

Indemnity Excess & Surplus Agency
1500 NW Bethany Blvd, Suite 235
Beaverton, OR 97006
503.526.9700 800.487.2442

**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"/> Cosmetic Aesthetics Clinic (Botox/Laser Hair Removal) | <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 (Telerradiology 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 | _____ |

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"/> % 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 Volunteer	Independent Contractor	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 Anesthetists	_____	_____	___ 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
9. (continued)	Employee or	Independent	Insured On Own

	<u>Volunteer</u>	<u>Contractor</u>	<u>Med Mal Policy?</u>	
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 ___
Other: _____	_____	_____	Yes ___	No ___

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

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

(a) Acid or chemical peels? _____

(b) Acupuncture? _____

(c) Angiography, arteriography or venography? _____

(d) Botox Injections _____

(e) Catheterization (other than urinary or umbilical?) _____

(f) Closed reduction of compound fractures? _____

(g) Collagen injections? _____

(h) Electrolysis? _____

(i) Laser Treatments (non-surgical)? If Yes, which of the following: _____

_____ Hair Removal

_____ Skin Resurfacing

_____ Tatoo Removal

Other: _____

(j) Microdermabrasion? _____

(k) Pain management (non-surgical)? _____

(l) Permanent Makeup Application? _____

(m) Psychiatric shock therapy? _____

(n) Radiation Therapy and/or Chemotherapy? _____

(o) Sclerotherapy? _____

(p) Silicone Injections? _____

13. Does the applicant perform any of the following surgical procedures? YES NO

(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) _____

13. (continued) 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. 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? _____

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

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

	<u>Last 12 months</u>	<u>Estimate for next 12 months</u>
Outpatient Visits	_____	_____
Surgical Procedures (not included in above)	_____	_____
Other: _____	_____	_____

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

<u>Profession for which students are being trained</u>	<u>Max # of students per session</u>	<u># of sessions per year</u>	<u>% of time in clinical setting</u>	<u>Qualification of Faculty (MD, RN, PHD)</u>
_____	_____	_____	_____%	_____
_____	_____	_____	_____%	_____

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

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Policy Term</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

25. 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 at the end of this application for each and every claim.
26. 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: _____

Date

Signature