ADMIRAL INSURANCE COMPANY A Berkley Company®

# Miscellaneous Medical Professional Liability Application (Claims Made Form)

1. Full Name of Applicant (Including all dba's and subsidiaries seeking coverage under the policy for which you are applying):

2. Mailing and Location Address: (If multiple addresses include an attachment with a complete schedule of all locations)

3. Internet Address:

4. Date Established:

5. Type of Entity: ◯ Corporation ◯ Partnership ◯ Individual ◯ Other :

6. Is this entity owned by, associated with or controlled by any other entity? ◯YES ◯NO If Yes, please give details:

7. Professional Activities and Specialty:

- ☐ Ambulance Service ☐ Ground ☐ Air
- ☐ Cosmetic Aesthetics Clinic (Medi-Spa)
- ☐ Dental Practice
- ☐ Drug and Alcohol Treatment
- ☐ Home Healthcare Agency
- ☐ Hospice
- ☐ Kidney Dialysis Center
- ☐ Laser Vision Correction Center
- ☐ Medical Clinic
- ☐ Medical Staffing
- ☐ Methadone Clinic
- ☐ Mental Health Services
- ☐ Nurses Registry
- ☐ Pharmacy
- ☐ Radiology (Teleradiology ◯YES ◯NO)
- ☐ Residential Care Facility
- ☐ Social Services
- ☐ Surgery Center
- ☐ Other (Please Provide Details)

8. If you provide Hospice Services, please list details of the services below:

| | | | | | |
|---|---|---|---|---|---|
| Private Home | % | Nursing Home | % | Other | % |
| Freestanding Hospice Center | % | Assisted Living Facility | % | | |
| Number of Licensed Beds | | Rehabilitation Hospital | % | | |

9. State the approximate division of patients :

| | | | |
|---|---|---|---|
| Cosmetic or Elective | % | Holistic or Alternative Medicine | % |
| Counseling | % | Hospice | % |
| Communicable Diseases | % | Obstetric | % |
| Dental | % | Pediatric | % |
| Developmentally Disabled | % | Psychiatric | % |
| Dialysis | % | Research or Experimental | % |
| Family Planning | % | Substance Abuse - Drug or Alcohol | % |
| General Medical | % | Surgical | % |
| Geriatric | % | Other (Please provide details): | % |

10. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

| | Employees or Volunteer | Independent Contractors | Insured On Own Med Mal Policy |
|---|---|---|---|
| Physicians (no surgery) | | | ◯YES ◯NO |
| Physicians (surgical) | | | ◯YES ◯NO |
| Physician Assistants | | | ◯YES ◯NO |
| Surgical Technicians | | | ◯YES ◯NO |
| Certified Nurse Anesthestists | | | ◯YES ◯NO |
| Nurse Practitioners | | | ◯YES ◯NO |
| Registered Nurses | | | ◯YES ◯NO |
| LPN's or Nurse Aides | | | ◯YES ◯NO |
| X-Ray Technicians | | | ◯YES ◯NO |
| Medical Assistants | | | ◯YES ◯NO |
| Optometrists | | | ◯YES ◯NO |
| Opticians | | | ◯YES ◯NO |
| Pharmacists | | | ◯YES ◯NO |
| Pharmacy Technicians | | | ◯YES ◯NO |
| Chiropractors | | | ◯YES ◯NO |
| Massage Therapists | | | ◯YES ◯NO |
| Laboratory Technicians | | | ◯YES ◯NO |
| Paramedics | | | ◯YES ◯NO |
| EMT's | | | ◯YES ◯NO |
| Social Workers | | | ◯YES ◯NO |
| Aestheticians | | | ◯YES ◯NO |
| Perfusionists | | | ◯YES ◯NO |

| | Employees or Volunteer | Independent Contractors | Insured On Own Med Mal Policy |
|---|---|---|---|
| Occupational Therapists | | | ◯YES ◯NO |
| Physical Therapists | | | ◯YES ◯NO |
| Speech Therapists | | | ◯YES ◯NO |
| Other | | | ◯YES ◯NO |

Total Staff:

**** Please attach copies of declarations pages on all individuals that carry their own medical malpractice.**

If you have a Medical Director, provide name, speciality and C.V.:

a) Are Medical Director's duties administrative only?

◯YES ◯NO

b) Does Medical Director provide direct patient care?

◯YES ◯NO

c) What medical malpractice limits is Medical Director required to carry?

11. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ◯YES ◯NO

If No, Please attach a detailed explanation.

12. Has the applicant or any of the above employees and/or independent contractors:

Please attach explanation for any of the questions below answered "YES":

