INFORMATION

A. BROKERAGE FIRM/AGENCY INFORMATION

CB Malaga Insurance Services LLC - www.cbmalagains.com
BROKERAGE FIRM/AGENCY NAME

CITY, STATE AND ZIP CODE

BROKER/AGENT NAME

BROKER/AGENT LICENSE NUMBER AND TYPE

877 - 245 - 5887
PHONE

_____-_____-______
FAX

E-MAIL

B. CONTACT INFORMATION

APPLICANT NAME

MAILING ADDRESS

COUNTY

STREET ADDRESS (IF DIFFERENT)

CONTACT PERSON NAME

TITLE

_____-_____-______
PHONE

_____-_____-______
FAX

E-MAIL

WEBSITE ADDRESS

C. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM): ____________________
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF THE APPLICANT'S CURRENT POLICY.

D. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM): ____________________
ANNUAL POLICY TERMS WILL BEGIN AND END ON THE SAME MONTH AND DAY.

II. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	OCCURRENCE/CLAIMS-MADE	DEDUCTIBLE
□ **PROFESSIONAL LIABILITY FACILITY**	$_____ PER EVENT/ $_____ AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE: ___________	□ NONE □ $5,000 □ $25,000 □ $10,000 □ $50,000 □ OTHER $ ____________ THE DEDUCTIBLE APPLIES TO: □ INDEMNITY ONLY □ INDEMNITY AND EXPENSE
□ **GENERAL LIABILITY**	$_____ PER EVENT/ $_____ GENERAL AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE: ___________	□ NONE □ $5,000 □ $25,000 □ $10,000 □ $50,000 □ OTHER $ ____________ THE DEDUCTIBLE APPLIES TO: □ INDEMNITY ONLY □ INDEMNITY AND EXPENSE
□ **EXCESS—PROFESSIONAL LIABILITY**	$_____ PER EVENT/ $_____ AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE: ___________	
□ **EXCESS—GENERAL LIABILITY**	$_____ PER EVENT/ $_____ GENERAL AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE: ___________	

II. COVERAGES, LIMITS AND DEDUCTIBLES (continued)

(*) If there are entities related to the named insured (subsidiaries, joint ventures, LLCs, partnerships, etc.) please complete section II. (Schedule of related entities) of the blood/organ/tissue bank laboratory facilities supplemental application or attach a copy of your organizational chart which includes the information requested.

If shared limit or separate limit coverage for employed or contracted physicians, surgeons, residents, interns, fellows, dentists, oral surgeons, CRNAs, Nurse midwives, CRNPs, podiatrists, physician assistants or surgical assistants is being requested, please complete Section III. (Coverages, limits and deductibles) of the blood/organ/tissue bank Laboratory facilities supplemental application.

III. GENERAL INFORMATION

A. Type of legal entity (please put an "x" in the applicable spaces)**:**

- ☐ Professional Corporation
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Corporation (LLC)
- ☐ Other (Please explain): ______________________________

B. Entity ownership (please put an "x" in the applicable spaces)**:**

- ☐ Physician owned
- ☐ Hospital owned
- ☐ Independently owned
- ☐ Other (Please explain): ______________________________

C. Are there any plans for mergers or acquisitions during the next 12 months? ☐ Yes ☐ No

If Yes, please explain: ______________________________

D. How many locations do you have? ____________

Please list all locations. If more than 3 locations, please attach a separate piece of paper showing the additional locations.

Location #1:

____

Ste Street City State Zip

Distance to nearest hospital ______________________

Date this location opened ______________________ Estimated number of specimens at this location ______

Location #2:

____

Ste Street City State Zip

Distance to nearest hospital ______________________

Date this location opened ______________________ Estimated number of specimens at this location ______

Location #3:

____

Ste Street City State Zip

Distance to nearest hospital ______________________

Date this location opened ______________________ Estimated number of specimens at this location ______

E. Do you plan to add any locations during the next 12 months? ☐ Yes ☐ No

F. Licenses held by your facility: ______________________________

G. Certifications/accreditations held by the facility: ______________________________

☐ CLIA ☐ AABB ☐ AATB ☐ Other (Please explain): ______________________________

Please provide a copy of the applicant's certificate/accreditation, including any recommendations made.

