MISCELLANEOUS MEDICAL PROFESSIONAL, GENERAL & PRODUCTS LIABILITY INSURANCE POLICY APPLICATION

NOTICE: THE POLICY FOR WHICH THIS APPLICATION IS MADE IS A CLAIMS MADE AND REPORTED POLICY. THIS POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSUREDS AND REPORTED IN WRITING TO THE UNDERWRITERS DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THIS POLICY CAREFULLY.

NOTICE TO NEW YORK APPLICANTS: THE POLICY FOR WHICH THIS APPLICATION IS MADE, IS A CLAIMS MADE POLICY. UPON TERMINATION OF COVERAGE FOR ANY REASON, A 60-DAY AUTOMATIC EXTENSION PERIOD WILL APPLY. FOR AN ADDITIONAL PREMIUM, AN OPTIONAL EXTENSION PERIOD CAN BE PURCHASED AS INDICATED IN ITEM 7. OF THE DECLARATIONS. EXCEPT AS OTHERWISE PROVIDED HEREIN, THIS POLICY ONLY APPLIES TO CLAIMS FIRST MADE DURING THE POLICY PERIOD, THE AUTOMATIC EXTENSION PERIOD OR, IF APPLICABLE, THE OPTIONAL EXTENSION PERIOD. NO COVERAGE EXISTS FOR CLAIMS MADE AFTER THE END OF THE POLICY PERIOD AND THE AUTOMATIC EXTENSION PERIOD UNLESS, AND TO THE EXTENT, THE OPTIONAL EXTENSION PERIOD APPLIES. NO COVERAGE WILL EXIST AFTER THE EXPIRATION OF THE AUTOMATIC EXTENSION PERIOD OR, IF PURCHASED, THE OPTIONAL EXTENSION PERIOD, WHICH MAY RESULT IN A POTENTIAL COVERAGE GAP IF PRIOR ACTS COVERAGE IS NOT SUBSEQUENTLY PROVIDED BY ANOTHER INSURER. DURING THE FIRST SEVERAL YEARS OF A CLAIMS-MADE RELATIONSHIP, CLAIMS-MADE RATES ARE COMPARATIVELY LOWER THAN OCCURRENCE RATES, AND THE INSURED CAN EXPECT SUBSTANTIAL ANNUAL PREMIUM INCREASES, INDEPENDENT OF OVERALL RATE INCREASES, UNTIL THE CLAIMS-MADE RELATIONSHIP REACHES MATURITY. THE UNDERWRITERS ARE NOT OBLIGATED TO PAY ANY LOSS AFTER THE LIMIT OF LIABILITY HAS BEEN EXHAUSTED BY PAYMENT OF LOSS. THE LIMIT OF LIABILITY AVAILABLE TO PAY DAMAGES OR SETTLEMENTS SHALL BE REDUCED AND MAY BE EXHAUSTED BY DEFENSE COSTS AND DEFENSE COSTS SHALL BE APPLIED TO THE RETENTION. THE UNDERWRITERS HAVE NO OBLIGATION TO PAY DEFENSE COSTS OR ANY SETTLEMENTS OR JUDGMENTS ONCE THE APPLICABLE LIMIT OF LIABILITY IS EXHAUSTED. PLEASE READ THIS POLICY CAREFULLY.

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

REQUIRED INFORMATION:

1. Loss History for the last TEN years. The loss run should be updated within the last 30 days and include a breakdown of total incurred losses (paid and reserves for both indemnity and expense), and a description of all losses, whether paid or outstanding (see appendix #2).
2. Specimen copy of contractual agreements with independent contractor physicians and/or hospitals and/or labs (if applicable).
3. Most recent local and/or State accreditation agency reports (if applicable).
4. Any marketing brochures or literature detailing services provided.

