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

LABORATORIES FACILITIES LIABILITY APPLICATION

IMPORTANT NOTICE: CLAIMS-MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD, FOR SERVICES RENDERED BETWEEN THE RETROACTIVE DATE AND EXPIRATION DATE OF THE POLICY. PLEASE CONTACT YOUR AGENT SHOULD YOU HAVE ANY QUESTIONS PERTAINING TO THE DIFFERENCES BETWEEN CLAIMS-MADE AND OCCURRENCE COVERAGE OR THE ADDITIONAL EXPENSE ASSOCIATED WITH AN "EXTENSION CONTRACT" OR "TAIL COVERAGE."

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, STATE, "N/A".
3. IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SUPPLEMENTAL FORM.

I. 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**	$_____ EACH 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**	$_____ EACH EVENT/ $_____ GENERAL AGGREGATE	□ OCCURRENCE □ CLAIMS-MADE RETRO-DATE _____	

IF YOU ARE REQUESTING SHARED LIMIT OR SEPARATE LIMIT COVERAGE FOR EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS, ORAL SURGEONS, CRNA'S, NURSE MIDWIVES, CRNPS, PODIATRISTS, PHYSICIAN ASSISTANTS OR SURGICAL ASSISTANTS, PLEASE COMPLETE SECTION III. (COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE) OF THE LABORATORY FACILITIES SUPPLEMENTAL APPLICATION.

(*) IF YOU HAVE ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCS, PARTNERSHIPS, ETC.) PLEASE COMPLETE SECTION II (SCHEDULE OF RELATED ENTITIES) OF THE LABORATORIES FACILITIES SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF YOUR ORGANIZATIONAL CHART INCLUDING THE INFORMATION REQUESTED.

II. 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

II. ORGANIZATION INFORMATION (CONTINUED)

C. **REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM):** _____
THIS DATE CANNOT BE EARLIER THAN THE EXPIRATION DATE OF YOUR CURRENT POLICY.

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

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, ACQUISITIONS OR CHANGES IN OWNERSHIP 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

IF YES, PLEASE EXPLAIN: _____

F. **LICENSES HELD BY YOUR FACILITY:** _____

G. **CERTIFICATIONS/ACCREDITATIONS HELD BY YOUR FACILITY:** _____
□ CLIA □ JCAHO □ ISO □ OTHER (PLEASE EXPLAIN): _____
PLEASE PROVIDE A COPY OF YOUR CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

IF NONE, PLEASE EXPLAIN: _____

H. **ARE <u>ALL</u> LOCATIONS ACCREDITED BY AT LEAST ONE OF THE ORGANIZATIONS LISTED ON QUESTION III.G.?** □ 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 NUMBER EMAIL

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. ARE YOU OPERATING AS A:

☐ CLINICAL PATHOLOGY LAB (TO INCLUDE HEMATOLOGY, HISTOPATHOLOGY, CYTOLOGY, ROUTINE PATHOLOGY)

☐ CLINICAL MICROBIOLOGY LAB (TO INCLUDE BACTERIOLOGY, MYCOBATERIOLOGY, VIROLOGY, MYCOLOGY, PARASITOLOGY, IMMUNOLOGY, SEROLOGY, ETC.)

☐ CLINICAL BIOCHEMISTRY LAB (TO INCLUDE BIOCHEMICAL ANALYSIS, HORMONAL ASSAYS, ETC.)

☐ BLOOD BANK

☐ RESEARCH LAB

B. DO YOU DO ANY OF THE FOLLOWING? IF SO, LIST THE NUMBER OF TESTS FOR THE MOST RECENT YEAR.

☐ PAP SMEAR _____ ☐ GENETIC TESTING _____ ☐ DRUG TESTING _____

☐ SURGICAL _____ ☐ PATERNITY TESTING _____

☐ FORENSIC TESTING _____ ☐ REPRODUCTIVE TESTING _____

C. DO YOU PROVIDE LABORATORY TESTING TO PATIENTS WITHOUT PHYSICIAN'S ORDERS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

