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Application For:

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1. Name of Applicant: _____

2. Mailing Address: _____ Phone: () _____

City: _____ County: _____ State: _____ Zip: _____

No. of Locations: _____ **(If multiple names and locations, please attach list)**

3. a) Date Established _____ Corporation Partnership Professional Assoc. Individual
For Profit Not for Profit

b) In what states is the Applicant registered and licensed to practice? _____

c) Please specify any professional societies or associations which you are a member. _____

4. a) Is the firm engaged in, owned by, associated with, or controlled by any other business? Yes No
b) Is the firm owned by any physician? Yes No
c) Is the firm owned by any a hospital, or are any services hospital based? Yes No
d) Have there been any changes in ownership of the business since the date the entity was established? Yes No

If "Yes" to any of the above, give details: _____

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

Check all that apply:

_____ MRI

_____ Computed Tomography

_____ X-ray

_____ Ultrasound

_____ Mammography

_____ Nuclear Medicine

_____ PET

_____ Other (Specify): _____

6. State approximate division of Applicant's patients among:

- | | | | | | |
|-------------------------------|---|----|-----------------------------|---|----|
| a) Alcoholics | (| %) | k) Obstetrical | (| %) |
| b) Counseling/Family Planning | (| %) | l) Pediatric | (| %) |
| c) Communicable | (| %) | m) Prisoners | (| %) |
| d) Dental | (| %) | n) Psychiatric | (| %) |
| e) Drug Addicts | (| %) | o) Research or Experimental | (| %) |
| f) General | (| %) | p) Senile or Aged | (| %) |
| g) Hemodialysis | (| %) | q) Stress Testing | (| %) |
| h) Holistic Medicine | (| %) | r) Surgical | (| %) |
| i) Medical | (| %) | s) Tubercular | (| %) |
| j) Mentally Retarded | (| %) | t) Other: _____ | (| %) |

7. a. List the number and type of Applicant's employees and volunteers below: If "None," state None. _____

Number Type of Profession

- i) _____ Laboratory Technicians
- ii) _____ Medical Directors
- iii) _____ Nurse Anesthetists
- iv) _____ Nurses, Licensed Practical
- v) _____ Nurse Practitioner
- vi) _____ Nurses Registered
- vii) _____ Other: _____

b. List the number and type of independent contractors who provide professional services on behalf of the Applicant. Use a separate sheet, if necessary.

If "None," state None. _____

c. Are all of the individuals listed in question 7.a. and 7.b. licensed in accordance with applicable state and federal regulations? Yes No

If "No," attach explanation.

d. Are all employed/contracted physicians board certified in their specialty? Yes No

(Attach detailed explanation for any "Yes" answers to the following:)

e. 1) Are criminal background checks conducted on all employees? Yes No

If "No," attach explanation.

2) Does the Applicant conduct preemployment screenings and any other necessary investigations prior to hiring all staff? Yes No

f. Has the Applicant or any of the individuals listed in question 7.a. and 7.b.:

- i) Ever been the subject or 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
- ix) 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? Yes No

- 8. a) Is there a written/formalized risk management/quality assurance program? Yes No
- b) Does the Applicant have a written credentialing process for employees and staff? Yes No
- c) Does the Applicant have written procedures for reporting all incidents? Yes No

If "No" to any of the above, attach explanation.

9. State approximate division of services being provided among the following settings:

- | | | | |
|-------------------------------|-------------|----------------------|-------------|
| a) Assisted Living Facilities | (%) | e) Nursing Homes | (%) |
| b) Clinics | (%) | f) Physician Offices | (%) |
| c) Emergency Rooms | (%) | g) Private Homes | (%) |
| d) Hospitals | (%) | h) Other: _____ | (%) |

- 10. Does the Applicant perform hospital emergency room care?
 - a. For its own patients? Yes No
 - b. For patients not its own? Yes No
 - c. If answer to (b) is "Yes," please specify: the percentage of its time devoted to this work = _____%, the number of hours per month devoted to this work = _____hrs.

- 11. Is anesthesia (other than topical or by means of local infiltration) administered by either Applicant or others? Yes No
- If "Yes," attach detailed explanation.**

12. State number of x-ray machines owned or operated and whether they are used for diagnosis or treatment or both:

Number of procedures: _____

- 13. 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:** _____
- _____
- _____

14. Does the Applicant sell or lease any equipment for use by any other persons or entities? Yes No
If "Yes," give details, including name, location, size and number of beds: _____

15. a) State sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
A. Charitable Contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee for Services	\$ _____	\$ _____
D. Other: _____	\$ _____	\$ _____
E. Other: _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

16. Number of estimated patient encounters last 12 months _____ and/or patient tests carried out _____. (Note: "patient encounters" refers to number of visits - not number of patients)

17. Number of estimated patient encounters and patient tests in the next 12 months:
 (Note: "patient encounters" refers to number of visits - not number of patients.)

Patient encounters _____
 Patient Tests _____

18. Describe Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If the expiring policy is claims made, what is the retroactive date? _____

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

If "Yes," please describe: _____

20. Is the Applicant currently insured under a Commercial General Liability Policy? Yes No
If "Yes," please give details:

Insurance Company	Type of Coverage	Limits BI	Limits PD	From	To
_____	_____	_____	_____	_____	_____

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

If "Yes," please describe: _____

22. Has any claim ever been made against the firm or any of its employees? Yes No
If "Yes," please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

23. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? Yes No

If "Yes," please give full details on the same basis as item 31.

24. Limits of Liability requested _____ Deductible _____

25. Desired term of policy: From _____ To _____

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and this Application will be attached and become a part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

It is warranted that the particulars and statements contained in the Application for the proposed Policy and any materials submitted herewith (which shall be retained on files by Underwriters and which shall be deemed attached hereto, as if physically attached hereto), are the basis for the proposed Policy and are to be considered as incorporated into and constituting a part of the proposed Policy.

It is agreed that in the event there is any material change in the answers to the questions contained herein proper to the effective date of the Policy, the Applicant will notify Underwriters and, at the sole discretion of Underwriters, any outstanding quotations may be modified or withdrawn.

For purposes of creating a binding contract of insurance by the Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall be the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

For Kentucky residents:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Name of Applicant: _____
Please Print Title Date

Signature: _____
Name Date