If none, please explain: ______________________________

____

H. Are all locations accredited by at least one of the organizations listed on Question III.G. above? ☐ Yes ☐ No

If No, please explain: ______________________________

I. How often is the medical director on-site at the facility? ______________________________

J. Medical Director:

____

Name of Medical Director

______-_______-_________ ______________________________

Phone Email

III. GENERAL INFORMATION (continued)

K. ANNUAL PAYROLL:

TOTAL ANNUAL PAYROLL: $__________________ **TOTAL PROJECTED ANNUAL RECEIPTS:** $_________________

L. GROSS REVENUE:

PRIOR YEAR GROSS REVENUE: $__________________ **PROJECTED GROSS REVENUE FOR UPCOMING YEAR:** $_________________

IV. LABORATORY OPERATIONS

A. IS THE FACILITY OPERATING AS A:

□ BLOOD BANK
□ TISSUE BANK
□ FERTILITY CLINIC
□ RESEARCH FACILITY
□ OTHER (PLEASE DESCRIBE): ___________________________

B.

BLOOD AND BLOOD RELATED EXPOSURES	UPCOMING YEAR PROJECTED ANNUAL DONATIONS	CURRENT YEAR ANNUAL DONATIONS	LAST PRIOR YEAR ANNUAL DONATIONS
PAID BLOOD DONATIONS			
VOLUNTEER BLOOD DONATIONS			
AUTOLOGOUS BLOOD DONATIONS			
FOREIGN (NON US) DONATIONS PURCHASED			
PHERESIS PROCEDURES			
OUTPATIENT TRANSFUSIONS			
THERAPEUTIC PLASMA EXCHANGE			
STEM CELL HARVESTING			
OTHER (PLEASE DESCRIBE): ______________________			

C.

OTHER BANKING AND HARVESTING	UPCOMING YEAR PROJECTED ANNUAL RECEIPTS	CURRENT YEAR ANNUAL RECEIPTS	LAST PRIOR YEAR ANNUAL RECEIPTS
ORGAN BANKING—DIRECT PROCESSING			
ORGAN BANKING—NO DIRECT PROCESSING			
TISSUE BANKING			
SPERM BANKING			
EGG BANKING			
OTHER (PLEASE DESCRIBE): ______________________			

D. IS THE MEDICAL HISTORY OF EACH TISSUE DONOR REVIEWED BY A PHYSICIAN? □ YES □ NO

IF NO, PLEASE EXPLAIN: ____

E. IS THERE A WRITTEN INFORMED CONSENT PROCESS IN PLACE? □ YES □ NO

F. IS THERE A WRITTEN POLICY/PROCEDURE IN PLACE TO ADDRESS (CHECK ALL THAT APPLY):

□ IDENTIFICATION OF SPECIMENS □ DOCUMENTATION OF ALL SPECIMENS
□ HANDLING OF SPECIMENS □ CHAIN OF CUSTODY FROM THE DONOR TO THE RECEIPIENT

G. IS AN AUDIT PERFORMED ON A REGULAR BASIS TO ENSURE THAT THESE WRITTEN POLICIES/PROCEDURES ARE FOLLOWED? □ YES □ NO

IF YES, PLEASE ELABORATE ON THE PROCESS: ____

____

H. DO STORAGE FACILITIES HAVE SYSTEMS AND PLANS FOR SAFE STORAGE DURING NATURAL DISASTERS AND POWER OUTAGES? □ YES □ NO

IF YES, DOES THIS SYSTEM INCLUDE A BACKUP GENERATOR? □ YES □ NO

I. IN THE APPLICANT'S FACILITY:

1. DO ALL SPECIMENS GO THROUGH DISINFECTION OR STERILIZATION AS PART OF THE PRODUCT PREPARATION? □ YES □ NO
2. ARE SPECIMENS STORED IN THE APPROPRIATE MANNER ACCORDING TO FDA GUIDELINES? □ YES □ NO
3. IS STERILITY/FREEDOM FROM CONTAMINATION MAINTAINED AND AUDITED THROUGHOUT THE CUSTODY CHAIN? □ YES □ NO

J. DOES THE FACILITY PROVIDE TESTING FOR OTHER DONOR FACILITIES? □ YES □ NO

IV. LABORATORY OPERATIONS

Please list the other facility and their locations (city/state): ______

______

Is the other facility required to carry professional limits equal to the applicant's limits? ☐ Yes ☐ No