D. DO YOU COMPLY WITH THE STANDARDS AND/OR RULES SET FORTH BY CLIA FOR CYTOLOGY TESTING (TO INCLUDE PAP SMEARS, ETC.) WITH RESPECT TO WORKLOAD LIMITATION AND SPECIALIZED PROFICIENCY TESTING? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

E. WHAT PERCENTAGE OF YOUR FACILITY'S WORK IS OUTSOURCED TO OTHER LABS? _____%

PLEASE LIST THE OTHER LABS AND THEIR LOCATIONS (CITY/STATE): _____

_____

F. DO YOU HAVE AN ELECTRONIC TRACKING SYSTEM FOR ALL SPECIMENS THAT ARE PROCESSED? ☐ YES ☐ NO

G. ARE THERE ANY CIRCUMSTANCES WHEN TEST RESULTS ARE REPORTED DIRECTLY TO THE PATIENTS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

H. DO YOU HAVE A MEDICAL REVIEW OFFICER? ☐ YES ☐ NO

I. DO ALL EMPLOYEES PARTICIPATE AT THE TIME OF HIRE AND IN REGULARLY SCHEDULED TRAINING REGARDING SAFETY AND OPEARATIONAL PROCEDURES? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

J. DO YOU HAVE A WRITTEN SAFETY MANUAL USED BY ALL EMPLOYEES? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

K. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

L. DO YOU HAVE REGULARLY-SCHEDULED MAINTENANCE AND CALIBRATION OF ALL EQUIPMENT? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

M. DO YOU HAVE A WRITTEN COMPLIANCE MANUAL DETAILING THE APPROPRIATE CLEANING AND HANDLING OF ALL SPECIMENS? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

N. DO YOU HAVE A WRITTEN SYSTEM/PROCESS TO ASSURE LAB VALUES ARE SENT TO PROVIDERS IN A TIMELY FASHION? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

O. DO YOU HAVE A WRITTEN SYSTEM/PROCESS FOR NOTIFICATION OF CRITICAL VALUES? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

P. DO YOU HAVE A WRITTEN PROCEDURE FOR FOLLOW-UP IF PROVIDER IS UNAVAILABLE TO RECEIVE INFORMATION? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

Q. DO YOU HAVE A LABORATORY SOFTWARE SYSTEM THAT IS CAPABLE OF INTERFACING WITH THE 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: _____

R. DO YOU HAVE A PROTOCOL FOR VERBAL ORDERS AND TELEPHONE REPORTING OF INFORMATION AND VALUES? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

S. DO YOU PERFORM CONSULTATIONS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? ☐ YES ☐ NO

IF YES, WHICH STATES: _____

T. DOES YOUR FACILITY CONTRACT WITH COURIERS TO PICK UP SPECIMENS? ☐ YES ☐ NO

IF YES, DO YOU PERFORM QUALITY AUDITS ON AN ANNUAL BASIS OR HAVE ACONTRACT OF QUALITY STANDARDS? ☐ YES ☐ NO

U. DOES YOUR STAFF TRANSPORT SPECIMENS IN FACILITY-OWNED VEHICLES? ☐ YES ☐ NO

V. DO YOU MAINTAIN OR TRANSPORT SPECIMENS IDENTIFIED AS SELECT AGENTS BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OR THE UNITED STATES DEPARTMENT OF AGRICULTURE? ☐ YES ☐ NO

V. MEDICAL STAFF

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

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

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

B. Are each of the physicians practicing at your 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 your facility: _____

IMPORTANT NOTE: If coverage is desired for health professionals other than physicians, please indicate that on Section III. (Coverages, Limits and Deductible Schedule) **and Section V.** (Schedule of Medical Professionals) **of the Laboratory Facilities Supplemental Application. If separate limits coverage is desired, also submit an application for each individual for which 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			
PHLEBOTOMISTS			
TRANSCRIPTIONIST			
MEDICAL LABORATORY ASSISTANT			
SPECIMEN PROCESSOR (SECRETARY)			

D. Do you supervise anyone other than your own employees? ☐ Yes ☐ No

If Yes, describe the responsibility of the individuals and what your relationships are to these individuals:

_____

Also, indicate by type of medical professional, the number of individuals you supervise:

_____

VI. RISK MANAGEMENT

A. Is there a formal risk management program? ☐ Yes ☐ No

B. Is there a full-time risk manager? ☐ Yes ☐ No

If No, what are their other responsibilities and how much time is devoted to risk management?

