

- f. Does Clinic use a collection agency? [] Yes [] No
If yes, name of agency: _____
Does the agency have authority to file a collection suit on Clinics behalf? [] Yes [] No
- g. Do owners, partners or directors, (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. _____

- h. Do you own or operate any business other than that shown in question 1a? [] Yes [] No
If yes, please attach detailed explanations of this activity.
- i. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? [] Yes [] No
If yes, please attach a copy of ALL of the advertisements.
- j. Names and locations of any hospitals or institutions Clinic use is in practice: _____

3. PROFESSIONAL SERVICES

- a. Do you perform:
 - (i) Acupuncture or acupuncture anesthesia? Explain: [] Yes [] No
 - (ii) Angiography/arteriography/venography? Describe: [] Yes [] No
 - (iii) Catheterization (other than urinary or umbilical)? Describe: [] Yes [] No
 - (iv) Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? [] Yes [] No
 - (v) Injection of radioisotopes and/or use of irradiated substances? Describe: [] Yes [] No

 - (vi) Radiation therapy and/or chemotherapy? Describe: [] Yes [] No
 - (vii) Psychiatric shock therapy? [] Yes [] No
 - (viii) Silicone injections? Describe: [] Yes [] No
 - (ix) Spinal anesthesia (other than saddle blocks or caudals)? [] Yes [] No
 - (x) Laser treatment? Describe: [] Yes [] No
 - (xi) Experimental procedures or research testing? Describe in detail on separate sheet. [] Yes [] No
 - (xii) Hypnosis? Describe: [] Yes [] No
- b. Do you perform:
 - (i) Norplant insertion/removals advise # yearly [] Yes [] No
 - (ii) Surgery other than incision of superficial boils or suturing superficial fascia? [] Yes [] No
 - (iii) Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker? [] Yes [] No
 - (iv) Tonsillectomies and/or adenoidectomies and/or caesarean sections? [] Yes [] No
 - (v) Cosmetic plastic surgery? Describe: [] Yes [] No
 - (vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles? [] Yes [] No
 - (vii) Hysterectomies? [] Yes [] No
 - (viii) Open reduction of fractures? Describe: [] Yes [] No
 - (ix) Surgery for weight reduction of patients? [] Yes [] No
 - (x) Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): [] Yes [] No
 - (xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: [] Yes [] No
 - (xii) Silicone implants? Describe: [] Yes [] No
 - (xiii) Sterilization procedures? Describe: [] Yes [] No
 - (xiv) Biopsies and/or endoscopies? List types performed: [] Yes [] No
 - (xv) Sex change operations? Describe and advise number yearly: [] Yes [] No
 - (xvi) Experimental surgery or surgical research? Describe in detail on separate sheet. [] Yes [] No
 - (xvii) Other surgery? Describe: [] Yes [] No

- c. (i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? [] Yes [] No
If yes, answer (ii) and (iii) below.
- (ii) List ALL surgical procedures performed (including minor surgery): _____

- (iii) Do you administer anesthesia (other than topical or local infiltration)?..... [] Yes [] No
If yes, please attach detailed explanation.
- d. Do you perform hospital emergency room care for patients not your own?..... [] Yes [] No
If yes, please attach explanation and also advise the number "patient contact" hours MONTHLY by you:
- (i) Emergency Room Physicians _____ hrs. (iii) Nurses _____ hrs.
(ii) Paramedics _____ hrs. (iv) Other _____ hrs.
- e. Do you use drugs for weight reduction or patients?..... [] Yes [] No
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.
- f. Do you administer any methadone treatment? [] Yes [] No
If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months _____; Next 12 months _____.
- g. Number of annual x-ray exposures: for diagnosis _____; for treatment _____.
- h. If x-ray treatment is given, what qualifications are required of the staff? _____

- i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity. [] Yes [] No
- j. Attach detailed description of any additional activities and/or procedures which you performed.

4. STAFF

a. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE.