K. What percentage of the applicant's blood is tested by another facility? ______%

Please list the other facility and their locations (city/state): ______

______

L. Does the applicant have an electronic tracking system for all specimens that are processed? ☐ Yes ☐ No

M. Does the applicant have a medical review officer? ☐ Yes ☐ No

N. Do all employees participate at the time of hire and in regularly scheduled training regarding safety and operational procedures? ☐ Yes ☐ No

If No, please explain: ______

O. Does the applicant have a written safety manual used by all employees? ☐ Yes ☐ No

If No, please explain: ______

P. Have any services been discontinued during the last 24 months? ☐ Yes ☐ No

If Yes, please describe: ______

Q. Does the applicant have regularly scheduled maintenance and calibration of all equipment? ☐ Yes ☐ No

If No, please explain: ______

R. Does the applicant have a written compliance manual detailing the appropriate cleaning and handling of all specimens? ☐ Yes ☐ No

If No, please explain: ______

S. Has the applicant implemented the FDA recommendations for questions related to potential donors regarding the following? (Check all that apply)**:**

- ☐ HIV Testing
- ☐ Hepatitis testing
- ☐ Smallpox
- ☐ Anthrax
- ☐ Other infectious diseases

T. Does the applicant have laboratory software system that is capable of interfacing with local hospital(s) and/or other labs and providers? ☐ Yes ☐ No

If No, please explain: ______

If Yes, is this system "auditable"? ☐ Yes ☐ No

If No, please explain: ______

U. Does the applicant's facility contract with couriers to pick up specimens? ☐ Yes ☐ No

If Yes, does the applicant perform quality audits of the courier on an annual basis or have a contract of quality standards? ☐ Yes ☐ No

If No, please explain: ______

V. Does the applicant's staff transport specimens in facilty-owned vehicles? ☐ Yes ☐ No

V. MEDICAL STAFF

A. Please provide the information requested below for each physician, if any, that practices at the applicant's facility. (If more room is needed, please attach a separate roster of medical staff with all of the information requested below).

IMPORTANT NOTE: **If coverage is desired for physicians, please indicate that on Section III** (Coverages, Limits and Deductibles Schedule)**, and list these Physicians in Section IV** (Schedule of Medical Professionals) **of the Blood/Organ/Tissue Bank Laboratory Facilities Supplemental Application. Also, complete a separate Physician Individual Professional Liability Insurance Application for each physician.**

PHYSICIAN'S NAME	INDICATE IF EACH IS A: MEMBER (M) PARTNER (P) SHAREHOLDER (S) EMPLOYEE (E) CONTRACTED PHYSICIAN (C) or ALL OTHER (AO)	PRIMARY LICENSE NUMBER	INDICATE PRIMARY SPECIALTY	INDICATE THE AVERAGE NUMBER OF HOURS PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT YOUR FACILITY

V. MEDICAL STAFF (continued)

B. ARE EACH OF THE PHYSICIANS PRACTICING AT THE APPLICANT'S FACILITY BOARD CERTIFIED? ☐ YES ☐ NO

IF NO, HOW MANY ARE NOT BOARD CERTIFIED? ______________________________

PLEASE LIST: ______________________________

C. PLEASE INDICATE THE NUMBER OF HEALTH PROFESSIONALS, OTHER THAN PHYSICIANS, WHO WORK AT THE APPLICANT'S FACILITY:

IMPORTANT NOTICE: IF COVERAGE IS DESIRED FOR HEALTH CARE PROFESSIONALS, OTHER THAN PHYSICIANS, PLEASE INDICATE THAT ON SECTION III (COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE), **AND LIST THESE HEALTH CARE PROVIDERS ON SECTION V** (SCHEDULE OF MEDICAL PROFESSIONALS) **OF THE BLOOD/ORGAN/TISSUE BANKS LABORATORY SUPPLEMENTAL APPLICATION. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL FOR WHOM COVERAGE IS REQUESTED.**

