PROFESSIONAL LIABILITY APPLICATION FOR ALLIED MEDICAL LABORATORIES, MEDICAL IMAGING CENTERS INSURANCE

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Applicant Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. County (parish) of Each Location:_____

_____

5. Person to Contact for Survey: Name:_____ Title:_____

6. Date Established:_____

7. The applicant is:

[ ] Corporation
[ ] Employee (W-2)
[ ] Independent Contractor (1099)
[ ] Partnership
[ ] Sole Practitioner
[ ] Sole Proprietorship
[ ] Student
[ ] Other; Describe: _____

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

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

10. 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.

_____

11. Total premises square footage occupied by applicant:_____

12. List memberships in professional organizations:_____

_____

PART II. EXPOSURES

1. Annual Gross Receipts or Budget: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

2. Number of tests performed: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

3. Number of patient contacts: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

4. Service is licensed as:_____

5. Describe the nature of insured's operation including types of services rendered and activities conducted:

   _____

   _____

   _____

6. (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. _____

   _____

7. 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	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. _____

_____

8. Provide the percentage of services provided for:

Hospitals	_____%	Nursing Homes	_____%	Industrial Facilities	_____%
Vet Clinics	_____%	Physicians' Offices	_____%	Other (describe)	_____%

_____

9. 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.

_____

10. (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: _____

11. Does the Applicant provide any services under contract? [ ] Yes [ ] No

If Yes, provide a details. _____

PART III. RISK MANAGEMENT

1. Name, qualifications, and number or years of experience of the Medical Director:

Name Title Experience/Training Association Membership

_____

2. Name, qualifications, and number or years of experience of the Medical Review Officer:

Name Title Experience/Training Association Membership

_____

3. (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? _____

4. (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 employed, 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? _____

5. Do you enter into any contractual agreements (other than lease of premises agreements)? [ ] Yes [ ] No

   If yes, attach explanation.

6. Does the applicant advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. [ ] Yes [ ] No

7. Do you require staff to report all incidents (accidents) which might result in a liability claim **and** are records of such reports kept on file by you? [ ] Yes [ ] No

   If not, are you agreeable to instituting this procedure? [ ] Yes [ ] No

8. Are the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. [ ] Yes [ ] No

9. Has the applicant or any of its employees:

   a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? [ ] Yes [ ] No

   b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? [ ] Yes [ ] No

   c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] Yes [ ] No

   If the answer to any of 12 is yes, please attach a detailed explanation.

10. Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. [ ] None [ ] Description Attached

PART IV. HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

2, List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

3. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] Yes [ ] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

_____

_____

_____

_____

4. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [ ] Yes [ ] No

If yes, describe the event and indicate the reason for anticipation of a claim:_____

_____

_____

_____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and MarketScout, any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

_____

Applicant Signature

_____

Title

_____

Date