	<u>Employees and Volunteers</u>	<u>Independent Contractors</u>		<u>Employees and Volunteers</u>	<u>Independent Contractors</u>
(i) Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	_____	_____	(xi) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	_____	_____
(ii) Physicians: Minor surgery or obstetrical procedures not constituting major surgery	_____	_____	(xii) Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet	_____	_____
(iii) Proctologists, Ophthalmologists and Urologists	_____	_____	(xiii) Unlicensed Interns	_____	_____
(iv) General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____	(xiv) Dentists (no oral surgery)	_____	_____
(v) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	_____	_____	(xv) Orthodontists	_____	_____
(vi) Oral Surgeons	_____	_____	(xvi) Podiatrists	_____	_____
(vii) Nurse Anesthetists	_____	_____	(xvii) Chiropractors	_____	_____
(viii) Optometrists, Opticians	_____	_____	(xviii) RN, LPNs	_____	_____
(ix) Pharmacists	_____	_____	(xix) Other _____	_____	_____
(x) Perfusionists	_____	_____	(xx) _____	_____	_____

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

- b. Are all of the above individuals licensed in accordance with applicable state and federal regulation? . [] Yes [] No
If no, please attach explanation.
- c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:
- (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association? [] Yes [] No
 - (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?..... [] Yes [] No
 - (iii) Ever been treated for alcoholism or drug addiction? [] Yes [] No
 - (iv) 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?..... [] Yes [] No
 - (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? [] Yes [] No
- d. Do you supervise any individual other than your own employees? [] Yes [] No
If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals. _____

Also, indicate by profession the number of individuals supervised.

<u>Number</u>	<u>Type of Profession</u>	<u>Number</u>	<u>Type of Profession</u>
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technician	_____	_____

5. REVENUES

- a. Please state sources and amounts of total revenue:

<u>Source</u>	<u>This Fiscal Year</u>	<u>Next Fiscal Year</u>
(i) Charitable Contributions	\$ _____	\$ _____
(ii) Government Funding	\$ _____	\$ _____
(iii) Fee for Service	\$ _____	\$ _____
(iv) Other _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

- b. Please provide number of outpatient visits:

<u>Type of Visit</u>	<u>Last 12 Months</u>	<u>Next 12 Months</u>
Clinics	_____	_____
Laboratory	_____	_____
Emergency Room	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL NO. OF VISITS	_____	_____

- c. If you have a training school, please complete the following. Attach separate schedule if needed.

<u>Specify Profession for Which Students Are Being Trained</u>	<u>Max. No. of Students Per Session</u>	<u>No. of Sessions Per Year</u>	<u>% of Time Involved in Clinical Setting</u>	<u>Number of Faculty</u>	<u>Qualifications of Faculty (i.e., MD, RN, PhD., etc.)</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

6. AFFILIATIONS

- a. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients?[Yes [No
If yes, please attach detailed explanation and a copy of ALL of the advertisements.
- b. Are you employed by any individual or entity other than that shown in Question 1(a) ?.....[Yes [No
If yes, please attach explanation.
- c. Are you under contract to any individual or entity other than that shown in Question 1(a)?[Yes [No
If this contract contains a hold-harmless agreement, copy of contract must be attached.
- d. Are you in the employ of or under contract to any federal governmental entity?[Yes [No

7. HISTORY/CLAIMS

- a. Has any claim or suit been brought against you and/or any of your employees?[Yes [No
If yes, a supplemental claim information form must be completed for each claim or suit.
- b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees?[Yes [No
If yes, please give details on separate sheet.
- c. Please list general liability insurance carried for each of the past three 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 Mo./Day/Yr.</u>	<u>Expiration Mo./Day/Yr.</u>	<u>Was this a Claims Made Policy Form?</u>		<u>Retro Date</u>
							<u>Yes</u>	<u>No</u>	
_____	_____	_____	_____	_____	_____	_____	[<input type="checkbox"/>]	[<input type="checkbox"/>]	_____
_____	_____	_____	_____	_____	_____	_____	[<input type="checkbox"/>]	[<input type="checkbox"/>]	_____
_____	_____	_____	_____	_____	_____	_____	[<input type="checkbox"/>]	[<input type="checkbox"/>]	_____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.



SHAND MORAHAN & COMPANY, INC.

Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY (Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES: (Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE: (7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM: (Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: