American College of Occupational and Environmental Medicine
Administered by NIA Insurance Services
Phone: 800-966-2155
Fax number: 440-893-9951
Email: 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 ___
- Partnership ___
- Corporation ___
- Governmental ___
- For-Profit ___
- Not-for-Profit ___

9. Please state number of years:
- Member of ACOEM _______ (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.

____
____
____
____
____

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

____
____

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: ____
____
____

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.

____
____

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

____
____
____
____

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: ____
____
____

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

____
____
____
____

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:
____
____

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

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

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.
____
____

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	Anglography/Arteriography/Venography?		
C	Catherierization (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 caudais)?		
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 carbuncies?		
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
29500 Aurora Rd. | Solon, Ohio 44139
Phone: 800-966-2155
Fax number: 440-893-9951
Email: quotes@statesideunderwriting.com

MISCELLANEOUS MEDICAL PROFFESIONAL 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 south 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.

____
____
____
____
____
____
____
____
____
____
____
____

SIGNED : __________________________________ ***DATE :*** _______________

MISCELLANEOUS MEDICAL PROFFESIONAL 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 : _____________