GENERAL INFORMATION:

a) Name of Applicant/Entity(s)_____
_____

b) Date of Incorporation/Start of Operations: _____

c) Physical Address (City, State, Zip Code) _____
_____
_____

Telephone_____Fax_____Website_____

d) Complete listing of insureds to be named under the policy (continue on a separate sheet if necessary) _____

_____

e) Additional insureds (explain relationship/ownership)
_____
_____

f) Full listing of locations (continue on a separate sheet if necessary) _____

_____

g) Please list any acquisitions made in the last 5 years (include name of entity and date acquired)
_____

h) Are any acquisitions planned within the next 12 months? Y/N. If yes, please explain
_____

i) Applicant is: (Individual/Partnership/Corporation/Joint Venture/LLC/Other – describe)

_____

j) For-profit/not-for-profit/publicly traded? If publicly traded please list exchange

_____

_____

Date established _____

k) List all states in which the applicant is operating. Is applicant licensed in the states in which it is operating? Y/N (If no please explain)

_____

l) (i) Please provide a list of organisations by whom the applicant is either licensed or accredited
_____

(ii) How long has the applicant held its license or accreditation?

(iii) Has the applicant ever had its licence or accreditation revoked? Y/N If yes, please explain
_____

m) Revenues/Annual Receipts – please provide the following:

	Projected, next Fiscal/Annual Period	Past 12 Months; Most recent, full-annual	First Year Prior Financial Year:
Total Gross Revenues/Receipts			
Amount of Total Gross Revenues/Receipts derived from sale of any products (if any)			
Cost of Goods (if any)			

PROFESSIONAL SERVICE/PRODUCT PROFILE:

a) Please describe your operations state total number of patient contacts in the previous 12 months (if applicable). Please also clarify type of patient contact – e.g. obtaining a specimen by your staff, visit, procedure or treatment performed on a patient by your staff, encounters with clinical trial applicant, etc.

_____

b) For the previous 12 months please provide a FULL listing of the services and/or products provided, and the exposure from each in the table below:

Class	Exposure Basis	Your exposure	Class	Exposure Basis	Your exposure
Acupuncturist/Acupuncture Clinic	# People		Massage Therapist	# People	
Addiction Counselor (Non-NAADAC)	# People		Medical Clinic	# Receipts	
Addiction Interventionist	# People		Medical Clinic – Counseling	# OPV's	
Administrative/Clerical	# People		Medical Clinic – LVN	# OPV's	
Adult Day Care	#Average Occupancy		Medical Clinic – Nurse Practitioner	# OPV's	
Alcohol & Drug Rehabilitation – Adults only	#Beds/Units		Medical Clinic - RN/ PT	# OPV's	
All other Aide, Assistant, or Technician	# People		Medical Director	# Directors	
Ambulance Services – Non-Emergency	# Runs		Medical Lab Technician	# People	
Ambulance Services – Emergency	# Runs		Medical Labs – DNA Testing	# Receipts	
Art, Music, Dance, Pet, and Recreation Therapist	# People		Medical Labs – Drug Testing	# Receipts	
Artificial Limb Clinics	# Receipts		Medical Labs – Fertility Testing	# Receipts	
Audiologist	# People		Medical Labs - Other	# Receipts	
Auricular & Full Body Acupuncture Therapy and	# People		Medical Office Assistant	# People	

Counseling					
Behavioral Analyst	# People		Medical Personnel Services (Home Health Only)	# Receipts	
Blood Bank Technician	# People		Medical Personnel Services (Staff Relief)	# Receipts	
Cardiology Technician	# People		Medical Personnel Services (skilled staff placement)	# Receipts	
Case Management – AIDS, Terminally Ill	# Receipts		Medical Records Technician	# People	
Case Management – All Other	# Receipts		Medical Technologist	# People	
Case Management – Geriatrics	# Receipts		Mental Health Clinics	# OPV's	
Case Management – Retarded	# Receipts		Mental Health Technician	# People	
Case management – Youth	# Receipts		MRI Technician	# People	
Case Workers and Case Manager	# People		Nurse	#People	
Certified Employee Assistance Professional	# People		Nurse Aide	# People	
Certified Tech./ Assistant	# People		Nurse Practitioner	# People	
Companion	# People		Nurse/RN	# People	
Consultants	# Receipts		Occupational Therapist	# People	
Counselor	# People		Occupational Therapy Assistant	# People	
Cytotechnologist	# People		Ocularists	# Receipts	
Diagnostic Imaging & X-Ray	# Receipts		Optical Goods Stores	#Gross Sales	
Diagnostician	# People		Optometrist	# People	
Dialysis Centers – Hemo	# OPV's		Pastoral Counselor	# People	
Dialysis Centers – In Home Peritoneal	# Service Hours		Pathology Assistant	# People	
Dialysis Centers – Peritoneal	# OPV's		Pharmacy	# Receipts	
Dialysis Technician	# People		Phlebotomist	# People	
Dietician/Nutritionist	# People		Physical Therapist	# People	
EKG/EEG Technician	# People		Physical Therapy Assistant	# People	
Health & Fitness Center	# Receipts		Physical Therapy Clinic	# Receipts	
Health Educator	# People		Psychiatric Social Worker	# People	
Hearing Aid Fitter	# People		Psychologist	# People	
Home Health Agencies	# Receipts		Radiation Therapy Technician	# People	
Home Health Aide	# People		Respiratory Therapist	# People	
Homemaker	# People		Sheltered Workshops	# People	

