**REQUESTED COVERAGE - MEDICAL LAB INCLUDING MEDICAL IMAGING**

- **Requesting Professional Liability:**
  - Requested Retro Date: 
  - Professional Liability Limits:
    - $100,000 / $300,000
    - $200,000 / $600,000
    - $250,000 / $750,000
    - $500,000 / $1,500,000
    - Other: 
  - Professional Liability Deductible:
    - $1,000,000 / $1,000,000
    - $1,000,000 / $2,000,000
    - $1,000,000 / $3,000,000
    - Other: 
    - $2,500
    - $5,000
    - $7,500
    - $10,000
    - Other: 

- **Requesting General Liability:**
  - Requested Retro Date: 
  - Occurrence Based Coverage
  - General Liability Limits:
    - $100,000 / $300,000
    - $200,000 / $600,000
    - $250,000 / $750,000
    - $500,000 / $1,500,000
    - Other: 
  - General Liability Deductible:
    - $1,000,000 / $1,000,000
    - $1,000,000 / $2,000,000
    - $1,000,000 / $3,000,000
    - Other: 
    - $2,500
    - $5,000
    - $7,500
    - $10,000
    - Other: 

- **Requesting Employee Benefits Liability:**
  - Requested Retro Date: 
  - Employee Benefits Liability Limits:
    - $100,000 / $300,000
    - $200,000 / $600,000
    - $250,000 / $750,000
    - $500,000 / $1,500,000
    - Other: 
  - Employee Benefits Liability Deductible:
    - $1,000,000 / $1,000,000
    - $1,000,000 / $2,000,000
    - $1,000,000 / $3,000,000
    - Other: 
    - $1,000
    - $2,500
    - $5,000
    - $7,500
    - $10,000

- **Requesting Non-Owned Auto Liability:**
  - Non-Owned Auto Liability Limits:
    - $100,000
    - $200,000
    - $250,000
    - Other: 
    - $500,000
    - $1,000,000

*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.*
MEDICAL LABS AND MEDICAL IMAGING CENTERS

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state “N/A”.
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

GENERAL INFORMATION

1. Full name of Applicant (Including DBA’s) _____________________________________________________________

2. Mailing Address:

   STREET   CITY   COUNTY   STATE   ZIP

3. Location Address: Check here if same as mailing: ☐

   (1) STREET   CITY   COUNTY   STATE   ZIP
   (2) STREET   CITY   COUNTY   STATE   ZIP
   (3) STREET   CITY   COUNTY   STATE   ZIP
   (4) STREET   CITY   COUNTY   STATE   ZIP

   Attach Additional Pages as Needed

4. Website Address: www._______________________________  5. Telephone: __________________________

6. Inspection/Risk Management Contact Name: _______________________________________________________

7. Inspection/Risk Management Contact E-mail: _______________________________________________________

8. Date Established _____________________ Years under current management _________________

9. Applicant is a:

   ☐ Individual  ☐ Professional Associations
   ☐ Corporation ☐ Partnership
   ☐ LLC        ☐ Joint Venture
   ☐ Other: __________________________________________

10. Enterprise is: ☐ For Profit    ☐ Not For Profit

Page 2 of 9
11. Please describe nature of applicant’s operations

________________________________________________________________________
________________________________________________________________________

12. Applicant’s operations are: ☐ Mobile ☐ Stationary

13. Please state sources and amounts of total revenue:

<table>
<thead>
<tr>
<th>Source</th>
<th>Last 12 months</th>
<th>Next 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charitable contributions</td>
<td>$_____________</td>
<td>$_____________</td>
</tr>
<tr>
<td>Government Funding</td>
<td>$_____________</td>
<td>$_____________</td>
</tr>
<tr>
<td>Fee for services</td>
<td>$_____________</td>
<td>$_____________</td>
</tr>
<tr>
<td>Other – specify:</td>
<td>$_____________</td>
<td>$_____________</td>
</tr>
<tr>
<td><strong>Total Gross Revenue</strong></td>
<td>$_____________</td>
<td>$_____________</td>
</tr>
</tbody>
</table>

14. Please indicate total number of:

Tests in the **last** 12 months
Tests in the **next** 12 months

15. Please provide percentage of specimens / images:
   a. Collected directly from patients
   b. Received by the applicant from outside sources

