

**APPLICATION FOR SPECIFIED  
MEDICAL PROFESSIONS FOR  
PROFESSIONAL LIABILITY  
INSURANCE**

(Claims Made Basis)

**APPLICANT'S INSTRUCTIONS:**

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.  
(PLEASE TYPE OR PRINT IN INK)

**1. APPLICANT INFORMATION**

a. Full name of applicant (include professional degree if applicant is an individual):

b. Principal business address:  
(Please attach a list of additional office addresses)

c. Number of Employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Total \_\_\_\_\_

c. Business Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

d. Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Are you a U.S. citizen? \_\_\_\_\_ Yes \_\_\_\_\_ No. If No, your status, date of entry into USA:

e. Square feet of total office space (all locations):

f. Your practice:

- |   |  |
|---|--|
| <input type="checkbox"/> Solo practitioner (unincorporated)<br><input type="checkbox"/> Solo practitioner (incorporated)<br><input type="checkbox"/> Partnership<br><input type="checkbox"/> Professional Association<br><input type="checkbox"/> Other (please describe) _____ | <input type="checkbox"/> Professional corporation (for profit)<br><input type="checkbox"/> Professional corporation (non-profit)<br><input type="checkbox"/> Employee of _____<br><div style="text-align: center;">(Give name of employer)</div> |
|---|--|

g. Formal business, corporate or partnership name:

h. Please list the names of all partners or members of your professional association/corporation who provide professional services:

i. Please attach a copy of your letterhead.

**2. EDUCATION/EXPERIENCE (Individual Applicant Only)**

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

(i) Where have you practiced your profession during the last ten years?

In \_\_\_\_\_

From \_\_\_\_\_ To

In \_\_\_\_\_

From \_\_\_\_\_ To

In \_\_\_\_\_

From \_\_\_\_\_ To

**2. EDUCATION/EXPERIENCE (Individual Applicant Only) (CONTD.)**

(ii) Have you ever failed any professional licensing or specialty organization examination? [ ] Yes [ ] No  
 If yes, please attach a detailed explanation including the dates and location.

**3. APPLICANT PRACTICE**

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation.

b. Please indicate your professional specialty (CHECK ONE):

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Chiropractor                | <input type="checkbox"/> Laboratory Technician     | <input type="checkbox"/> Optician           | <input type="checkbox"/> Social Worker         |
| <input type="checkbox"/> Counselor ( Describe) _____ | <input type="checkbox"/> Medical Personnel Pool    | <input type="checkbox"/> Optometrist        | <input type="checkbox"/> Speech Therapist      |
|  | <input type="checkbox"/> Naprapath                 | <input type="checkbox"/> Orthotist          | <input type="checkbox"/> Veterinarian          |
| <input type="checkbox"/> Dental Hygienist            | <input type="checkbox"/> Nurse, Licensed Practical | <input type="checkbox"/> Perfusionist       | <input type="checkbox"/> Visiting Nurse Assoc. |
| <input type="checkbox"/> Hearing Aid Fitter          | <input type="checkbox"/> Nurse, Registered         | <input type="checkbox"/> Pharmacist         | <input type="checkbox"/> X-ray Technician      |
| <input type="checkbox"/> Home Health Care Agcy.      | <input type="checkbox"/> Nurses Registry           | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other (Specify) _____ |
| <input type="checkbox"/> Inhalation Therapist        | <input type="checkbox"/> Occupational Therapist    | <input type="checkbox"/> Psychologist       |  |

c. Please indicate the sources and amounts of actual and projected revenue:

<u>SOURCE</u>	<u>Amount This Fiscal Year</u>	<u>Amount Next Fiscal Year</u>
(i) Charitable Contributions:	\$ _____	\$ _____
(ii) Government Funding:	\$ _____	\$ _____
(iii) Fee for Services:	\$ _____	\$ _____
(iv) Other: _____	\$ _____	\$ _____
<b>TOTAL GROSS REVENUE</b>	<b>\$ _____</b>	<b>\$ _____</b>

d. Please provide the number of patient or client visits:

