Allied Healthcare
Professional Liability
Application

APPLICATION FOR ALLIED HEALTHCARE PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

NOTICE: THE COVERAGE APPLIED FOR PROVIDES CLAIMS-MADE COVERAGE WHICH PROVIDES LIABILITY COVERAGE ONLY IF A CLAIM IS MADE DURING THE POLICY PERIOD OR ANY APPLICABLE EXTENDED REPORTING PERIOD. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE WITH YOUR INSURANCE AGENT OR BROKER.

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

APPLICANT INFORMATION

1. Applicant (include professional degree if applicant is an individual): ______________________________
2. Formal business, corporate or partnership name(s) : ______________________________
3. Principal business premise address: ______________________ (Street) ______________________ (County)

   ______________________ (City) __________ (State) ______________ (Zip)

   Please attach a list of additional office addresses.

4. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____
5. Business Phone: ______________________
6. Square feet of total office space (all locations): ________
7. Your practice:
   - Solo practitioner (unincorporated)
   - Professional corporation (for profit)
   - Solo practitioner (incorporated)
   - Professional corporation (non-profit)
   - Partnership
   - Employee of ______________________ (Give name of employer)
   - Professional Association
   - Other (please describe) ______________________
8. Please list the names of all partners or members of your professional association/corporation who provide professional services: ______________________
9. Please attach a copy of your letterhead.
10. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No

    If yes, has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No

EDUCATION/EXPERIENCE (Individual Applicant Only)

1. Institution Name and Address | Years of Training | Degree or Certification Attained

Institution Name and Address	Years of Training	Degree or Certification Attained
______________________	From ________ To ________	______________________
______________________	From ________ To ________	______________________
______________________	From ________ To ________	______________________

2. Where have you practiced your profession during the last ten years?
   In ______________________________ From ______________ To______________
   In ______________________________ From ______________ To______________
   In ______________________________ From ______________ To______________

3. 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.

APPLICANT PRACTICE

1. Please list all the states where you are licensed to practice. If NONE, please attach an explanation:
   ____

2. Please indicate all of your professional staff's specialty. Use additional sheets if necessary.

Professional Specialty	No. of Staff

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

	Source	Amount This Fiscal Year	Amount Next Fiscal Year
(i)	Charitable Contributions:	$	$
(ii)	Government Funding:	$	$
(iii)	Fee for Services:	$	$
(iv)	Other:____________	$	$
TOTAL GROSS REVENUE		**$**	**$**

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

Type of Visit	Number of Visits Last 12 Months	Number of Visits Next 12 Months
Clinic		
Laboratory		
Other (specify)____________		
TOTAL NUMBER OF VISITS		

5. Please specify any professional societies or associations in which you are a member:
   ____

6.. 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: ____________________

7. 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) ____________

8. Please indicate the approximate division of your patients or clients among:

_____% Hemodialysis _____% Psychiatric

_____% Holistic Medicine _____% Drug Addicts _____% Physical Rehabilitation

_____% Surgical _____% Alcoholics _____% Disability Evaluation

_____% Stress Testing _____% Obstetrical _____% Research or Experimental

_____% Communicable _____% Dental _____% ____________________

_____% Family Planning _____% Pediatric _____% ____________________

9. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

Type of Profession	No.	Type of Profession	No.
Counselors	________	Opticians	________
Laboratory Technicians	________	Optometrists	________
Nurse Anesthetists	________	Perfusionists	________
Nurses, Licensed Practical	________	Pharmacists	________
Nurse Practitioner	________	Physiotherapists	________
Nurses, Registered	________	Social Workers	________
Speech Therapists	________	Other (please specify)	________

. Are all of the above individuals licensed in accordance with applicable state and federal regulations? Yes No
If no, please attach an explanation.

APPLICANT PROCEDURES

1. Description of Professional Services	Percent of Time Supervised	Qualifications of Supervisor
______________________________	________ %	________________
______________________________	________ %	________________
______________________________	________ %	________________

. Do you render professional services that do not involve contact with a patient? Yes No
If yes, please describe these services in detail. ______________________________

____

2. Do you perform or assist in any surgical procedures? [ ] Yes [ ] No

3. Please list ALL surgical procedures performed (including minor surgery):

____

4. 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.

5. 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:

6. Do you perform radiation therapy? Yes No
7. Do you perform psychiatric shock therapy? Yes No
8. Do you compound in bulk, manufacture or wholesale medicine? Yes No

   If yes, please provide a detailed explanation.

   ____

9. Do you perform veterinary services? Yes No

   If yes, please indicate the approximate division of your work among the following categories.

   _______ % Greyhounds _______ % Thoroughbreds

   _______ % Animals valued over $5,000.

   Please attach an explanation including the frequency and the type(s) of animals treated.

