

2. EDUCATION/EXPERIENCE (Individual Applicant Only)

<u>Institution Name and Address</u>	<u>Years of Training</u>	<u>Degree or Certification Attained</u>
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

- (i) Where have you practiced your profession during the last ten years?
- In _____ From _____ To _____
- In _____ From _____ To _____
- In _____ From _____ To _____
- (ii) Have you ever failed any professional licensing or specialty organization examination? [] Yes [] No
If yes, please attach a detailed explanation including the dates and location.

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

b. Please indicate your professional specialty (CHECK ONE):

- | | | |
|------------------------------------------------------|----------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Naprapath | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Counselor (Describe) _____ | <input type="checkbox"/> Nurse, Licensed Practical | <input type="checkbox"/> Physical Therapist |
| | <input type="checkbox"/> Nurse, Registered | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Nurses Registry | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Hearing Aid Fitter | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Home Health Care Agcy. | <input type="checkbox"/> Optician | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Inhalation Therapist | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Visiting Nurse Assoc. |
| <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Orthotist | <input type="checkbox"/> X-ray Technician |
| <input type="checkbox"/> Medical Personnel Pool | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Other (Specify) _____ |

c. Please indicate the sources and amounts of actual and projected revenue:

<u>Source</u>	<u>Amount This Fiscal Year</u>	<u>Amount Next Fiscal Year</u>
(i) Charitable Contributions:	\$ _____	\$ _____
(ii) Government Funding:	\$ _____	\$ _____
(iii) Fee for Services:	\$ _____	\$ _____
(iv) Other: _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

d. Please provide the number of patient or client visits:

<u>Type of Visit</u>	<u>Number of Visits Last 12 Months</u>	<u>Number of Visits Next 12 Months</u>
Clinic	_____	_____
Laboratory	_____	_____
Other (specify) _____	_____	_____
TOTAL NUMBER OF VISITS	_____	_____

e. Please specify any professional societies or associations in which you are a member: _____

f. Are you associated with or do you work for a physician or surgeon? [] Yes [] No
If yes, please give the name and the specialty of the physician: _____

- g. Please give the approximate percentage of time spent in the following work locations:
- | | | |
|------------------------------------|---------------------------|--------------------------------------------------|
| _____ % Administrative Office | _____ % Laboratory | _____ % Hospital Ward (specify) |
| _____ % Classroom | _____ % Operating Room | _____ |
| _____ % Emergency Dept of Hospital | _____ % Outpatient Clinic | _____ % Professional Office (specify profession) |
| _____ % Nursing Home | _____ % Patient's Home | _____ |
| _____ % Other (specify) _____ | | |
- h. Please indicate the approximate division of your patients or clients among:
- | | | |
|---------------------------|----------------------|----------------------------------|
| _____ % Hemodialysis | _____ % Psychiatric | _____ % Bariatrics |
| _____ % Holistic Medicine | _____ % Drug Addicts | _____ % Physical Rehabilitation |
| _____ % Surgical | _____ % Alcoholics | _____ % Disability Evaluation |
| _____ % Stress Testing | _____ % Obstetrical | _____ % Research or Experimental |
| _____ % Communicable | _____ % Dental | _____ % _____ |
| _____ % Family Planning | _____ % Pediatric | _____ % _____ |
- i. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.
- | <u>Type of Profession</u> | <u>No.</u> | <u>Type of Profession</u> | <u>No.</u> |
|----------------------------|------------|---------------------------|------------|
| Inhalation Therapists | _____ | Opticians | _____ |
| Laboratory Technicians | _____ | Optometrists | _____ |
| Nurse Anesthetists | _____ | Perfusionists | _____ |
| Nurses, Licensed Practical | _____ | Pharmacists | _____ |
| Nurse Practitioner | _____ | Physiotherapists | _____ |
| Nurses, Registered | _____ | Social Workers | _____ |
| Speech Therapists | _____ | Other (please specify) | _____ |
- j. Are all of the above individuals licensed in accordance with applicable state and federal regulations? [] Yes [] No
If no, please attach an explanation.

