



Patriot Insurance Agency, Inc.

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE FOR CLINICS: MEDICAL, PUBLIC HEALTH, DENTAL AND H.M.O. (CLAIMS MADE BASIS)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If a question is not applicable, state **NOT APPLICABLE**.
2. If space is insufficient to answer any questions fully, use last page or attach separate sheet.
3. Application must be signed and dated by owner, partner, officer or administrator.
4. If the answer to any question is none, state NONE.
5. Please do not complete application earlier than 45 days before proposed effective date of coverage.

(PLEASE TYPE OR PRINT IN INK)

1. (a) Full Name of Applicant: _____ (b) Business Phone (_____) _____

2. (a) Principal Business Address: (Attached list of any additional locations.)

No.	Street	Town	County	State	Zip
3. Total sq. Ft. occupied by applicant (all locations): _____
4. Indicate year established: _____
5. Amount of insurance desired: _____ (Limits in policy will govern coverage.)
6. (a) Applicant is:

<input type="checkbox"/> Professional Corporation (for profit)	<input type="checkbox"/> Partnership
<input type="checkbox"/> Professional Corporation (non-profit)	<input type="checkbox"/> Professional Association
<input type="checkbox"/> Other (describe) _____	
- (b) The business, corporate or partnership name is: _____
- (c) Give names of all partners or members of the firm who provide professional services: _____

- (d) Attach a copy of letterhead or other business stationery.
7. In what states is the applicant registered and licensed to practice? _____
(If none, attach explanation)

8. Indicate applicant's professional specialty: _____

9. Does the applicant maintain any beds for overnight occupancy? Yes No.
If yes, complete application form SM 271 or SM 686.

10. State approximate division of applicant's patients or clients among:

(a) Hemodialysis	_____%	(g) Psychiatric	_____%	(m) Bariatrics	_____%
(b) Holistic Medicine	_____%	(h) Drug Addicts	_____%	(n) Physical Rehabilitation	_____%
(c) Surgical	_____%	(I) Alcoholics	_____%	(o) Disability Evaluation	_____%
(d) Stress Testing	_____%	(j) Obstetrical	_____%	(p) Research on Experimental	_____%
(e) Communicable	_____%	(k) Dental	_____%	(q) _____	_____%
(f) Family Planning	_____%	(l) Pediatric	_____%	(r) _____	_____%

11. Does the applicant use a collection agency? Yes No. If yes, give name of agency _____
Has the agency authority to file a collection suite at its discretion? Yes No.

12. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes No. . If yes, give details, including name, location, size and number of beds.

13. Indicate professional societies or associations in which applicant is a member: _____

14. Does the applicant perform: YES NO

A.	Acupuncture or acupuncture anesthesia? Explain: _____	A.	<input type="checkbox"/>	<input type="checkbox"/>
B.	Angiography/Arteriography/Venography? Describe: _____	B.	<input type="checkbox"/>	<input type="checkbox"/>
C.	Cauterization (other than urinary or umbilical)? Describe procedure: _____	C.	<input type="checkbox"/>	<input type="checkbox"/>
D.	Closed reduction of compound fractures and/or Normal Deliveries and/or Dermabrasion?	D.	<input type="checkbox"/>	<input type="checkbox"/>
E.	Injection of radioisotopes and/or use of irradiated substances? Describe: _____	E.	<input type="checkbox"/>	<input type="checkbox"/>
F.	Radiation Therapy and/or Chemotherapy? Describe: _____	F.	<input type="checkbox"/>	<input type="checkbox"/>
G.	Psychiatric shock therapy?	G.	<input type="checkbox"/>	<input type="checkbox"/>
H.	Silicone Injections? Describe: _____	H.	<input type="checkbox"/>	<input type="checkbox"/>
I.	Spinal Anesthesia (other than saddle blocks or caudal(s))	I.	<input type="checkbox"/>	<input type="checkbox"/>
J.	Laser treatment? Describe: _____	J.	<input type="checkbox"/>	<input type="checkbox"/>
K.	Experimental procedures or research testing? Describe in detail on separate sheet	K.	<input type="checkbox"/>	<input type="checkbox"/>
L.	Hypnosis? Describe: _____	L.	<input type="checkbox"/>	<input type="checkbox"/>