10. Do you administer artificial insemination? Yes No

    If yes, please answer the following questions:

    a. What type(s) of animals are involved? ____
    b. Are you responsible for the storage of the semen? Yes No

       If yes, please explain. ____
    c. What percent of your practice is involved with artificial insemination? ________ %

11. Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action? Yes No

    If yes, please attach a detailed explanation.

PERSONNEL

1. Please list the number and type of independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.

No.	Type of Profession	No.	Type of Profession	No.	Type of Profession
_____	Inhalation Therapists	_____	Laboratory Technicians	_____	Nurse Anesthetists
_____	Nurses, Licensed Practical	_____	Nurse Practitioner	_____	Nurse, Registered
_____	Opticians	_____	Optometrists	_____	Perfusionists
_____	Pharmacists	_____	Physiotherapists	_____	Social Workers
_____	Speech Therapists	_____	Other (specify)___________________________________		

2. Do you supervise any individuals who are not your own employees? Yes No

   If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

3. Please indicate by profession the number of individuals you supervise.

No.	Type of Profession	No.	Type of Profession
____	Physicians	____	Laboratory technicians
____	X-ray technicians	____	Other (please specify):___________________________

APPLICANT AFFILIATIONS

1. Do you own or operate any business other than that shown in Question 1(a) above? Yes No
   If yes, please give details on a separate sheet.
2. Are you employed by any individual or entity other than that shown in Question 1(a) above? Yes No
   If yes, please attach an explanation describing details of your responsibilities.
3. Are you under contract to any individual or entity other than that shown in Question 1(a) above? Yes No
   If yes, please attach an explanation describing details of your responsibilities.

   If your contract contains a hold-harmless agreement, a copy of the contract must be attached.
4. Are you employed by or under contract to any government entity? Yes No
   If yes, please attach an explanation including the details of your responsibilities.
5. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? Yes No
   If yes, please attach a copy of ALL of your advertisements.
6. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? Yes No
   If yes, please attach a detailed explanation and a copy of ALL of your advertisements.
7. 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.
8. If you have a training school, please complete the following. Attach a separate sheet if needed.

Specify Profession for which Students are being trained	Maximum # of students per session	# of sessions per year	% of time involved in clinical setting	# of faculty	Qualifications of faculty (e.g. MD, RN, PhD, etc.)

9. Do you use a collection agency? Yes No
   If yes, please state the name of the agency
10. Does the agency have the authority to file a collection suit at its discretion? Yes No

APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

Have you or any of your employees:

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

3. Ever been treated for alcoholism or drug addiction? Yes No
4. 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
5. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? Yes No
6. Previous Professional Liability Insurance:

Policy Period	Insurer	Indicate whether Claims Made or Occurrence policy	Limits of Liability	Deductible	Retro Date	Premium

7. Does the Applicant carry General Liability Insurance? Yes No

   If Yes, provide: Insurer: ____
8. Limits: ____
9. Does coverage include Products/Completed Operations Hazards? Yes No
10. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? Yes No
11. 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.
12. 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.

FRAUD WARNINGS

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 and subjects that person to criminal and civil penalties (In Oregon, the aforementioned actions may constitute a fraudulent insurance act which may be a crime and may subject the person to penalties). (In New York, the civil penalty is not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.) **(Not applicable in AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OK, OR, PA, PR, RI, TN, VA, WA, WV)**

Applicable in Alabama, Arkansas, District of Columbia, Louisiana, Maryland, New Mexico, Rhode Island, and West Virginia: Any person who knowingly (or willfully in MD) presents a false or fraudulent claim for payment of a loss or benefit or who knowingly (or willfully in MD) presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

Applicable in California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a 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.

Applicable in Colorado: 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in Florida and Oklahoma: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony. (In FL, a person is guilty of a felony of the third degree.)

Applicable in Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in Kentucky: 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.

Applicable in Maine, Tennessee, Virginia and Washington: 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 a denial of insurance benefits.

Applicable in Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

REPRESENTATIONS

Verus Underwriting Managers, a Berkley Company, is authorized to make any inquiry in connection with this application. Signing this application does not bind Verus Underwriting Managers or the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application, and all previous applications and material changes thereto of which Verus Underwriting Managers or the Company receives notice is on file with Verus Underwriting Managers and is considered physically attached to and part of the policy if issued. Verus Underwriting Managers and the Company will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify Verus Underwriting Managers, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I/We warrant to Verus Underwriting Managers and the Company, that I/We 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 and deemed incorporated therein, should Verus Underwriting Managers and the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Verus Underwriting Managers or the Company.

It is understood and agreed that prior to the inception date of the policy no applicant knew, nor could have reasonably foreseen, any negligent act, error or omission or breach of professional duty, or personal injury or other circumstances that reasonably might result in a Claim covered by this policy.

Name of Applicant:		
Signature of person authorized to execute on behalf of the applicant:		**Date:**
Print Name and Title of person authorized to execute on behalf of the applicant:		
Name and address of Broker:		

A copy of this application should be retained for your records.