Hospice Care	# Receipts		Social Services Agencies	# Receipts	
Imaging Technician	# People		Speech Therapist	# People	
Intern Mental Health/Addiction Counselor	# People		Speech-Language Pathologist	# People	
Lab Technician	# People		Testing Services	# Receipts	
Licensed or Certified Mental Health Counselor	# People		Testing Services (Specimen Collection Only)	# Receipts	
LVN/LPN	# People		Ultrasound Technician	# People	
Marriage and Family Therapists/Counselor	# People		X-Ray Technician	# People	
All Other-Please describe					

c) Does the applicant anticipate making any significant changes in the services/products provided within the next 12 months? Y/N. If yes, Please explain

_____

d) **Products you sell.** Please describe the products you sell and the Gross Sales derived from each (continue on a separate sheet if necessary)

Product Name	Product decription	Gross Sales

Note that the following products listed below will be **Excluded** in your policy.

Please check the box confirming that you have read and understand these products are **Excluded**……[ ] Yes [ ] No

Anabolic-Androgenic Steroids, Anabolic Steroids
Androstenedione
Aristolochic acid
Ephedra, Mahuang and Psuedoephedrine
Ephedra/Ephedrine Alkaloids
Fenfluramine
GHB, GHV (Y-Hydroxybutyric Acid)
GVL (Gamma-Valerolactone)
GB; 1, 4 Butanediol
Germander
Glibenclamide,Glyburide, Liqiang 4
Jin Bu Huan
Kava, Ava, Kava-Kava and related derivatives
Lobelia
Pennyroyal Oil
Stephania, or any adulterated botanicals
Yohimbe

And any product, supplement or additive determined by the United States Food and Drug Administration at any time to be a "Class I Health Hazard." Class I. Heath Hazard means a product presenting a reasonable probability that the use of or exposure to it will cause serious adverse health consequences or death.

MEDICAL STAFF PROFILE:

a) Please provide (on a separate sheet if necessary) a full listing of Employed Physicians on an FTE basis, complete with specialty

_____

b) Please provide details of all other staff utilised (on an FTE basis)

Health Professional	Employed (FTE)	Contracted (FTE)
RN's		
LPN's		
Pharmacist		
Medical Technician		
Pathologist		
Cytotechnologist		
Lab Technician		
Phlebotomist		
Other (please provide description)		

c) i) Does the applicant contract with other physician groups? Y/N. If yes, please provide total FTE count and specialities (on a separate sheet if necessary)

_____

ii) Are contracted physicians required to carry professional liability insurance? Y/N. If yes, please indicate minimum limits required

_____

_____

iii) Is the applicant named as an additional insured on the contracted physician's professional liability policy? Y/N

_____

BUSINESS CONTRACTS:

a)

Does the applicant have any contracts that do not contain the following provisions that inure to applicant's benefit? (Indicate Yes or No; if yes, please explain)	
All duties and responsibilities of each party	
Arbitration clause	
Choice of law or jurisdiction	
Force Majeure (extends to any and all events outside applicants control)	
Guarantees	
Hold harmless agreements/ indemnification	
Limitation of consequential damages	
Limitation of liabilities	
Warranty disclaimers In Georgia: Representation disclaimers	

b) In addition, does an attorney review all contracts or agreements including changes prior to use?