16. Please provide the percentage of services provided for:

<table>
<thead>
<tr>
<th>Type</th>
<th>Hospitals</th>
<th>Nursing Homes</th>
<th>Physician offices</th>
<th>Industrial Facilities</th>
<th>Veterinary Clinics</th>
<th>Other (describe):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
</tbody>
</table>

17. Please indicate the number and types of Medical **Imaging** Tests performed. Check here if “None” ☐

<table>
<thead>
<tr>
<th>TYPE OF TEST</th>
<th>IN LAST 12 MONTHS</th>
<th>PROJECTED FOR NEXT 12 MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Density Scan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT/ CT Scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG/EEG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PET scans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound/ Sonography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Ray</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (describe):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. Please indicate the number and types of Medical LAB Tests performed. Check here if “None” □

<table>
<thead>
<tr>
<th>TYPE OF TEST</th>
<th>IN LAST 12 MONTHS</th>
<th>PROJECTED FOR NEXT 12 MONTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cytopathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Histopathology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV / AIDS Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or Alcohol Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNA Testing to include paternity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER: (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER: (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. Is the applicant involved in any of the following (explain all “yes” answers in the space provided below or additional pages as needed):
   a. Blood banking or cross matching? □ YES □ NO
   b. Manufacturing, dispensing, or testing pharmaceuticals? □ YES □ NO
   c. The use of radioactive material other than used in X-Ray equipment? □ YES □ NO
   d. Therapy or treatment procedures? □ YES □ NO
   e. Medical, genetic, AIDS or drug research □ YES □ NO
   f. Manufacturer and/or sell laboratory equipment or supplies, reagents or software □ YES □ NO

___________________________________________________________________________________
___________________________________________________________________________________

20. Is the applicant involved in reading or interpreting of X-Rays, Medical images, Pathology Slides or other similar tests? □ YES □ NO If yes, who is performing these services? Please also indicate if this is contracted or employed individual or group.
   ________________________________ □ Employee □ Contractor

21. If the applicant is providing any reading or interpretation services, are said results conveyed to the patient on the applicant’s letterhead?
   □ YES □ NO □ N/A

22. Please indicate any accreditations or approval’s held by the applicant:
   □ Joint Commission
   □ CLIA Approved Lab
   □ National Institute on Drug Abuse (NIDA) Approved
   □ ACR accreditation
   □ Other: ________________________________
   □ Other: ________________________________
23. Please provide number of employed and contracted staff:

<table>
<thead>
<tr>
<th>Profession</th>
<th>Employed</th>
<th></th>
<th>Contracted</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-time</td>
<td>Part-time</td>
<td>Full-time</td>
<td>Part-time</td>
</tr>
<tr>
<td>Lab Technicians</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>RN/LPN</td>
<td></td>
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<tr>
<td>Pathologists</td>
<td></td>
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<tr>
<td>Phlebotomists</td>
<td></td>
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<tr>
<td>Physician (other than pathologists or radiologists)</td>
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<tr>
<td>Radiologists</td>
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<tr>
<td>X-Ray Technicians</td>
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<tr>
<td>Other: Specify</td>
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</table>

24. Are all above individuals licensed in accordance with applicable state and federal regulations?  
☐ YES ☐ NO

25. Do all physicians **employed and contracted** carry their own professional liability coverage?  
If yes, what limits do they carry? ___________________

☐ YES ☐ NO

26. Please provide the name and specialty of the applicant’s Medical Director: ____________________________

Does the applicant’s Medical Director have direct patient care?  
☐ YES ☐ NO Please specify ☐ Full Time or ☐ Part Time

27. Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at your facility:

☐ Check of educational background, or residency program, when applicable.
☐ Check of previous employers (☐ In writing ☐ By Telephone)
☐ Criminal background check (☐ STATE ☐ FEDERAL)
☐ Drug / Alcohol / Abuse Screening (circle all that are used)
☐ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
☐ Require information on any professional liability or work-related claim that has previously been made against any Individual?

