

American Academy of Clinical Toxicology  
Administered by NIA Insurance Services  
Phone: 800-966-2155  
Fax number: 440-893-9951  
Email: [quotes@statesideunderwriting.com](mailto:quotes@statesideunderwriting.com)

This is an application form for a **CLAIMS MADE** policy

**INSTRUCTIONS:**

1. Please answer all questions (if not applicable, show N/A) and attach all additional information/explanations as required for each location.
2. Please date and have two signatures on the applications.
3. "Applicant" refers to the company, its predecessors, and all proposed Insureds, including Subsidiaries.
4. PLEASE READ STATEMENT AT THE END OF APPLICATION CAREFULLY.
5. For multiple locations, please complete a separate application for each.
6. Please do not leave prior insurance coverage blank and include a copy of your current malpractice declarations pages - applications cannot be quoted without this data.

**SECTION I - APPLICANT'S INFORMATION**

1. Name: \_\_\_\_\_
2. Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Email Address: \_\_\_\_\_
3. Website Address (if applicable): www. \_\_\_\_\_
4. Current Carrier: \_\_\_\_\_ Proposed Inception Date: \_\_\_\_\_
5. Limits: \$\_\_\_\_\_ Deductible: \$\_\_\_\_\_ Premium: \$\_\_\_\_\_
6. Claims Made or Occurrence? \_\_\_\_\_ If CM, Retro Date: \_\_\_\_\_
7. If CM, please note that we will only offer retro date inception on evidence of trailing out prior carrier or if prior occurrence policy held. Please condition if applicable. This should be a certificate of insurance and must be attached to the application.  
\_\_\_\_\_  
\_\_\_\_\_
8. Applicant is:    - Individual            \_\_\_\_\_            - For-Profit            \_\_\_\_\_  
                         - Partnership            \_\_\_\_\_            - Not-for-Profit        \_\_\_\_\_  
                         - Corporation            \_\_\_\_\_  
                         - Governmental        \_\_\_\_\_
9. Please state number of years:  
    - Member of AACT \_\_\_\_\_ (please note membership is required to bind)  
    - In operation \_\_\_\_\_  
    - Under current ownership \_\_\_\_\_  
    - Under current management \_\_\_\_\_

**10. If start-up:**

- Please describe experience and qualifications relevant to the role.
- Have you ever been involved in disciplinary proceedings or a professional liability claim or circumstance when working elsewhere? If so, please describe below and include reserve, award or settlement amounts.

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**11. Please list professional associations to which the Applicant belongs:**

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**12. Annual Gross Revenues (please project for 2008)**

2008: \$\_\_\_\_\_ 2007: \$\_\_\_\_\_

**13. Is the Applicant controlled or owned by, or associated or affiliated with, or does it own, any other firm or business enterprise? Yes\_\_\_\_\_ No \_\_\_\_\_**

If yes, please explain: \_\_\_\_\_

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**14. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?**

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give details, including name, location, size and number of beds.

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**15. Please detail principle exposures and reasons for purchasing insurance.**

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**16. Are any significant changes in the nature or size of the Applicant's business anticipated over the next 12 months? Or have there been any such changes in the past 12 months?**

Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, please explain: \_\_\_\_\_

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17. Please detail physician arrangements and advise limits held and with which carriers.

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18. Does the applicant maintain any beds for overnight occupancy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, total number: \_\_\_\_\_

19. Does the Applicant use a written contract?

Always \_\_\_\_\_ Sometimes \_\_\_\_\_ Never \_\_\_\_\_

If not always, please explain how the scope of services to be provided is agreed:

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20. Professional Activities and Specialty (Attach narrative description if necessary).

Check One:

Home Healthcare Agency       Residential Healthcare Facility  
 Medical/Testing Laboratory       Other (Specify) \_\_\_\_\_  
 Nurse's Registry      \_\_\_\_\_  
 Out-Patient Clinic      \_\_\_\_\_

21. a. List the number and type of applicant's employees and volunteers: IF NONE STATE NONE.

Type of Profession		NUMBER	Type of Profession		NUMBER
A	Inhalation Therapists		I	Perfusionists	
B	Laboratory Technicians		J	Pharmacists	
C	Nurse Anesthetists		K	Physicians – Minor Surgery	
D	Nurses, Licensed Practical		L	Physicians – No Surgery	
E	Nurse Practitioner		M	Physiotherapists	
F	Nurses Registered		N	Social Workers	
G	Opticians		O	Speech Therapists	
F	Optometrists		P	Other	

b. List the number and type of independent contractors who provide professional services on behalf of the applicant. IF NONE, STATE NONE.

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c. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, attach explanation.

**ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:**

Has the applicant or have any of the above employees:

		Yes	No
A	Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental administrative agency, hospital or professional association?		
B	Ever been convicted for an act committed in violation of any law or ordinance other than traffic offences?		
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?		

**22. Does the applicant perform:**

		Yes	No
A	Acupuncture or acupuncture anaesthesia?		
B	Angiography/Arteriography/Venography?		
C	Catherization (other than urinary or umbilical)?		
D	Closed reduction of compound fractures and/or Normal Deliveries and/or Dermabrasion?		
E	Injection of radioisotopes and/or use of irradiated substances?		
F	Radiation Therapy and/or Chemotherapy?		
G	Psychiatric shock therapy?		
H	Silicone Injections?		
I	Spinal Anesthesia (other than saddle blocks or caudals)?		
J	Laser treatment?		