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED
CLINICAL BIOLOGIST			
PATHOLOGIST ASSISTANT			
MICROBIOLOGIST ASSISTANT			
MEDICAL BIOCHEMIST ASSISTANT			
LABORATORY MANAGER			
DEPARTMENT SUPERVISOR			
CHIEF TECHNOLOGIST (LEAD TECHNOLOGIST)			
CYTOTECHNOLOGIST			
MEDICAL TECHNOLOGIST			
HISTOTECHNOLOGIST			
MEDICAL LABORATORY TECHNICIAN			
PHLEBOTOMIST			
TRANSCRIPTIONIST			
MEDICAL LABORATORY ASSISTANT			
SPECIMEN PROCESSOR (SECRETARY)			
OTHER (PLEASE SPECIFY): ____________			
OTHER (PLEASE SPECIFY): ____________			

D. DOES THE APPLICANT SUPERVISE ANYONE OTHER THAN ITS OWN EMPLOYEES? ☐ YES ☐ NO

IF YES, DESCRIBE THE RESPONSIBILITY OF THE BOTH THE SUPERVISORY AND SUPERVISED INDIVIDUALS, AND THE RELATIONSHIPS BETWEEN THE INDIVIDUALS:

____

ALSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL, THE NUMBER OF INDIVIDUALS THE FACILITY SUPERVISES:

____

VI. RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM THAT:

1. IDENTIFIES/RECOGNIZES PATTERNS OF OCCURRENCES OR POTENTIALS FOR OCCURRENCES? ☐ YES ☐ NO
2. IMPLEMENTS AND MONITORS CORRECTIVE ACTION PLANS? ☐ YES ☐ NO
3. DEVELOPS AND IMPLEMENTS ACTION PLANS FOR CONTINUOUS PROCESS IMPROVEMENTS? ☐ YES ☐ NO
4. MONITORS, ANALYZES AND SETS IN ACTION QUALITY INDICATORS? ☐ YES ☐ NO
5. EMPLOYS A SYSTEM FOR ASSESSING AND RESPONDING TO PATIENT AND EMPLOYEE SATISFACTION? ☐ YES ☐ NO
6. PROVIDES FOCUSED INTERVENTIONS AND EDUCATION TO IMPROVE PATIENT SAFETY? ☐ YES ☐ NO

B. IS THERE AN ORIENTATION PROGRAM FOR ALL NEW EMPLOYEES? ☐ YES ☐ NO

C. IS THERE ONGOING TRAINING FOR COMPLIANCE, SAFETY AND EQUIPMENT USAGE? ☐ YES ☐ NO

D. IS THERE A FORMALIZED INFECTION CONTROL PLAN, PARTICULARLY FOR THE CLEANING OF EQUIPMENT? ☐ YES ☐ NO

E. ARE STAFF TRAINED AND TESTED ON EMERGENCY PROCEDURES ON A REGULAR BASIS AND ARE DIRECTIONS FOR SUMMONING HELP AND/OR TRANSFER CLEARLY POSTED? ☐ YES ☐ NO

F. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR THESE RISK MANAGEMENT ACTIVITIES:

______________________________ ______________________________

NAME TITLE

VI. RISK MANAGEMENT (continued)

H. (CONTINUED)

ARE THE RESPONSIBILITIES CLEARLY DEFINED IN THE JOB DESCRIPTION FOR THE POSITION? ☐ YES ☐ NO

VII. CREDENTIALING

A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF, DOES THE APPLICANT:

1. VERIFY EDUCATIONAL BACKGROUND? ☐ YES ☐ NO
2. CHECK ALL REFERENCES INCLUDING PAST EMPLOYERS? ☐ YES ☐ NO
3. CHECK FOR PENDING LICENSE SUSPENSIONS, REVOCATIONS OR DISCIPLINARY ACTIONS BY OTHER FACILITIES? ☐ YES ☐ NO
4. CHECK CRIMINAL HISTORY? ☐ YES ☐ NO
5. REQUIRE PRIOR MEDICAL PROFESSIONAL CLAIM HISTORY? ☐ YES ☐ NO

B. ARE CREDENTIALS OF EACH PHYSICIAN REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES? ☐ YES ☐ NO

C. IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK? ☐ YES ☐ NO

D. HAS AN APPLICANT'S LICENSE OR CERTIFICATION EVER BEEN INVESTIGATED, LIMITED, REVOKED, SUSPENDED, REFUSED, CANCELLED, OR VOLUNTARILY SURRENDERED BY OR TO ANY STATE OR FEDERAL LICENSING BOARD OR REGULATORY AGENCY? THIS INCLUDES, BUT IS NOT LIMITED TO, MEDICARE, MEDICAID, OR ANY REIMBURSEMENT PROGRAMS. ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ______________________________

E. DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN WORKING AT THE APPLICANT'S FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

1. IF YES, WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED ? $ ______________ / $______________
2. ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

F. WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED FOR NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT THE APPLICANT'S FACILITY TO CARRY? $ ______________ / $______________

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

G. HAS THE LICENSE OF ANY PHYSICIAN BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ______________________________

H. HAS THE APPLICANT MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK OF ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF DURING THE LAST FIVE YEARS? ☐ YES ☐ NO

VIII. PHYSICAL PLANT

A. PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY THE APPLICANT. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE, PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.

ADDRESS OF PROPERTY	TYPE OF USE/ OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	FIRE PROTECTION*
PATIENT CARE BUILDINGS:						
OTHER BUILDINGS:						

*FOR EACH BUILDING, INDICATE IF THERE IS A: SPRINKLER SYSTEM—FULL, PARTIAL OR NO SPRINKLER SYSTEM; SMOKE DETECTOR, HEAT DETECTOR; FIRE ALARM—CENTRAL STATION OR LOCAL ALARM

B. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: ______________________________

IX. GENERAL LIABILITY

DOES THE APPLICANT DESIRE GENERAL LIABILITY COVERAGE? ☐ YES ☐ NO

IF YES, COMPLETE THIS SECTION. IF NO, SKIP TO SECTION X.

A. IS THERE A PREVENTATIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR ALL MACHINES OR DEVICES AT THE FACILITY? ☐ YES ☐ NO

1. HOW OFTEN ARE NON-EXPENDABLE MACHINES OR DEVICES INSPECTED AND MAINTAINED? ______________________________
2. WHO PERFORMS THE MAINTENANCE OF THE ABOVE EQUIPMENT? ☐ EMPLOYEE ☐ INDEPENDENT CONTRACTOR
3. IF INDEPENDENT CONTRACTOR, WHAT ARE THE MINIMUM GENERAL LIABLITY LIMITS THAT IS REQUIRED BY THE FACILITY FOR THE INDEPENDENT CONTRACTOR? $ ______________ / $______________

IX. GENERAL LIABILITY (continued)

4. Does the applicant obtain a certificate of insurance annually from the Independent Contractor to verify this coverage is in place? ☐ Yes ☐ No

B. Is any of the bio-medical equipment used at the facility owned by physicians? ☐ Yes ☐ No
If Yes, who is responsible for the preventative maintenance, inspection and repair of the equipment?
____

C. Is the applicant's bio-medical equipment ever loaned or donated to others for their use? ☐ Yes ☐ No
If Yes, describe: ______________________________

D. Does the applicant rent or lease medical equipment from others? ☐ Yes ☐ No
If Yes, who is responsible for the maintenance of the equipment? ______________________________
____

E. Does the applicant use an advertising agency? ☐ Yes ☐ No
1. If Yes, what minimum professional liability limits does the facility require that the Advertising Agency maintain?
$____________ / $____________
2. Is the applicant included as an additional insured on the Advertising Agency's policy? ☐ Yes ☐ No
3. Is there a hold harmless agreement in the contract in favor of the applicant? ☐ Yes ☐ No

F. Are there any plans for new construction or renovations for the facility during the next 12 months? ☐ Yes ☐ No
If Yes, please describe the changes planned including the time frame and the estimated cost:
____

G. Please indicate below which of the following apply and specify the corresponding projections for the next 12 months:
1. Habitational Risk: ☐ Apartment ☐ Dwelling ☐ Hotel ☐ None ☐ Other, please describe: ____________
   A) Number of Units: _______ Units Year Built: ________
   b) Are there at least two exits located remotely from each other? ☐ Yes ☐ No
   c) For apartment buildings and hotels, are there lighted emergency exit signs? ☐ Yes ☐ No
2. Paid Parking: Receipts/Year: $____________
3. Special Athletic or Fund Raising Events: Receipts/Year: $____________
   Describe planned events for the upcoming year and indicate if alcohol will be served: ______________________________
   ____