<u>Type of Visit</u>	<u>Number of Visits Last 12 Months</u>	<u>Number of Visits Next 12 Months</u>
Clinic	_____	_____
Laboratory	_____	_____
Other (specify) _____	_____	_____
<b>TOTAL NUMBER OF VISITS</b>	<b>_____</b>	<b>_____</b>

e. Please specify any professional societies or associations in which you are a member:

f. Are you associated with or do you work for a physician or surgeon? [ ] Yes [ ] No

If yes, please give the name and the specialty of the physician:

g. Please give the approximate percentage of time spent in the following work locations:

_____ % Administrative Office	_____ % Laboratory	_____ % Hospital Ward (specify) _____
_____ % Classroom	_____ % Operating Room	
_____ % Emergency Dept of Hospital	_____ % Outpatient Clinic	_____ % Professional Office (specify profession) _____
_____ % Nursing Home	_____ % Patient=s Home	
_____ % Other (specify) _____		

**3. APPLICANT PRACTICE (CONTD.)**

h. Please indicate the approximate division of your patients or clients among:

Hemodialysis	_____%	Psychiatric	_____%	Bariatrics	_____%
Holistic Medicine	_____%	Drug Addicts	_____%	Physical Rehabilitation	_____%
Surgical	_____%	Alcoholics	_____%	Disability Evaluation	_____%
Stress Testing	_____%	Obstetrical	_____%	Research or Experimental	_____%
Communicable	_____%	Dental	_____%	_____	_____%
Family Planning	_____%	Pediatric	_____%	_____	_____%

i. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

<u>TYPE OF PROFESSION</u>	<u>NO.</u>	<u>TYPE OF PROFESSION</u>	<u>NO.</u>
Inhalation Therapists	_____	Opticians	_____
Laboratory Technicians	_____	Optometrists	_____
Nurse Anesthetists	_____	Perfusionists	_____
Nurses, Licensed Practical	_____	Pharmacists	_____
Nurse Practitioner	_____	Physiotherapists	_____
Nurses, Registered	_____	Social Workers	_____
Speech Therapists	_____	Other (please specify)	_____

j. Are all of the above individuals licensed in accordance with applicable state and federal regulations? [ ] Yes [ ] No  
If no, please attach an explanation.

**4. APPLICANT PROCEDURES**

a. Do you render professional services directly to patients? YES NO  
[ ] [ ]

If yes, please describe in detail and indicate the extent of supervision by others.

<u>Description of Professional Services</u>	<u>Percent of Time Supervised</u>	<u>Qualifications of Supervisor</u>
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____

b. Do you render professional services that do not involve contact with a patient? [ ] [ ]  
If yes, please describe these services in detail.

c. (i) Do you perform or assist in any surgical procedures? [ ] [ ]

(ii) Please list ALL surgical procedures performed (including minor surgery): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? [ ] [ ]  
If yes, please attach a detailed explanation.

(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? [ ] [ ]  
If yes, please attach a detailed explanation.

**4. APPLICANT PROCEDURES (CONTD.)**

d. Do you perform radiation therapy? [ ] [ ]

e. Do you perform psychiatric shock therapy? [ ] [ ]

f. Do you compound in bulk, manufacture or wholesale medicine? [ ] [ ]  
If yes, please provide a detailed explanation.

g. (i) Do you perform veterinary services? [ ] [ ]  
If yes, please indicate the approximate division of your work among the following categories.

\_\_\_\_\_ % Greyhounds \_\_\_\_\_ % Thoroughbreds  
\_\_\_\_\_ % Animals valued over \$5,000.

Please attach an explanation including the frequency and the type(s) of animals treated.

h. (ii) Do you administer artificial insemination? [ ] [ ]  
If yes, please answer the following questions:

(i) What type(s) of animals are involved? \_\_\_\_\_

(ii) Are you responsible for the storage of the semen? [ ] [ ]  
If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

(iii) What percent of your practice is involved with artificial insemination? \_\_\_\_\_ %

i. Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action? [ ] [ ]  
If yes, please attach a detailed explanation.