_____

C. What is the name and title of the person responsible for these activities:

_____ _____

Name Title

VI. RISK MANAGEMENT (CONTINUED)

D. **IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS?** ☐ YES ☐ NO

E. **IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE?** ☐ YES ☐ NO

1. IF YES, IS THE PERSON RESPONSIBLE FOR RISK MANAGEMENT A MEMBER OF THIS COMMITTEE? ☐ YES ☐ NO
2. T OWHOM IS THE QUALITY ASSURANCE COMMITTEE ACCOUNTABLE?

NAME _____ TITLE _____

F. **IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS THAT IS PART OF THE QUALITY MGMT. PROGRAM?** ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

G. **IS THERE AN ON-GOING CONTINUEING EDUCATION PROGRAM FOR:**

NURSING STAFF? ☐ YES ☐ NO

OTHER ALLIED HEALTH PROFESSIONALS? ☐ YES ☐ NO

H. **NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:**

NAME _____ TITLE _____

VII. CREDENTIALING

A. **WHEN HIRING PROFESSIONALS AND SUPPORT STAFF DO YOU:**

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 PRIVELEGES?** ☐ YES ☐ NO

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

D. **DOES MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN, PODIATRIST AND DENTIST WORKING AT YOUR FACILITY MAINTAIN PROFESSIONAL LIABILITY INSURANCE?** ☐ YES ☐ NO

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

E. **WHAT ARE THE MINIMUM LIMITS OF LIABILITY YOU REQUIRE NON-PHYSICIAN MEDICAL PROFESSIONAL WORKING AT YOUR FACILITY TO CARRY?**

$_____ / $_____

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIUDAL TO VERIFY COVERAGE? ☐ YES ☐ NO

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

IF YES, PLEASE EXPLAIN: _____

G. **HAVE YOU 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

IF YES, PLEASE EXPLAIN: _____

VIII. PHYSICAL PLANT

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

ADDRESS OF PROPERTY TO BE INSURED	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

DO YOU DESIRE GENERAL LIABILITY COVERAGE? ☐ YES ☐ NO

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

A. IS THERE A PREVENTATIVE MAINTENANCE PROGRAM IN PLACE FOR THE 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 ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS
3. IF INDEPENDENT CONTRACTOS, WHAT ARE THE MINIMUM GENERAL LIABILITY LIMITS THAT YOU REQUIRE THEM TO CARRY?

   $_____ / $_____
4. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

B. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE PREVENTATIVE MAINTENANCE, INSPECTION AND REPAIR OF THE EQUIPMENT? _____

C. DO YOU LEND OR DONATE YOUR BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE? ☐ YES ☐ NO

IF YES, DESCRIBE: _____

D. DO YOU RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? _____

E. DO YOU USE AN ADVERTISING AGENCY? ☐ YES ☐ NO

1. IF YES, WHAT IS THE MINIMUM MINIMUM PROFESSIONAL LIABILITY LIMITS THAT YOU REQUIRE THEM TO CARRY?

   $_____ / $_____
2. ARE YOU 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 YOUR FACILITY? ☐ YES ☐ NO

F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS 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 PROJECTED NUMBER OR AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS.

☐ HABITATIONAL RISK: INDICATE IF AN: ☐ APARTMENT ☐ DWELLING ☐ HOTEL

1. NUMBER OF UNITS: _____ UNITS YEAR BUILT: _____

   A) ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER? ☐ YES ☐ NO

   B) FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? ☐ YES ☐ NO

   ☐ PAY PARKING: RECEIPTS/YEAR: $_____

   ☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS: RECEIPTS/YEAR: $_____
2. DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED: _____

H. DO YOU LEASE SPACE TO OTHERS? ☐ YES ☐ NO

IF YES, INDICATE THE FOLLOWING:

_____
CITY, STATE AND ZIP CODE

_____ _____
SQUARE FOOTAGE OCCUPANCY/USE OF SPACE

1. DOES YOUR LEASE REQUIRE THE TENANT TO CARRY A GENERAL LIABILITY (GL) INSURANCE POLICY WITH A LIMIT OF $1,000,000 PER OCCURRENCE? ☐ YES ☐ NO
2. DO YOU OBTAIN CERTIFICATES OF INSURANCE ANNUALLY TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO
3. IS THE TENANT REQUIRED TO LIST YOU AS AN ADDITIONAL INSURED ON THEIR GENERAL LIABILITY POLICY? ☐ YES ☐ NO

X. EXCESS LIABILITY

DO YOU DESIRE EXCESS LIABILITY COVERAGE? ☐ YES ☐ NO

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

A. HAVE YOUR 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 INCRASED?

$_____ / $_____ _____ _____
MM YYYY

XI. COVERAGE HISTORY AND INFORMATION

****NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATE OF MISSOURI.**

A. **HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER INSURANCE COVERAGE?** □ YES □ NO

IF YES, PLEASE PROVIDE DETAILS: _____

_____

B. **PLEASE CHECK WHICH TYPE OF NOTICE YOUR PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE THEY WILL FORMALLY RECOGNIZE A CLAIM UNDER THEIR POLICY:**

□ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

□ WRITTEN NOTICE FROM YOU THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

C. **HAVE YOU CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS?** □ YES □ NO

IF YES, HAVE YOU FORWARDED THEM TO YOUR CURRENT INSURER? □ YES □ NO

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 YOUR 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! FULLY COMPLETE)

FOR EACH CLAIM, POTENTIAL CLAIM OR SUIT MENTIONED BELOW, PLEASE COMPLETE SECTION I. (LOSS HISTORY) OF THE LABORATORY FACILITY SUPPLEMENTAL APPLICATION.

A. HAS YOUR 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 YOUR INSURER? ☐ YES ☐ NO

B. DOES YOUR ORGANIZATION OR ANY OF YOUR EMPLOYEES/CONTRACTORS HAVE KNOWLEDGE OF ANY INCIDENT, OR UNEXPECTED ADVERSE OUTCOME RESULTING IN INJURY OR DEATH, CLAIM, POTENTIAL CLAIM, OR SUIT IN WHICH YOU 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 ORGANIZATION WHICH MAY GIVE RISE TO A CLAIM? ☐ YES ☐ NO

IF YES, HOW MANY? _____

IF YES, HAVE THESE BEEN REPORTED TO YOUR INSURER? ☐ YES ☐ NO

XIII. ATTACHMENTS

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

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

XIV. PLEASE READ AND SIGN

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 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

XV. FRAUD NOTICE

MANDATORY: ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

INITIAL HERE

XVI. SUPPLEMENTAL INFORMATION

LABORATORIES FACILITIES SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF YOU HAVE BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY FOR LESS THAN TEN YEARS, 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.

THE LOSS INFORMATION SHOULD ADDRESS BOTH YOUR 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), HEALTHCARE 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 YOUR 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

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 LABORATORY FACILITIES LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE LABORATORY FACILITIES 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 LABORATORY FACILITIES LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE LABORATORY FACILITIES LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - 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 LABORATORY FACILITIES.**	☐ NONE ☐ $25,000 ☐ $5,000 ☐ $50,000 ☐ $10,000 ☐ 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 LABORATORY FACILITIES.**	☐ NONE ☐ $25,000 ☐ $5,000 ☐ $50,000 ☐ $10,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE

III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (IF SHARED OR SEPARATE PHYSICIAN OR ALLIED COVERAGE IS BEING REQUESTED) (CONTINUED)

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 SERVICE). **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 STATUS: (C)ONTRACT (E)MPLOYED (F)ACULTY (R)ESIDENT	NUMBER OF PROCEDURES PERFORMED AT THE PATHOLOGY LAB	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOY-MENT 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)