

ADMIRAL INSURANCE COMPANY
 9606 North Mopac, Suite 450
 Austin, Texas 78759

**APPLICATION FOR MISCELLANEOUS MEDICAL
 PROFESSIONAL LIABILITY INSURANCE
 (CLAIMS MADE)**

1. Full Name of Applicant: _____

 (Include 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. Website Address (if applicable): _____

4. Date Established: _____ 5. Type of Entity: ___ Corp ___ 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: Check One

- | | |
|--|--|
| <input type="checkbox"/> Ambulance Service (___ Ground ___ Air) | <input type="checkbox"/> Mental Health Services |
| <input type="checkbox"/> Day Spa/Medical Spa | <input type="checkbox"/> Nurses Registry |
| <input type="checkbox"/> Dental Practice | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Drug and Alcohol Treatment | <input type="checkbox"/> Radiology (Teleradiology Y or N circle) |
| <input type="checkbox"/> Home Healthcare Agency | <input type="checkbox"/> Residential Care Facility |
| <input type="checkbox"/> Kidney Dialysis Center | <input type="checkbox"/> Social Services |
| <input type="checkbox"/> Laser Vision Correction Center | <input type="checkbox"/> Surgery Center |
| <input type="checkbox"/> Medical Clinic | <input type="checkbox"/> Other (Please provide details): _____ |
| <input type="checkbox"/> Methadone Clinic | _____ |
| <input type="checkbox"/> Services to Nursing Homes/Assisted Living | _____ |
| <input type="checkbox"/> Medical Staffing | |

Do you sell or lease any medical equipment or products? ___ Yes ___ No If Yes, please complete the Durable Medical Equipment Supplemental Application if coverage is requested.

8. State the approximate division of applicants patients:

- | | |
|---|--|
| <input type="checkbox"/> % Alcoholics | <input type="checkbox"/> % Mentally Retarded |
| <input type="checkbox"/> % Cosmetic or Elective | <input type="checkbox"/> % Prenatal/Obstetrical |
| <input type="checkbox"/> % Counseling/Family Planning | <input type="checkbox"/> % Pediatric |
| <input type="checkbox"/> % Communicable | <input type="checkbox"/> % Psychiatric |
| <input type="checkbox"/> % Dental | <input type="checkbox"/> % Research or Experimental |
| <input type="checkbox"/> % Dialysis | <input type="checkbox"/> % Senile or Elderly |
| <input type="checkbox"/> % Drug Addicts | <input type="checkbox"/> % Surgical |
| <input type="checkbox"/> % Holistic or Alternative Medicine | <input type="checkbox"/> % Other (Please provide details): _____ |
| <input type="checkbox"/> % Medical | _____ |

9. 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:

	Employee or <u>Volunteer</u>	Independent <u>Contractor</u>	Insured On Own <u>Med Mal Policy</u>	Limits <u>Required</u>
Physicians (no surgery)	_____	_____	Yes ___ No	_____
Physicians (surgical)	_____	_____	Yes ___ No	_____
Physician Assistants	_____	_____	Yes ___ No	_____
Surgical Technicians	_____	_____	Yes ___ No	_____
Certified Nurse Anesthetists	_____	_____	Yes ___ No	_____
Nurse Practitioners	_____	_____	Yes ___ No	_____
Registered Nurses	_____	_____	Yes ___ No	_____

9. (continued)	Employee or Volunteer	Independent Contractor	Insured On Own Med Mal Policy?	Limits Required
LPN's or Nurse Aides	_____	_____	Yes ___ No ___	_____
X-Ray Technicians	_____	_____	Yes ___ No ___	_____
Medical Assistants	_____	_____	Yes ___ No ___	_____
Optometrists	_____	_____	Yes ___ No ___	_____
Electrologist	_____	_____	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 ___	_____
Other: _____	_____	_____	Yes ___ No ___	_____

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

*If you have a Medical Director, provide name, specialty 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? _____

10. Are all of the above individuals licensed in accordance with applicable state and federal regulations?
 ___ Yes ___ No If No, please attach a detailed explanation.

11. Has the applicant or any of the above employees and/or independent contractors: YES NO
 If Yes, please attach a detailed explanation.

- (a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? _____
- (b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? _____
- (c) Ever been treated for alcoholism or drug addiction? _____
- (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? _____

12. Does the applicant perform any of the following non-surgical procedures or treatment? YES NO Est. Annual Procedures

- (a) Acid or chemical peels? (Specify solution strength) _____
- (b) Acupuncture? _____
- (c) Angiography, arteriography or venography? _____
- (d) Botox Injections (Advise who performs) _____
- (e) Catheterization (other than urinary or umbilical?) _____
- (f) Closed reduction of compound fractures? _____
- (g) Dermal Filler Injections (Advise type, who performs) _____
- (h) Electrolysis (Advise who performs) _____
- (i) Laser Treatments (non-surgical)? If Yes, which of the following: _____
 - _____ Hair Removal _____
 - _____ Skin Resurfacing _____
 - _____ Tattoo Removal _____
 - Other: _____ _____
- (j) Mesotherapy (Advise who performs) _____
- (k) Microdermabrasion? (Advise who performs) _____
- (l) Pain management (non-surgical)? _____
- (m) Permanent Makeup Application? (Advise who performs) _____
- (n) Psychiatric shock therapy? _____
- (o) Radiation Therapy and/or Chemotherapy? _____
- (p) Sclerotherapy? (Advise who performs) _____

(q) Lipo-Dissolve, Lipostabil, Lipolysis or LipoShape (Advise who performs)
NOTE: THESE PROCEDURES WILL NOT BE COVERED UNLESS PERFORMED BY A TRAINED PHYSICIAN OR PHYSICIAN ASSISTANT.