15. Does the applicant perform any:

A.	Surgery other than incision of superficial boils or suturing superficial facial	A.	<input type="checkbox"/>	<input type="checkbox"/>
B.	Circumosions and/or dilation and curettage and/or insertion of temporary pacemakers?	B.	<input type="checkbox"/>	<input type="checkbox"/>
C.	Tonsillectomies and/or Adenoidectomies and/or Caesarian Sections?	C.	<input type="checkbox"/>	<input type="checkbox"/>
D.	Cosmetic Plastic Surgery? Describe: _____	D.	<input type="checkbox"/>	<input type="checkbox"/>
E.	Excision of large cysts and/or I & D of deep-seated boils or carbuncles?	E.	<input type="checkbox"/>	<input type="checkbox"/>
F.	Hysterectomies?	F.	<input type="checkbox"/>	<input type="checkbox"/>
G.	Open reduction of fractures? Describe: _____	G.	<input type="checkbox"/>	<input type="checkbox"/>
H.	Surgery for weight reduction of patients?	H.	<input type="checkbox"/>	<input type="checkbox"/>
I.	Abortions and/or menstrual extractions? Describe (include trimester, method, And number of abortions performed per month): _____	I.	<input type="checkbox"/>	<input type="checkbox"/>
J.	Cryosurgery (other than use on benign or pre-malignant dermatological Lesions)? Describe: _____	J.	<input type="checkbox"/>	<input type="checkbox"/>

15. Does the applicant perform any (Continued) YES NO
- | | | | | |
|----|--|----|--------------------------|--------------------------|
| K. | Silicone implants? Describe: _____ | K. | <input type="checkbox"/> | <input type="checkbox"/> |
| L. | Sterilization Procedures? Describe: _____ | L. | <input type="checkbox"/> | <input type="checkbox"/> |
| M. | Biopsies and/or endoscopies? List types performed: _____ | M. | <input type="checkbox"/> | <input type="checkbox"/> |
| N. | Sex change operations? Describe and advise number yearly: _____ | N. | <input type="checkbox"/> | <input type="checkbox"/> |
| O. | Experimental surgery or surgical research? Describe in detail on separate sheet. | O. | <input type="checkbox"/> | <input type="checkbox"/> |
| P. | Other Surgery? Describe: _____ | P. | <input type="checkbox"/> | <input type="checkbox"/> |

16. (a) Does applicant perform or engage in any surgical procedure(s) in its professional office or similar non-hospital facility? Yes No. If yes, answer (b) and (c) below.
- (b) List ALL surgical procedures performed (including minor surgery): _____
- (c) Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others Yes No. If yes, attach detailed explanation.

17. Does the applicant perform hospital emergency room care for patients not its own? Yes No. If yes, attach explanation and also advise the number "patient contract" hours MONTHLY by applicant's:

- | | | | | | |
|----|---------------------------|------------|----|--------|------------|
| A. | Emergency Room Physicians | _____ hrs. | C. | Nurses | _____ hrs. |
| B. | Paramedics | _____ hrs. | D. | _____ | _____ hrs. |

18. Does the applicant use drugs for weight reduction or patients? Yes No. If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions or weight reduction drugs, and quantity dispensed by applicant.

19. Does the applicant administer any methadone treatment? Yes No. If yes, describe on separate sheet treatment and controls used and indicate number of treatment during: Last 12 months _____; Next 12 months _____.

20. Number of annual X-ray exposures: for diagnosis _____; for treatment _____.

21. If X-ray treatment is given, what qualifications are required of the staff? _____

22. Does the applicant participate in any activity, e.g., newspaper columns, broadcasts, etc., whereby professional advise is offered to the public? Yes No. If yes, please attach detailed explanation of this activity.

23. Does applicant own or operate any business other than that show in Question 1(a) above Yes No. If yes, please give details on separate sheet.

24. Indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE.

	No. of Employees and Volunteers	No. of Independent Contractors	No. of Employees and Volunteers	No. of Independent Contractors
(a) Physicians: NO surgery (other than incision of boils, suturing of skin) or obstetrical procedures	_____	_____	(g) Physicians & Surgeon's Assistants, Nurse Practitioners (describe duties on separate sheet)	_____
(b) Physicians: Minor Surgery or obstetrical procedures not constituting major surgery	_____	_____	(h) Unlicensed Interns	_____
			(I) Dentist (no oral surgery	_____

25. Indicate the number of professional employees, volunteers and independent contractors.
IF NONE, STATE NONE. (Continued).

	No. of Employees and Volunteers	No. of Independent Contractors		No. of Employees and Volunteers	No. of Independent Contractors
(c) Proctologists, Ophthalmologists and Urologists	_____	_____	(j) Orthodontists	_____	_____
(d) General Surgeons, Cardio Surgeons and Surgeon, and Otolaryngologists (no plastic surgery)	_____	_____	(k) Oral Surgeons	_____	_____
(e) Obstetrics-Synecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	_____	_____	(m) Optometrists, Opticians	_____	_____
			(n) Pharmacists	_____	_____
			(o) Perfusionists	_____	_____
			(p) Podiatrists	_____	_____
(f) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	_____	_____	(q) Chiropractors	_____	_____
			(r) Rns, LPNs	_____	_____

NOTE: If you require any of the above to be Named Insureds, please submit separate application for each such individual.