_____

INSURED HISTORY - CLAIMS, LOSSES, INCIDENTS:

a) Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf? .....[ ] Yes [ ] No
If Yes, how many? _____Complete a copy of our Supplemental Claim form for each

b) Are you or any organization proposed for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit that has not been reported to the current or any prior insurer? .....[ ] Yes [ ] No
If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each

c) Has your or any of your staff's license to practice medicine or license to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? (if yes, please attach explanation).....[ ] Yes [ ] No

d) Are you or any organization proposed for this insurance aware of any claim or suit, or any incident or occurrence that may result in a general liability or products liability claim that has not been reported to the current or any prior insurer?.....[ ] Yes [ ] No
If Yes, how many? _____ Complete a copy of our Supplemental Claim form for each

COVERAGE HISTORY:

a) Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

MISSOURI APPLICANTS: DO NOT ANSWER QUESTION b. BELOW.

b) Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? Y/N. If yes, please explain. .....[ ] Yes [ ] No

_____

_____

c) Has the applicant or any staff: .....[ ] Yes [ ] No
   a. ever been the subject of disciplinary or investigative proceedings or reprimand 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 refuses or accepted only on special terms or ever voluntarily surrendered same?
   (If yes, please provide detailed explanation on any/all incidents)

_____

_____

COVERAGE REQUEST:

Coverage	Limits Requested	Deductible/SIR Requested	Retroactive Date Requested
Professional Liability			
Products Liability			
General Liability			
Other (provide details)			

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE UNDERWRITERS IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE UNDERWRITERS TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL ATTACHMENTS, AND THE MATERIALS SUBMITTED HEREWITH ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE UNDERWRITERS IN ISSUING ANY POLICY.

THIS APPLICATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE UNDERWRITERS AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE UNDERWRITERS ARE AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT DEEMS NECESSARY.

THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGES, AND THE UNDERWRITERS MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE. IN MAINE, THE INSURER MAY MODIFY, BUT MAY NOT WITHDRAW ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE.

IN ARIZONA, FAILURE TO PROVIDE A TRUE AND ACCURATE REPSONSE TO THE FOREGOING QUESTIONS MAY, AT THE OPTION OF THE UNDERWRITERS', RESULT IN THE CANCELLING OF INSURANCE ISSUED IN RELIANCE ON THIS APPLICATION AND/OR DENIAL OF CLAIMS UNDER ANY POLICY ISSUED. FOR WASHINGTON, COVERAGE CANNOT BE VOIDED UNLESS THE INSURED MAKES FALSE STATEMENTS WITH THE INTENT TO DECEIVE.

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE INCLUDING ATTACHMENT 'A' AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

WARNING

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM

CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurer to defraud or attempt to defraud the insurer. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurer or agent of an insurer who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

KANSAS: any person who, with intent to defraud or knowing that (s)he is facilitating a fraud against the insurer, submits an application for the issuance or rating of an insurance policy, or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

LOUISIANA AND MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurer to defraud the insurer. Penalties may include imprisonment, fines or denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NEW YORK AND KENTUCKY: Any person who knowingly and with intent to defraud an insurer or other person files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. New York applicants are subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. Pennsylvania applicants are subject to criminal and civil penalties.

AUTHORIZED SIGNATURE OF APPLICANT
(Must be signed by corporate officer with authority to sign on Applicant's behalf)

TITLE

Printed Name

Date

Effective Date Requested for this Insurance

If this Application is completed in Florida, please provide the Insurance Agent's name and license number as designated. If this Application is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Name of Insurance Agent

License Identification No.

MISCELLANEOUS MEDICAL PROFRESSIONAL & PRODUCTS LIABILITY INSURANCE POLICY APPLICATION

APPENDIX #1: SUPPLEMENTAL NARRATIVE DESCRIPTION OF PRODUCTS/SERVICES

- **Refer to item c) of the Professional Service/Product Profile Section of the main application**
- **Use additional pages if necessary**

Product/Service	Full Description