**23. Does the applicant perform any:**

		Yes	No
A	Surgery other than incision of superficial boils or suturing superficial fascia?		
B	Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers?		
C	Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections?		
D	Cosmetic Plastic Surgery?		
E	Excision of large cysts and/or I&D of deep-seated boils or carbuncles?		
F	Hysterectomies?		
G	Open reduction of fractures?		
H	Surgery for weight reduction of patients?		
I	Abortions and/or menstrual extractions? Describe (include trimester, method and number of Abortions performed per month):		
J	Silicone implants?		
K	Sterilization Procedures?		
L	Biopsies and/or endoscopies? List types performed:		
M	Sex change operations? Describe and advise the number performed per year:		
N	Other surgery? Describe:		

24. Does the applicant use drugs for weight reduction of patients? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant.

25. Does the applicant administer any methadone treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, describe treatment and controls used and indicate number of treatments during:  
Last 12 months:

Next 12 months:

26. Number of patient encounters last 12 months \_\_\_\_\_ and/or patient tests carried out \_\_\_\_\_.

(NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

27. Number of estimated patient encounters next 12 months \_\_\_\_\_ and/or patient tests carried out \_\_\_\_\_.

(NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

28. Does the Applicant have a written procedures manual for employees to follow?

Yes \_\_\_\_\_ No \_\_\_\_\_

29. Does the Applicant have a formalised training program for employees? Yes \_\_\_\_\_ No \_\_\_\_\_

30. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (day/mo/yr)

31. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give details: \_\_\_\_\_

32. Has any insurer cancelled or refused to renew any similar insurance during the past five years? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**SECTION II – BUILDING INFORMATION**

33. Year Built: \_\_\_\_\_ Protection Class: \_\_\_\_\_ Square Footage: \_\_\_\_\_

34. Number of Floors: \_\_\_\_\_ Number of Exits: \_\_\_\_\_

35. Major Renovations/Additions: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give dates and describe: \_\_\_\_\_

Summary of insurance coverage:  
\_\_\_\_\_  
\_\_\_\_\_

**The Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage:**

**Please ensure that additional information is attached where applicable.**

**The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.**

**The Applicant on behalf of all proposed Insureds further warrant that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.**

**\*Please note that this application will not be reviewed unless it is signed and dated.\***

\_\_\_\_\_  
Date Signature of Applicant's Authorized Principal or Officer

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date Signature of Applicant's Administrator or Medical Director

\_\_\_\_\_  
Title

Administered by NIA Insurance Services  
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Phone: 800-966-2155  
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**MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY**

ATTACHMENT 'A'

**FINANCIAL SCHEDULE**

**Please provide the following information concerning the current year estimated financial figures and two previous years:**

Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

	2006 \$	2007 \$	2008 (projected) \$
TOTAL REVENUES	_____	_____	_____
TOTAL GROSS ASSETS	_____	_____	_____
TOTAL CAPITAL (EQUITY)	_____	_____	_____
TOTAL DEBT	_____	_____	_____
SHORT TERM DEBT      maximum	_____	_____	_____
(due within One year)      minimum	_____	_____	_____
TOTAL LONG-TERM DEBT	_____	_____	_____
TOTAL ESTABLISHED CREDIT LINES WITH BANKS	_____	_____	_____
NET INCOME AFTER TAX	_____	_____	_____
DEPRECIATION/AMORTIZATION	_____	_____	_____

Any further details you may wish to include:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNED : \_\_\_\_\_ DATE : \_\_\_\_\_

**MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY**

ATTACHMENT 'B' - Claims

Please complete this form if the applicant is aware of any errors, omissions or (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years.

1. Name of Applicant: \_\_\_\_\_
2. Name of Member of Staff involved in claim: \_\_\_\_\_
3. Name of (potential) claimant: \_\_\_\_\_
4. Date of Incident: \_\_\_\_\_ Date claim made: \_\_\_\_\_
5. Under which policy was the claim made? Carrier: \_\_\_\_\_  
Policy No: \_\_\_\_\_
6. Status of claim: Closed \_\_\_\_\_ (Please indicate total loss) \_\_\_\_\_  
Open \_\_\_\_\_ (Please complete questions 7,8,& 9)
7. Total defence costs and expenses to date:  
\_\_\_\_\_
8. Damages or other relief sought by the claimant(s):  
\_\_\_\_\_
9. Please advise the following details:
  - i) The specific act, error or omission upon which the claimant bases the claim.
  - ii) A brief description of the claim.
  - iii) Details of the current status and proposed strategy for handling the claim.\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNED :** \_\_\_\_\_ **DATE :** \_\_\_\_\_

**MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY**

ATTACHMENT 'C'

1. Please list all non-patient professional services rendered for a fee for which you wish to also have professional liability coverage:

\_\_\_\_\_

\_\_\_\_\_

2. Annual Gross Revenues for services rendered in question one above (please project for 2008).

2008: \$ \_\_\_\_\_ 2007: \$ \_\_\_\_\_

3. Are the revenues in question two above included in question twelve of the main application: Yes \_\_\_\_\_ No \_\_\_\_\_

4. With respect to the services mentioned in question 1 above, please indicate the Applicant's five largest jobs/projects during the past three years, showing client's name, services provided and gross revenues for each:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Please provide total number of independent reviews performed in 2007 \_\_\_\_\_  
2008 \_\_\_\_\_

6. Please provide total current number of full time employees \_\_\_\_\_ and  
part time employees \_\_\_\_\_

7. Please provide total number who earn \$30,000 or less \_\_\_\_\_ \$30,000 to  
\$50,000 \_\_\_\_\_ \$50,000 to \$100,000 \_\_\_\_\_ over \$100,000 \_\_\_\_\_

SIGNED : \_\_\_\_\_

DATE : \_\_\_\_\_