H. Does the applicant lease space to others? ☐ Yes ☐ No
1. If Yes, indicate the following for the leased space:
   ____
   City, State and Zip Code
   ____________ ______________________________
   Square footage Occupancy/Use of space
2. Does the lease require the tenant to carry a general liability (GL) insurance policy with a limit of $1,000,000 per occurrence? ☐ Yes ☐ No
3. Does the applicant obtain certificates of insurance annually to verify coverage is in place? ☐ Yes ☐ No
4. Is the tenant rquired to add the applicant as an additional insured on their GL policy? ☐ Yes ☐ No

X. EXCESS LIABILITY

Does the applicant desire Excess Liability coverage? ☐ Yes ☐ No
If Yes, complete this section. If No, skip to Section XI

A. Has the applicant's excess professional or commercial general liability limits been increased within the last five years? ☐ Yes ☐ No
If Yes, what was the prior limit and when was it increased?
$____________ / $____________ ______ / ________
MM YYYY

XI. COVERAGE HISTORY AND INFORMATION

****NOTE: Question A is not to be completed in the states of MISSOURI or CALIFORNIA.**

A. Has any company ever cancelled or refused to offer insurance coverage to the applicant? ☐ Yes ☐ No
If Yes, please provide details: ______________________________
____

B. Please check which type of notice the applicant's present professional liability insurer requires before they will formally recognize a claim under the policy:
☐ Summons and complaint or attorney demand letter
☐ Written notice from the facility that a potentially compensable event has occurred

C. Has the applicant conducted a recent review of all known claims as well as any incidents which may give rise to future claims? ☐ Yes ☐ No

XI. COVERAGE HISTORY AND INFORMATION (continued)

1. If Yes, has the notice been forwarded to the applicant's current insurer? ☐ Yes ☐ No
2. If Yes, provide the date of the review and the name and title of the person conducting the review:

______ / ________ ____________________ ____________________
MM YYYY Name Title

D. Please provide the applicant's insurance history for the last five years:

POLICY PERIOD	MOST RECENT YEAR	YEAR 1 PRIOR	YEAR 2 PRIOR	YEAR 3 PRIOR	YEAR 4 PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
GENERAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
EXCESS LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					

E. Please provide a detailed description for all individual losses for (1) Open; and, (2) Closed, claims with combined paid and reserved amounts of $50,000 or more including expenses:

1. DATE: _______ _________ DOLLAR AMOUNT: $________________
   MM YYYY

   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY

   DESCRIPTION: ____
2. DATE: _______ _________ DOLLAR AMOUNT: $________________
   MM YYYY

   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY

   DESCRIPTION: ____
3. DATE: _______ _________ DOLLAR AMOUNT: $________________
   MM YYYY

   COVERAGE: ☐ PROFESSIONAL LIABILITY ☐ GENERAL LIABILITY

   DESCRIPTION: ____

XII. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY!)

A. Has the applicant's organization (independently or through a named insured) been involved now or in the past, directly or indirectly, in a claim, potential claim or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization? ☐ Yes ☐ No

If Yes, how many? __________
If Yes, have these been reported to the applicant's insurer? ☐ Yes ☐ No

B. Does the applicant's organization or any of its employees/contractors have knowledge of any incident or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which the applicant may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or

XII. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY!) (continued)

ORGANIZATION WHICH MAY GIVE RISE TO A CLAIM? ☐ YES ☐ NO

IF YES, HOW MANY? __________

IF YES, HAVE THESE BEEN REPORTED TO THE APPLICANT'S INSURER? ☐ YES ☐ NO

XIII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION:

A. **A COPY OF THE APPLICANT'S CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.**
B. **FINANCIAL INFORMATION.** LAST THREE (3) YEARS AUDITED FINANCIAL STATEMENTS, AND ANNUAL REPORTS INCLUDING AUDITOR'S OPINION.
C. **MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.**
D. **COPY OF THE APPLICANT'S LETTERHEAD.**
E. **LIST OF THE OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.**
F. **COPY OF THE APPLICANT'S CURRENT PROFESSIONAL LIABILITY INSURANCE POLICY AND ENDORSEMENTS.**
G. **LOSS INFORMATION.** RECENTLY VALUED LOSS RUNS FROM INSURANCE CARRIERS COVERING THE LAST TEN (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS.
H. **ANNUAL REPORT** IF ONE IS PUBLISHED.
I. ORGANIZATIONAL CHART **INCLUDING THE NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.**
J. **COPY OF THE APPLICANT'S CURRENT INSURANCE POLICY.**

XIV. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DECEIVE, OR DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR FAILS TO PROVIDE COMPLETE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY BE PROSECUTED UNDER STATE LAW AND MAY BE GUILTY OF A FELONY AND SUBJECT TO CRIMINAL AND CIVIL PENALTIES, FINES, DENIAL OF INSURANCE OR CONFINEMENT IN PRISON.