4. APPLICANT PROCEDURES

- a. Do you render professional services directly to patients? [] Yes [] No. If yes, please describe in detail and indicate the extent of supervision by others.
- | <u>Description of Professional Services</u> | <u>Percent of Time Supervised</u> | <u>Qualifications of Supervisor</u> |
|---------------------------------------------|-----------------------------------|-------------------------------------|
| _____ | _____ % | _____ |
| _____ | _____ % | _____ |
| _____ | _____ % | _____ |
- b. Do you render professional services that do not involve contact with a patient? [] Yes [] No. If yes, please describe these services in detail. _____
- c. (i) Do you perform or assist in any surgical procedures? [] Yes [] No
(ii) Please list ALL surgical procedures performed (including minor surgery): _____

- (iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? [] Yes [] No. If yes, please attach a detailed explanation.
- (iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? [] Yes [] No. If yes, please attach a detailed explanation.
- d. Do you perform radiation therapy?.....[] Yes [] No
- e. Do you perform psychiatric shock therapy?[] Yes [] No
- f. Do you compound in bulk, manufacture or wholesale medicine?[] Yes [] No
If yes, please provide a detailed explanation. _____

g. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered? [] Yes [] No
 If yes, please give details including the name, location, size and number of beds.

h. If you have a training school, please complete the following. Attach a separate sheet if needed.

<u>Specify Profession For Which Students Are Being Trained</u>	<u>Max. No. Of Students Per Session</u>	<u>No. of Sessions Per Year</u>	<u>% of Time Involved in Clinical Setting</u>	<u>Number of Faculty</u>	<u>Qualifications of Faculty (e.g. MD, RN, PhD, etc.)</u>
----------------------------------------------------------------	-----------------------------------------	---------------------------------	-----------------------------------------------	--------------------------	-----------------------------------------------------------

i. (i) Do you use a collection agency? [] Yes [] No
 If yes, please state the name of the agency

(ii) Does the agency have the authority to file a collection suit at its discretion? [] Yes [] No

7. APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

a. Have you or any of your employees:

(i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [] Yes [] No

(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?..... [] Yes [] No

(iii) Ever been treated for alcoholism or drug addiction? [] Yes [] No

(iv) 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?..... [] Yes [] No

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? [] Yes [] No

b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

<u>Policy Insurance Carrier</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible (If any)</u>	<u>Premium</u>	<u>Inception Mo./Day/Yr.</u>	<u>Expiration Mo./Day/Yr.</u>	<u>Was this a Claims Made Policy Form?</u>		<u>Retro Date</u>
							<u>Yes</u>	<u>No</u>	
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	_____	_____	[]	[]	_____

c. Has any claim or suit been brought against you and/or any of your employees? [] Yes [] No
 If yes, a Supplemental Claim Information Form must be completed for each claim or suit.

d. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? [] Yes [] No
 If yes, please give details on a separate sheet.

* 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. **I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.**

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.



BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for us

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED:



- o DEERFIELD INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
- o MARKEL INSURANCE COMPANY

If you obtained this application at www.markelshand.com, please submit this application through your local insurance professional.

SUPPLEMENT FOR HOME HEALTH CARE, NURSE REGISTRY, INFUSION THERAPY OR OTHER MEDICAL STAFFING FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____
2. Type of Firm (check all that apply): _____ Home Health Care _____ Infusion Therapy _____ Visiting Nurse Agency
_____ Nurse Registry _____ Other Medical Staffing (specify) _____
3. Date Established: _____
4. Location(s) where services are provided (total must equal 100%):
_____ %Home _____ %Hospice _____ %Nursing Home _____ %Assisted Living Facility _____ %Hospital
_____ %Clinic/Doctor's Office _____ %Adult Day Care _____ % Other Facility (specify) _____

5. Employees/Independent Contractors – Annual Staffing:

<u>Type of Employee/Independent Contractor</u>	<u>No. Full-Time</u>	<u>No. Part-Time</u>	<u>Billable Hours Per Year</u>
Employed Registered Nurse	_____	_____	_____
Contracted Registered Nurse	_____	_____	_____
Employed Licensed Practical Nurse	_____	_____	_____
Contracted Licensed Practical Nurse	_____	_____	_____
Employed Certified Nurse Assistant	_____	_____	_____
Contracted Certified Nurse Assistant	_____	_____	_____
Employed Nurse Practitioner/Physician Assistant	_____	_____	_____
Contracted Nurse Practitioner/Physician Assistant	_____	_____	_____
Employed Companion/Home Health Aide	_____	_____	_____
Contracted Companion/Home Health Aide	_____	_____	_____
Employed Social Worker	_____	_____	_____
Contracted Social Worker	_____	_____	_____
Employed Physical Therapist	_____	_____	_____
Contracted Physical Therapist	_____	_____	_____
Employed Other Medical (specify) _____	_____	_____	_____
Contracted Other Medical (specify) _____	_____	_____	_____

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

Name of Applicant

Title

Signature of Applicant

Date