25. Are all of the above individuals licensed in accordance with applicable state and federal regulation?
 Yes No. If no, attach explanation.

26. ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or any of the above employees:

YES NO

(a) Ever been subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association

(a)

(b) Ever been convicted for a act committed in violation of any law or ordinance other than traffic offenses?

(b)

(c) Ever been treated for alcoholism or drug addiction?

(c)

(d) Ever had any state professional license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?

(d)

(e) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?

(e)

27. Does the applicant supervise any individuals other than its own employees? Yes No. If yes, provide detailed explanation or responsibilities and relationship to the entity which employs these individuals.

28. State sources and amounts of total revenue:

Source	Amount This Fiscal Year	Amount Next Fiscal Year
A. Charitable Contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee for Service	\$ _____	\$ _____
D. _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

29. Provide number of outpatient visits:

Type of Visit	Number of Visits Last 12 Months	Number of Visits Next 12 Months
Clinic	# _____	# _____
Laboratory	# _____	# _____
Emergency Room	# _____	# _____
_____	# _____	# _____
_____	# _____	# _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

30. If applicant has a training school, complete the following. Attach separate schedule if needed.

<u>Specify Profession for Which Student Are Being Trained</u>	<u>Max. No. of Students Per Session</u>	<u>No. of Sessions per Year</u> <u>Clinical Setting</u>	<u>% of Time Involved in Faculty</u>	<u>Number of Qualification of Faculty</u> <u>(Eg. MD, RN, Phd, etc.)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

31. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone director?) Yes No. If yes, attach a copy of ALL of the advertisements.

32. 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, attach detailed explanation and a copy of ALL of the advertisements.

33. Is the applicant employed by any individual or entity other than that shown in Question 1(a) above? Yes No. If yes, attach detailed explanation.

34. Is the applicant under contract to any individual or entity other than shown in Question 1(a) above?
 Yes **No.** If this contract contains a hold-harmless agreement, copy of contract must be attached.
35. Is the applicant in the employ of any federal governmental entity? **Yes** **No.** . If yes, attached explanation.
36. Is the applicant under contract to any federal governmental entity? **Yes** **No.** If yes, attached explanation.
37. Name and give locations of any hospitals or institutions the applicant uses in practice: _____
38. Describe in detail any additional activities and/or procedures performed by the applicant:
39. Has any claim or suit been brought against the applicant and/or any of its employees **Yes** **No.**
 If yes, a supplemental claim information form must be completed for each claim or suit.
40. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against the applicant or any of its employees? **Yes** **No.** If yes, give details on separate sheet.
41. List prior professional liability Insurance carried for each of the past four years. ***IF NONE, STATE NONE.***

<u>Insurance Carrier</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible (if any?)</u>	<u>Premium</u>	<u>Inception Exp. Mo/Dav/Yr</u>	<u>Expiration Mo/Dav/Yr</u>	<u>Was this a Claims Made Policy Form?</u>
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No.
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No.
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No.
_____	_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No.

42. If prior professional liability insurance was on a claims made basis, advise the retroactive exclusion date of the coverage. _____

WARRANTY: It is warranted to Royal Surplus Insurance that the information contained herein is true and that shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of the application by issuance of a policy. If we hereby authorize the release of claim information form any prior Insurer to Landmark Insurance Company PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force.

Signature of Applicant _____ Title _____ Date _____

One signed copy will be attached to the policy, cover note or certificate, if issued.

*SIGNING THIS FORM AND TENDERING PREMIUM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Applicant MUST be currently signed and dated to be considered for quotation.

CHECKLIST FOR CLINICAL SERVICES

Account Number: _____ Contact Name: _____

Telephone Number: _____ Fax Number: _____

Services Provided:

SONOGRAM:

Vaginal Probe:

External Probe:

DOPPLER

TESTING FOR SEXUAL TRANSMITTED DISEASES

**Please provide in full detail the following on a separate sheet of paper:*

1. Approximate number of patient contacts
2. Please provide a list of your responses to the following questions:
 1. What diseases are being testing?
 2. How will the specimen be collected?
 3. Who is performing the Lab Work?
 4. What treatment is being afforded?

BLOOD WORK

LAMINARY REMOVAL

ANY PRE NATAL CARE

IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES

GYNOCOLOGIST SERVICES

IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES

OTHER SERVICES: _____

IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES

DOCTOR(S) TO BE INCLUDED

**If Yes, please provide a copy of the Doctor/Physician's license and
also a Description of the type of services they will be providing.**

Director's Signature

Date

