



1. NAME OF APPLICANT: _____
(If other than parent firm, supply full details of ownership entity)

2. a) MAILING ADDRESS: _____ Phone No. _____
(If multiple name and locations, please attach list)

b) Square feet of total office space (all locations) _____

3. a) DATE ESTABLISHED: _____ Corp. _____ Partnership _____ Prof. Assoc. _____ Individual _____

b) In what state is the applicant registered and licensed to practice? _____

c) Normal hours of operation: _____

4. Is the firm engaged in, owned by, associated with or controlled by any other business? _____
If yes, give details _____

5. PROFESSIONAL ACTIVITIES AND SPECIALTY (Attach narrative description if necessary) Check One:

_____ Health Maintenance Organization

_____ Home Healthcare Agency

_____ Medical/Testing Laboratory

_____ Nurse's Registry

_____ Out-Patient Clinic

_____ Services to nursing homes

_____ Residential Healthcare Facility

_____ Other (Specify) _____

6. State approximate division of applicant's patients among:

- (a) Alcoholics () %
- (b) Counseling/Family Planning () %
- (c) Communicable () %
- (d) Dental () %
- (e) Drug Addicts () %
- (f) General () %
- (g) Hemodialysis () %
- (h) Holistic Medicine () %
- (i) Medical () %
- (j) Mentally Retarded () %

- (k) Obstetrical () %
- (l) Pediatric () %
- (m) Psychiatric () %
- (n) Research or Experimental () %
- (o) Senile or Aged () %
- (p) Stress Testing () %
- (q) Surgical () %
- (r) Tubercular () %
- (s) Other _____ () %

7. a. List the number and type of applicant's employees and volunteers: If None, State None.

NUMBER	Type of Profession	NUMBER	Type of Profession
(a) _____	Inhalation Therapists	(e) _____	Nurse Practitioner
(b) _____	Laboratory Technicians	(f) _____	Nurses Registered
(c) _____	Nurse Anesthetists	(g) _____	Opticians
(d) _____	Nurses, Licensed Practical	(h) _____	Optometrists

NUMBER	Type of Profession	NUMBER	Type of Profession
(i) _____	Perfusionists	(m) _____	Physiotherapists
(j) _____	Pharmacists	(n) _____	Social Workers
(k) _____	Physicians -- minor surgery	(o) _____	Speech Therapists
(l) _____	Physicians -- no surgery	(p) _____	Other

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b. List the number and type of independent contractors who provide professional services on behalf of the applicant. IF NONE, STATE NONE. _____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations? ___ Yes ___ No
If no, attach explanation.

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

- Has the applicant or have any of the above employees:
- | | YES | NO |
|--|---------|-----|
| (a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? | (a) ___ | ___ |
| (b) Ever been convicted for an 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 or license to prescribe or dispense narcotics refused, Suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? | (d) ___ | ___ |
8. Does the applicant perform:
- | | YES | NO |
|---|--------|-----|
| A. Acupuncture or acupuncture anesthesia? Explain: _____ | A. ___ | ___ |
| B. Angiography/ Arteriography/ Venography? Describe: _____ | B. ___ | ___ |
| C. Catheterization (other than urinary or umbilical)?
Describe Procedure: _____ | C. ___ | ___ |
| D. Closed Reduction of compound fractures and/or Normal Deliveries and/or Dermabrasion? | D. ___ | ___ |
| E. Injection of radioisotopes and/or use of irradiated substances?
Describe: _____ | E. ___ | ___ |
| F. Radiation Therapy and/or Chemotherapy? Describe: _____ | F. ___ | ___ |
| G. Psychiatric shock therapy? | G. ___ | ___ |
| H. Silicone Injections? Describe: _____ | H. ___ | ___ |
| I. Spinal Anesthesia (other than saddle blocks or caudals)? | I. ___ | ___ |
| J. Laser treatment? Describe: _____ | J. ___ | ___ |
9. Does the applicant perform any:
- | | | |
|--|--------|-----|
| A. Surgery other than incision of superficial boils or suturing superficial fascia? | A. ___ | ___ |
| B. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? | B. ___ | ___ |
| C. Tonsillectomies and/ or Adenoidectomies and/or Caesarean Sections? | C. ___ | ___ |
| D. Cosmetic Plastic Surgery? Describe: _____ | D. ___ | ___ |
| E. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? | E. ___ | ___ |
| F. Hysterectomies? | F. ___ | ___ |
| G. Open reduction of fractures? Describe: _____ | G. ___ | ___ |
| H. Surgery for weight reduction of patients? | H. ___ | ___ |
| I. Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): _____ | I. ___ | ___ |
| J. Cryosurgery (other than use on benign or pre-malignant dermatological lesions)?
Describe: _____ | J. ___ | ___ |
| K. Silicon Implants? Describe: _____ | K. ___ | ___ |
| L. Sterilization Procedures? Describe: _____ | L. ___ | ___ |
| M. Biopsies and/or endoscopies? List types performed: _____ | M. ___ | ___ |
| N. Sex change operations? Describe and advise the number performed per year: _____ | N. ___ | ___ |
| O. Other Surgery? Describe: _____ | O. ___ | ___ |
10. Does the applicant perform hospital emergency room care?
- (a) for its own regular patients? ___ Yes ___ No (b) for patients not its own? ___ Yes ___ No
- (b) if the answer to (b) is yes, please specify: the percentage of its time devoted to this work = _____%, the number of hours per month devoted to this work = _____ hrs.

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11. Does the applicant use drugs for weight reduction of 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 for weight reduction drugs, and quantity dispensed by applicant.
12. Does the applicant administer any methadone treatment? Yes No If yes, describe treatment and controls used and indicate number of treatments during last 12 months _____ Next 12 months _____
13. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes No If yes, attach detailed explanation.
14. Does the applicant maintain any beds for overnight occupant? Yes No If yes, total number: _____
15. State number of X – ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom treatment is given and number of procedures: _____

16. 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. _____

17. State sources and amounts of total revenue

Source	Amount Last Policy Year	Est. Amount This Policy Year
A. Charitable Contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee for Service	\$ _____	\$ _____
D. _____	\$ _____	\$ _____
E. _____	\$ _____	\$ _____
TOTAL GROSS REVENUE:	\$ _____	\$ _____

18. Number of patient encounters last 12 Months _____ and/or patient tests carried out _____
 (NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

19. Number of estimated patient encounters next 12 months _____ and/or patient tests carried out _____
 (NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

20. If applicant has a training school, complete the following.

Specify profession for which students are being trained	Max. No. of students per session	No. of sessions per year	% of Time involved in clinical setting	Number of students	Qualifications of faculty (e.g. MD, RN, PHD)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

21. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims-made policy, what is the retroactive date? _____

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22. Is the Applicant currently insured under a Commercial General Liability Policy? Yes ___ No ___ If yes, please give details:

Insurance Company	Type of Coverage	BI	Limits	PD	Effective From	To
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23. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? Yes ___ No ___
If yes, please give details: _____

24. Has any claim ever been made against the firm or any of its employees? Yes ___ No ___ If yes, please attach details stating: 1) date when claim was made; 2) date of the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

25. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any present or past Partners or Officers? Yes ___ No ___ If yes, please give full details on the same basis as item 23.

26. Has any insurer cancelled or refused to renew any similar insurance during the past five years? _____

27. Limits of Liability requested _____ Deductible _____

28. Desired term of policy: From _____ To _____

29. The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy.

The applicant understands that and subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Date

Signature of Applicant Title

Producer