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**MEDICAL LABORATORIES,  
 MEDICAL IMAGING CENTERS AND  
 BLOOD PLASMAPHERESIS  
 CENTERS 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 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: \_\_\_\_\_ Business Phone: ( ) \_\_\_\_\_
- b. Principal Business Address: \_\_\_\_\_
- c. Secondary locations: \_\_\_\_\_
- d. Total sq. ft. occupied by applicant (all locations): \_\_\_\_\_
- e. Number of Employees: Full time \_\_\_\_\_ Part time \_\_\_\_\_ Seasonal \_\_\_\_\_ Total \_\_\_\_\_
- f.  Corporation  Individual  Partnership  Other (describe)
- Year established: \_\_\_\_\_ State where applicant is licensed to practice: \_\_\_\_\_
- Is Laboratory or Center  Mobile  Stationary
- g. Limits, deductible and effective date requested: \_\_\_\_\_ (per claim) \_\_\_\_\_ (agg.) \_\_\_\_\_ Deductible  
 Effective Date \_\_\_\_\_

**2. OPERATIONS**

- |   |  |
|---|--|
| <p>a. Please describe fully the exact purpose of the operations, services and procedures provided. (Attach copy of brochure, if available.):</p>  | <p>d. Are you under contract to or in the employ of any federal governmental entity? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach explanation.</p>  |
| <p>b. (i) State annual gross receipts last 12 months \$ _____<br/>         Anticipated next 12 month \$ _____</p> <p>(ii) Number of tests performed last 12 months _____<br/>         Anticipated next 12 months _____</p> <p>(iii) Number of patient contacts last 12 months _____<br/>         Anticipated next 12 months _____</p> | <p>e. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please attach detailed explanation and a copy of ALL of the advertisements.</p>      |
| <p>c. For medical imaging centers only, please indicate number of tests in each category annually:</p> <p>MRIs _____ CT scans _____ Mammograms _____<br/>         Ultrasounds _____</p>   | <p>f. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, attach detailed explanation and a copy of ALL of the advertisements.</p> |

### 3. SERVICES

a. Service is provided for: Hospitals \_\_\_\_\_%      Nursing Homes \_\_\_\_\_%      Industrial Facilities \_\_\_\_\_%  
 Physicians' Offices \_\_\_\_\_%      Other \_\_\_\_\_% (describe) \_\_\_\_\_

b. Are you involved in any: (If yes, please attach full description) Yes    No

Services open to the public (health fairs, shopping mall exhibits, etc.)	[ ]	[ ]
Blood banking or cross matching	[ ]	[ ]
Medical, genetic, AIDS or drug research	[ ]	[ ]
Manufacturing, dispensing or testing pharmaceuticals	[ ]	[ ]
Use of injected or ingested materials	[ ]	[ ]
Use of any radioactive material other than normal x-ray equipment	[ ]	[ ]
Therapy or treatment procedures	[ ]	[ ]
Environmental analyses	[ ]	[ ]
Manufacturer and/or sell laboratory equipment or supplies, reagents or software	[ ]	[ ]
Intravenous transfusions of blood or in the procurement of blood or blood products	[ ]	[ ]
Drug testing: If yes, _____% of your gross receipts	[ ]	[ ]
Testing for AIDS: If yes, _____% of your gross receipts	[ ]	[ ]

c. Specimens: \_\_\_\_\_% collected direct from patient by applicant; describe types of specimens collected: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_% received by applicant from outside sources.

d. Do you provide any services under contract? [ ] Yes [ ] No  
 If Yes, please attach explanation.

### 4. STAFF

a. Total number of employees: \_\_\_\_\_ Professional \_\_\_\_\_  
 \_\_\_\_\_ Physicians      \_\_\_\_\_ Nurses      \_\_\_\_\_ X-Ray Technicians  
 \_\_\_\_\_ Technologies      \_\_\_\_\_ Phlebotomists      \_\_\_\_\_ Other Technicians  
 \_\_\_\_\_ Other (describe) \_\_\_\_\_

Do employed physicians carry their own professional liability insurance? [ ] Yes [ ] No

What limits of liability do they carry? \$ \_\_\_\_\_

b. (i) Name and qualifications of Medical Director:\*

(ii) Name and qualifications of Medical Review Officer (MRO):\*

\*Please attach Curriculum Vitae (C.V.).

c. (i) Are there any contracted physicians? [ ] Yes [ ] No  
 How many? \_\_\_\_\_

(ii) Do they carry professional liability insurance? [ ] Yes [ ] No

(iii) What limits of liability do they carry? \$ \_\_\_\_\_

### 5. CLAIMS/HISTORY

a. Have you or any of your employees ever: (If Yes, please attach full description.) Yes    No

(i) been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association?	[ ]	[ ]
(ii) been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	[ ]	[ ]

**5. CLAIMS/HISTORY (CONTD.)**

(iii) had any professional liability insurance canceled, declined, refused, renewal or accepted only on special terms? Yes      No       
[ ] [ ]

b. Are you licensed in accordance with all applicable state and federal laws? [ ] [ ]

(i) Approved by National Institute on Drug Abuse (NIDA) if lab is involved in drug testing? [ ] [ ]

(ii) CLIA approved? [ ] [ ]  
**If no to either of the above, provide detailed explanation.**

(iii) Have you or any of your employees had any professional licensed refused, suspended, revoked, renewal refused or accepted only on special terms or have you or any of your employees voluntarily surrendered any professional license? [ ] [ ]

c. Has any claim or suit for alleged malpractice been brought against you and/or any of your employees? [ ] [ ]

d. Has any claim or suit for alleged malpractice been made against you and/or any of your employees that has NOT been reported to a prior Insurer? [ ] [ ]

e. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you and/or any of your employees? [ ] [ ]

**If Yes to any questions, c - e above, please complete Supplemental Claim Information Form SM 174.**

f. a. List prior professional liability insurance carried for each of the past five years. If none, check here [ ].  
 b. Attach a copy of the Declarations Page from your most recent coverage.

Insurance Co.	Limits of Liability	Premium	Inception Exp. Mo./Day/+Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retroactive Date
					Yes	No	
_____					[ ]	[ ]	_____
_____					[ ]	[ ]	_____
_____					[ ]	[ ]	[ ]

g. Year 2000 computer systems issue:

(i) Does your computer systems store a four-digit year? [ ] Yes [ ] No

(ii) If no, please attach a description of corrective measures taken and anticipated resolution date.

(iii) Are you, in the course of your business, working to solve the year 2,000 problem as a consultant/advisor or as a part of your employment? [ ] Yes [ ] No

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

\* 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.

\_\_\_\_\_  
 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.