	YES	NO	Est. Annual Procedures
13. Does the applicant perform any of the following surgical procedures?	_____	_____	_____
(a) Abortions? If Yes, please answer the following: What is the maximum trimester? _____ What methods? _____ How many per month? _____	_____	_____	_____
(b) Biopsies and/or endoscopies? If Yes, list types performed. _____	_____	_____	_____
(c) Circumcisions?	_____	_____	_____
(d) Cosmetic Plastic Surgery? If Yes, what percentage of practice? _____ %	_____	_____	_____
(e) Cryosurgery?	_____	_____	_____
(f) Deliveries? (If Yes, C-Sections? _____ Yes _____ No)	_____	_____	_____
(g) Dilation and curettage?	_____	_____	_____
(h) Gastric bypass surgery or other stomach banding procedures for weight loss?	_____	_____	_____
(i) Hysterectomies?	_____	_____	_____
(j) Minor surgical procedures only?	_____	_____	_____
(k) Major surgical procedures?	_____	_____	_____
(l) Mastectomies or lumpectomies?	_____	_____	_____
(m) Neurosurgery?	_____	_____	_____
(n) Organ transplant surgery?	_____	_____	_____
(o) Orthopedic surgery other than spinal?	_____	_____	_____
(p) Penile lengthening or enhancement surgery?	_____	_____	_____
(q) Sex change operations or sexual reassignment surgery?	_____	_____	_____
(r) Spinal surgery?	_____	_____	_____
(s) Surgical podiatry?	_____	_____	_____
(t) Vasectomies?	_____	_____	_____

*Please attach a complete list of all surgical procedures performed at this facility.

14. Does the applicant administer methadone treatment? _____ Yes _____ No If Yes, how many slots? _____

15. Does the applicant administer detoxification treatment? _____ Yes _____ No (How many patients annually? _____)
 Do you offer rapid detoxification under anesthesia? _____ Yes _____ No (How many patient annually? _____)

16. Does the applicant maintain any beds for overnight occupancy? _____ Yes _____ No
 If Yes, what is the total number of beds? _____

17. 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:

18. Is anesthesia (other than topical or by means of local infiltration) administered at the applicant's facility?
 _____ Yes _____ No If Yes, how many procedures per year require general anesthesia? _____

19. 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 # of students per session	# of sessions per year	% of time in clinical setting	# of faculty	Qualification of Faculty (MD, RN, PHD)
_____	_____	_____	_____ %	_____	_____
_____	_____	_____	_____ %	_____	_____

20. State sources and amounts of total revenue:

	<u>Last 12 months</u>	<u>Estimate for next 12 months</u>
Charitable Contributions	\$ _____	\$ _____
Government Funding	\$ _____	\$ _____
Fee for service	\$ _____	\$ _____
Sales or Lease of Medical Products	\$ _____	\$ _____

Other: _____ \$ _____ \$ _____
 Total Gross Revenues: \$ _____ \$ _____

21. Please provide the number of annual patient encounters or client visits:

	Last 12 months	Estimate for next 12 months
Outpatient Visits	_____	_____
Surgical Procedures (not included in above)	_____	_____
Perfusion, Autotransfusion – Case Load	_____	_____
Pharmacy – Number of Prescriptions	_____	_____
If any Compounding, advise %	_____ %	_____ %
Other: _____	_____	_____

22. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage:

Carrier	Limit	Deductible	Premium	Policy Term	Retroactive Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

23. Is the applicant currently insured under a Commercial General Liability policy? Yes No If Yes, please attach a copy of the declarations page.

24. 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.

25. 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. _____

26. Has any claim ever been made against the applicant or any of its employees? Yes No If Yes, how many? _____
 Please complete the Supplemental Claim Information Form at the end of this application for each and every claim.

27. 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. _____

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 statement and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

 Signature of Applicant or Authorized Representative

 Date

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

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim)

- 1. Name of applicant/named insured: _____

- 2. Name of other parties or defendants named in suit: _____

- 3. Date of alleged error or occurrence, or contact date: _____

- 4. Date claim was made: _____

- 5. Name of claimant: _____

- 6. Name of Insurance Company handling your claim: _____

- 7. Present status of claim or final disposition: _____

Circle One: **CLOSED** **OPEN**

- 8. Defense costs paid to date inclusive of any deductible: _____

- 9. If closed, total loss paid, inclusive of any deductible: _____

- 10. If claim is open or pending, what are the insurers reserves?
 Defense: _____ Loss: _____

- 11. Description of case and events including allegations and assessment of liability: _____

- 12. Claimants last settlement demand: _____

- 13. Describe steps taken to avoid a similar incident: _____

_____ Date

_____ Signature