**5. PERSONNEL**

a. Please list the number and type of independent contractors who provide professional services on your behalf.  
IF NONE, STATE NONE.

<u>NO.</u>	<u>Type of Profession</u>	<u>NO.</u>	<u>Type of Profession</u>	<u>NO.</u>	<u>Type of Profession</u>
_____	Inhalation Therapists	_____	Laboratory Technicians	_____	Nurse Anesthetists
_____	Nurses, Licensed Practical	_____	Nurse Practitioner	_____	Nurse, Registered
_____	Opticians	_____	Optometrists	_____	Perfusionists
_____	Pharmacists	_____	Physiotherapists	_____	Social Workers
_____	Speech Therapists	_____	Other (specify) _____		

b. Do you supervise any individuals who are not your own employees? [ ] Yes [ ] No  
If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

c. Please indicate by profession the number of individuals you supervise.

<u>NO.</u>	<u>Type of Profession</u>	<u>NO.</u>	<u>Type of Profession</u>
_____	Physicians	_____	Laboratory technicians
_____	X-ray technicians	_____	Other (please specify): _____

**6. APPLICANT AFFILIATIONS**

YES NO

- a. Do you own or operate any business other than that shown in Question 1(a) above?  
If yes, please give details on a separate sheet. [ ] [ ]
- b. Are you employed by any individual or entity other than that shown in Question 1(a) above?  
If yes, please attach an explanation describing details of your responsibilities. [ ] [ ]
- c. Are you under contract to any individual or entity other than that shown in Question 1(a) above?  
If yes, please attach an explanation describing details of your responsibilities. If your contract contains a hold-harmless agreement, a copy of the contract must be attached. [ ] [ ]
- d. Are you employed by or under contract to any government entity?  
If yes, please attach an explanation including the details of your responsibilities. [ ] [ ]
- e. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)?  
If yes, please attach a copy of ALL of your advertisements. [ ] [ ]
- f. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients?  
If yes, please attach a detailed explanation and a copy of ALL of your advertisements. [ ] [ ]
- g. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered?  
If yes, please give details including the name, location, size and number of beds. [ ] [ ]

h. If you have a training school, please complete the following. Attach a separate sheet if needed.

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 Faculty	Qualifications of Faculty (e.g. MD, RN, PhD, etc.)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

- i. (i) Do you use a collection agency?  
If yes, please state the name of the agency [ ] [ ]
- (ii) Does the agency have the authority to file a collection suit at its discretion? [ ] [ ]

**7. APPLICANT HISTORY/CLAIMS**

**(Attach a detailed explanation for any "YES" answers)** YES NO

- a. Have you or any of your employees:
  - (i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [ ] [ ]
  - (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] [ ]
  - (iii) Ever been treated for alcoholism or drug addiction? [ ] [ ]

**7. APPLICANT HISTORY/CLAIMS (CONTD.)**

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

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

b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Policy Insurance Carrier	Policy Number	Limits of Liability	Deductible (If any)	Premium	Inception Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retro Date
							Yes	No	
							_____	[ ]	[ ]
							_____	[ ]	[ ]
							_____	[ ]	[ ]
							_____	[ ]	[ ]

c. Year 2000: YES NO

(i) Does your computer system store a four-digit year? [ ] [ ]

(ii) If NO, please attach a description of corrective measures taken and the date upon which you anticipate the problem will be solved.

(iii) Are you, in the course of your business, involved in working to solve the year 2000 problem as a consultant/advisor or as a part of your employment? [ ] [ ]

(iv) If YES, what percentage of your work is involved? \_\_\_\_\_%

d. Has any claim or suit been brought against you and/or any of your employees? [ ] [ ]  
If yes, a Supplemental Claim Information Form must be completed for each claim or suit.

e. 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? [ ] [ ]  
If yes, please give details on a separate sheet.

\* 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.