28. Does your facility have written job descriptions?  
☐ YES ☐ NO
29. Building Description

<table>
<thead>
<tr>
<th>Buildings / Locations</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Construction:</td>
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<tr>
<td>No. of Stories:</td>
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<tr>
<td>Square Footage</td>
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<tr>
<td>Date Built:</td>
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<tr>
<td>Smoke detectors:</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
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<tr>
<td>Local/Central station fire alarm:</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Sprinkler System:</td>
<td>□ Yes □ No □ Partial</td>
<td>□ Yes □ No □ Partial</td>
<td>□ Yes □ No □ Partial</td>
<td>□ Yes □ No □ Partial</td>
</tr>
</tbody>
</table>

30. Do any of the Applicant’s locations have any (explain any “yes” answers on page 8):
   a. Exposure to flammables, explosive, chemicals? □ YES □ NO
   b. Catastrophe exposure? □ YES □ NO
   c. Exposure to radioactive materials? □ YES □ NO

31. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? If Yes, complete a supplemental claims form for each. □ YES □ NO

32. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? If Yes, complete a supplemental claims form for each. □ YES □ NO

**COVERAGE HISTORY**

33. Please list professional liability insurance carried for each of the past five years.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Dates covered</th>
<th>Limits of Liability Per claim/agg.</th>
<th>Deductible</th>
<th>Premium</th>
<th>Retroactive date</th>
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34. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

<table>
<thead>
<tr>
<th>Insurer</th>
<th>Dates covered</th>
<th>Limits of Liability Per claim/agg.</th>
<th>Deductible</th>
<th>Premium</th>
<th>Occurrence or Claims – Made?</th>
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If the current expiring GL policy is claims-made, what is the retroactive date? ________

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35. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? If yes, provide details within the supplemental information or attach additional pages as need. □ YES □ NO

36. Has the applicant or any of its employees ever been charged with, or convicted of a crime other than minor traffic violations? If yes, provide details within the supplemental information or attach additional pages as need. □ YES □ NO

37. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? If yes, provide details within the supplemental information or attach additional pages as need. □ YES □ NO

38. Has any claim or suit for malpractice or professional liability ever been made against the applicant OR any other person proposed for this insurance? How Many? ______ (Complete Supplemental Claims form for Each) □ YES □ NO

39. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? If yes, please explain in detail, completing a supplemental claim form for each. □ YES □ NO

40. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant’s current or prior insurer? If yes, please explain in detail, completing a supplemental claim form for each. □ YES □ NO

SUPPLEMENTAL INFORMATION (reference question number if applicable)

________________________________________________________________________
________________________________________________________________________
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FRAUD WARNING

NOTICE TO ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NORTH CAROLINA, NORTH DAKOTA, OREGON, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, TEXAS, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WISCONSIN, AND WYOMING APPLICANTS: In some states, 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime in many states.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policy holder or claimant for the
NOTICE TO OHIO APPLICANTS: If any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: 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.

NOTICE TO TENNESSEE APPLICANTS: Any person who knowingly, and with intent to defraud any insurance company, or statement of a 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.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 the person to criminal and civil penalties.

NOTICE TO VIRGINIA APPLICANTS: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

NOTICE TO NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and criminal penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

NOTICE TO MAINE APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: 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.

The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.

The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant’s acceptance of the company’s quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.

Applicant: ___________________________________________ Title: ______________________________

FEIN #: ____________________________________________

Applicants Signature: ________________________________ Date: ______________________________

Agent/Broker Name: ____________________________________

Page 8 of 9
If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient:____________________________________________ Age:______ Sex:_______
Incident☐ Claim☐

Date reported to insurance company: ______________
Name of insurance company: _______________________________________________
Date of incident and your treatment: __________________________________________________________
Allegations / Circumstances: ___________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Additional Defendants: _______________________________________________________________________

What is the present condition of the patient?______________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

STATUS OF CLAIM
☐Suit threatened, no action taken
☐Suit filed but dropped by claimant
☐Summary judgment in your favor

☐Court outcome in YOUR favor:
☐Jury verdict
☐Directed verdict

☐Unresolved/Open
☐Awaiting mediation
☐Awaiting court action

Reserve amount: $__________________

☐Suit settled out of court

a. Date claim paid: ______________
b. Amount paid: $_____________
c. Did you want to settle?
☐Yes ☐No

☐Court outcome in favor of plaintiff:
☐Jury verdict
☐Directed verdict

Amount of loss payment: $__________________

Name and address of the attorney assigned to your case: ____________________________________________
___________________________________________________________________________________________

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes: ☐ No: ☐

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

Signature: __________________________________ Date:_____________________
Printed Name: __________________________________