a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? ◯YES ◯NO

b) Ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? ◯YES ◯NO

c) Ever been treated for alcoholism or drug addiction? ◯YES ◯NO

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? ◯YES ◯NO

13. Does the applicant perform any of the following non-surgical procedures or treatment?

a) Acid or chemical peels ◯YES ◯NO

Solution Strength _____ If over 30%, is this done by licensed MD ◯YES ◯NO

b) Acupuncture ◯YES ◯NO

c) Angiography, Artiography, Venography ◯YES ◯NO

d) Botox Injections ◯YES ◯NO

e) Catheterization (other than urinary or umbilical) ◯YES ◯NO

f) Closed reduction of compound fractures ◯YES ◯NO

g) Collagen injections ◯YES ◯NO

h) Electrolysis ◯YES ◯NO

i) Laser Treatments (non-surgical) If Yes, which of the following: ◯YES ◯NO

- ☐ Hair Removal
- ☐ Skin Resurfacing
- ☐ Tatoo Removal

Other: _____

j) Lipodissolve ◯YES ◯NO

k) Mesotherapy ◯YES ◯NO

l) Microdermabrasion ◯YES ◯NO

m) Pain management (non-surgical) ◯YES ◯NO

n) Permanent Makeup Application ◯YES ◯NO

o) Psychiatric shock therapy ◯YES ◯NO

p) Radiation Therapy and/or Chemotherapy ◯YES ◯NO

q) Sclerotherapy ◯YES ◯NO

r) Silicone Injections ◯YES ◯NO

14. Does the applicant perform any of the following surgical procedures?

a) Abortions If Yes, please answer the following: ◯YES ◯NO

What is the maximum trimester

What methods

How many per month

b) Bariatric Surgery If Yes, attach a list of types performed ◯YES ◯NO

c) Biopsies ◯YES ◯NO

d) Circumcisions ◯YES ◯NO

e) Colonoscopies or Endoscopies ◯YES ◯NO

f) Cosmetic Plastic Surgery If Yes, what percentage of Practice? ◯YES ◯NO

g) Cryosurgery ◯YES ◯NO

h) Deliveries ◯YES ◯NO If Yes, C Sections? ◯YES ◯NO

i) Dilation and curettage ◯YES ◯NO

j) Hysterectomies ◯YES ◯NO

k) Minor surgical procedures only ◯YES ◯NO

l) Major surgical procedures ◯YES ◯NO

m) Mastectomies or lumpectomies ◯YES ◯NO

n) Neurosurgery ◯YES ◯NO

o) Organ transplant surgery ◯YES ◯NO

p) Orthopedic surgery other than spinal ◯YES ◯NO

q) Penile lengthening or enhancement surgery ◯YES ◯NO

r) Sex change operations or sexual reassignment surgery ◯YES ◯NO

s) Spinal surgery ◯YES ◯NO

t) Surgical podiatry ◯YES ◯NO

u) Vasectomies ◯YES ◯NO

v) Other

15. Does the applicant administer methadone treatment? ◯YES ◯NO

If yes, how many slots?

16. Does the applicant administer detoxification treatment? ◯YES ◯NO

How many patients annually?

17. Does the applicant maintain any beds for overnight occupancy? ◯YES ◯NO

If Yes, what is the total number of beds?

18. Does the applicant provide services to Nursing Homes or Assisted Living Centers? ◯YES ◯NO

If Yes, please provide description of the services, and the percentage (%) of total revenue derived from these services:

19. Is anesthesia (other than topical or by means of local infiltration) administered at the applicant's facility? ◯YES ◯NO

If Yes, what percentage of procedures require general anesthesia?

20. Does the applicant sell any products? ◯YES ◯NO

If Yes, please include product brochures.

a) What kind of products?

b) Do any of these products require a physicians prescription? ◯YES ◯NO

c) Do you re-label these products in your own name? ◯YES ◯NO

21. State sources and amounts of total revenue:

| | Last 12 months | Estimate for next 12 months |
|---|---|---|
| Charitable Contributions | | |
| Government Funding | | |
| Fee for service | | |
| Other income: | | |
| Total Gross Revenues | | |

22. Please provide the number of annual patients encounters or client visits:

| | Last 12 months | Estimate for next 12 months |
|---|---|---|
| Outpatient Visits (Non-Surgical) | | |
| Surgical Procedures (not included in above) | | |
| Other | | |

23. If the applicant has or is a training school, please provide the following: (attach separate sheet if more room needed)

| Profession for which students are being trained. | Max # students per session. | # of sessions per year | % of time in clinical settings | Qualifications of Facility (MD, RN,PHD) |
|---|---|---|---|---|
| | | | | |
| | | | | |

24. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If None, state NONE)

| Carrier | Limit | Deductible | Premium | Policy Term |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

25. What is the retroactive date on your current policy?

26. Is the applicant currently insured under a Commercial General Liability policy? ◯YES ◯NO

If Yes, please attach copies of declaration page.

27. Does the applicant own, operate or manage any business other than the one (s) described in this application for which you are applying for coverage? ◯YES ◯NO

If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

28. Has any application for professional liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? ◯YES ◯NO

If Yes, please provide details including name of carrier and dates.

29. Has any claim ever been made against the Applicant or any of its employees? ◯YES ◯NO

If Yes, please complete the Supplemental Claim Information Form with your submission of this application. Form Link

30. Is the applicant aware of any circumstances which may result in any claim against them or their employees? ◯YES ◯NO

If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident.

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☐ I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Current Date 09/29/2010

Title

**If you prefer not to return application with an electronic signature, please print and sign below:**

Signature of Applicant or Authorized Representative

Current Date:

Title

Type or print your name & title

Type or print your phone number

Type or print your e-mail address

**Please attach the following documents to this application:**

* Resumes or CV's on principals and partners
* Copies of brochures, marketing or advertising materials
* Five years of currently valued company loss runs.
* Information on disciplinary actions, license revocations, etc.
* Copy of most current declarations page