Initial Here

XV. IMPORTANT NOTICE—REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES

THE INSURANCE APPLIED FOR BY THIS APPLICATION MAY BE CLAIMS-MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE. PLEASE READ AND REVIEW THE POLICY CAREFULLY.

ON BEHALF OF THE ENTITY APPLYING FOR COVERAGE HEREIN:

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO MATERIAL FACT HAS BEEN KNOWINGLY SUPPRESSED OR MISSTATED.

I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY.

I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY PHYSICIAN, DENTIST, FIRM OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND COVERAGE.

BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT THERE IS NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED A COMPLETED APPLICATION; (2) OFFERED A PREMIUM QUOTE; AND (3) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND THAT IF THE PREMIUM OR FIRST INSTALLMENT IS PAID BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF THESE TERMS ARE NOT COMPLIED WITH, THERE WILL BE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I FURTHER ACKNOWLEDGE THAT ANY AND ALL RESPONSES TO QUESTIONS, STATEMENTS AND EXPLANATIONS MADE IN THIS APPLICATION, OR IN ANY AND ALL DOCUMENTS, SUPPLEMENTAL PAGES OR OTHER ATTACHMENTS (HEREINAFTER "**ATTACHMENTS**") ARE TRUE AND THAT I, NOR ANY APPLICANT, HAVE KNOWINGLY SUPPRESSED OR MISSTATED ANY MATERIAL FACTS AND I, AND ANY APPLICANT, AGREE THAT THIS APPLICATION, AND ANY **ATTACHMENTS**, SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER INDIVIDUALS OR ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND, IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REQUESTED, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION, AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

SIGNATURE OF AUTHORIZED INDIVIDUAL	TITLE	DATE

XVI. SUPPLEMENTAL INFORMATION

BLOOD/ORGAN/TISSUE BANK LABORATORY SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF THE APPLICANT HAS BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE FOR LESS THAN TEN YEARS OR IF THE FACILITY PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE INSURANCE COMPANY.

THE LOSS INFORMATION SHOULD ADDRESS BOTH THE FACILITY'S PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: ____________________

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION.

CLAIM NUMBER ____________________

A. CLAIMANT NAME: ____________________ AGE: ________

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU. ________ MM ________ YYYY

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. ________ MM ________ YYYY

D. NAME OF DOCTOR(S), HEALTH CARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLVED IN THE CLAIM OR SUIT:

____

E. DEFENDING INSURANCE CARRIER NAME:

____

F. WAS A CLAIM MADE OR A SUIT FILED? ☐ YES ☐ NO

G. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT: ☐ OPEN ☐ CLOSED

IF CLOSED, DATE OF CLOSING/SETTLEMENT OR AWARD: ________ MM ________ YYYY

IF CLOSED, WAS PAYMENT MADE? ☐ YES ☐ NO

IF NO, WAS CLAIM OR SUIT WITHDRAWN? ☐ YES ☐ NO

AMOUNT PAID ON YOUR BEHALF: $ ____________

TOTAL AMOUNT OF SETTLEMENT OR AWARD: $ ____________

WAS THIS MATTER CLOSED WITH YOUR CONSENT? ☐ YES ☐ NO

IF OPEN, HAS SETTLEMENT BEEN OFFERED? ☐ YES ☐ NO

IF OPEN, HAS TRIAL DATE BEEN SET? ☐ YES ☐ NO

TRIAL DATE: ________ MM ________ YYYY

H. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: ____________________

TREATMENT PROVIDED: ____________________

ALLEGED NEGLIGENCE: ____________________

ALLEGED INJURY: ____________________

I. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY INCLUDING THE APPLICANT'S LEVEL OF INVOLVEMENT).

____

____

II. SCHEDULE OF RELATED ENTITIES

LIST OF ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.)

NAME OF ENTITY	DESCRIPTION OF OPERATIONS	DATE ACQUIRED, CREATED OR MERGED	INDICATE YOUR OWNERSHIP PERCENTAGE IN THIS ENTITY	COVERAGE DESIRED? If yes, indicate shared or separate limits.

III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE

(IF SHARED OR SEPARATE PHYSICIAN OR ALLIED COVERAGE IS BEING REQUESTED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW.

COVERAGE	REQUESTED LIMITS	OCCURRENCE / CLAIMS MADE	DEDUCTIBLE / SIR
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE BLOOD/ORGAN/TISSUE BANK LABORATORY LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE BLOOD/ORGAN/ TISSUE BANK LABORATORY LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE BLOOD/ORGAN/TISSUE BANK LABORATORY LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE BLOOD/ORGAN/ TISSUE BANK LABORATORY LIABILITY APPLICATION.
EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS-SEPARATE LIMIT COVERAGE	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: ____________ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE BLOOD/ ORGAN/TISSUE BANK LABORATORY.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ __________________ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ **PROFESSIONAL LIABILITY- EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS- SEPARATE LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: ____________ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE BLOOD/ ORGAN/TISSUE BANK LABORATORY.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ __________________ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE

IMPORTANT NOTE:

UNLESS OTHERWISE INDICATED BELOW, REQUESTED COVERAGE WILL BE LIMITED TO PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED, WHILE EMPLOYED OR UNDER CONTRACT WITH THE APPLICANT OR RELATED ENTITY (SERVICES LIMITED TO DUTY AND SCOPE OF SERVICES).

CHECK ONE:

☐ LIMITED TO DUTY AND SCOPE OF APPLICANT AS INDICATED ABOVE

☐ REQUESTING 24-HOUR COVERAGE

IV. SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND / OR ORAL SURGEONS, PLEASE PROVIDE THE INFORMATION BELOW. ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED (SHARED LIMIT OR SEPARATE LIMIT COVERAGE). CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

NAME OF MEDICAL PROFESSIONAL	EMPLOYMENT STAUS: (C)ONTRACT (E)MPLOYED (F)ACULTY (R)ESIDENT	NUMBER OF PROCEDURES PERFORMED AT THE BLOOD/ ORGAN/TISSUE BANK LABORATORY	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOYMENT WITH NAMED INSURED	RESTRICTED (RE) TO NAMED INSURED'S OPERATION OR 24-HOUR (24)	LIMITS: SHARED (SH), SEPARATE (SE)

V. SCHEDULE OF MEDICAL PROFESSIONALS - CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND / OR SURGICAL ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION BELOW. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED. CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF CLAIMS MADE COVERAGE IS BEING REQUESTED, COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE DATE OF EMPLOYMENT WITH THE NAMED INSURED ENTITY. (*) IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE DATE OF THE EMPLOYMENT WITH THE NAMED INSURED, PRIOR ACTS COVERAGE WILL BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

INSTRUCTIONS FOR COMPLETING EACH COLUMN

#1) EMPLOYMENT STATUS: (C) CONTRACT, (E) EMPLOYED OR (F) FACULTY
#2) SPECIALTY: CRNA, CRNP, NURSE MIDWIFE, PA, PODIATRIST, SURGICAL ASSISTANT
#3) IF CRNP OR PA, DOES INDIVIDUAL PRESCRIBE MEDICATION? INDICATE YES OR NO.
#4) IF CLAIMS MADE COVERAGE TYPE, INDICATE RETRO DATE.
#5) DATE OF EMPLOYMENT WITH FIRST NAMED INSURED (FNI).
#6) FULL TIME EQUIVALENCY (FTE) - CALCULATE FTE BY DIVIDING THE TOTAL # OF HOURS OF PROFESSIONAL SERVICE PER WEEK BY 40 HOURS.
#7) LICENSE NUMBER.
#8) COVERAGE SCOPE: (RE) RESTRICTED TO NAMED INSURED'S OPERATION OR (24) 24-HOUR COVERAGE.
#9) LIMITS: (SH) SHARED OR (SE) SEPARATE.

COLUMN #:	1	2	3	4	5	6	7	8	9
NAME OF MEDICAL PROFESSIONAL	(C), (E) OR (F)	SPECIALTY	PRESCR.? YES/NO	IF CM, RETRO DATE	DATE OF EMPL. WITH FNI	FTE	LICENSE #	(RE) OR (24)	(SH) OR (SE)