ADMIRAL INSURANCE COMPANY
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MEDICAL TESTING LABORATORY PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

1. **Full and Legal Name of applicant:**____
____
(Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. **Internet Address(es):**____

3. **Mailing Address of Principal Office (Attach a schedule of all locations if more than one.)**
____
____

4. **List all states in which applicant operates and percentage of work in each state:**_______________________
____

5. **Does applicant have a location at a hospital or within another medical facility? ___ YES ___ NO If Yes, please provide details:** ____

6. **Applicant is a: ___Individual ___LLC ___Corporation ___Partnership ___Joint Venture**
Other (specify): ____

7. **Date Established: _______________(mm/dd/yy)**

8. **Has the name of the applicant ever changed or has there been any acquisition, consolidation, dissolution, merger or any other change in business organization during the past five (5) years? ___ YES ___ NO If Yes, provide full details.**____
____

9. **During the next twelve (12) months, does the applicant contemplate offering any services not currently offered, or any mergers or acquisitions? ___ YES ___ NO If Yes, please provide details.** _______________________
____
____

10. **Professional Activities and Specialties (describe):** ____
____
____
____

11. **State approximate % of gross income derived from the following types of tests (total should be 100%):**

_____% Alcohol/Drug Testing	_____% HIV (AIDS)	_____% X-Ray
_____% CT/CAT	_____% Immunology	_____% Other ________
_____% Cytology	_____% MRI	_______________
_____% DNA	_____% Occupational	_______________
_____% Fertility/Pregnancy/Paternity	_____% PET/SPECT	100% Total
_____% Hematology	_____% STD's	
_____% Hepatitis	_____% Sonography	
_____% Histology	_____% Ultrasound	

12. **What is the total # of tests estimated for the next 12 months? __________ Last 12 months? __________**

13. **Specimen collection:**
    a) **Samples collected by you or your employees at your lab site:** _________%
    b) **Samples collected by others and sent into or delivered to your lab site:** _________%
    ***These should add up to 100%**

14. **Does Applicant own (wholly or in part), operate, or administer any other type of facility, such as a hospital, nursing home, assisted living facility or other institution where medical services are customarily rendered? ___ Yes ___ No If Yes, please provide details.**____

15. **State sources and amounts of <u>TOTAL GROSS REVENUE/RECEIPTS</u>:**

<u>Source of Revenue</u>	**<u>Estimated for Next 12 Months</u>**	**<u>Last 12 Months</u>**
Charitable Contributions:	**$______________________**	**$________________________**
Government Funding:	**$______________________**	**$________________________**
Fee for Service:	**$______________________**	**$________________________**
Other_______________________	**$______________________**	**$________________________**
TOTAL GROSS REVENUE:	$______________________	$________________________

16. **Staff:**

		<u>Employees</u>	***Independent <u>Contractors</u>***	***Insured on Own Med Mal Policy<u>?</u> <u>(Yes or No)</u>***
A.	**Principals, Partners, Officers, Directors**	__________	__________	__________
B.	**Physicians**	__________	__________	__________
C.	**LPN/LVN**	__________	__________	__________
D.	**Nurse Anesth.**	__________	__________	__________
E.	**Nurses Aides**	__________	__________	__________
F.	**Certified Lab Tech./Technologist.**	__________	__________	__________
G.	**Certified Medical Assistant**	__________	__________	__________
H.	**EEG/EKG Tech./Technologist**	__________	__________	__________
I.	**X-Ray Tech./Technologist**	__________	__________	__________
J.	**Phlebotomist**	__________	__________	__________
K.	**Medical Tech./Technologist**	__________	__________	__________
L.	**Radiation Therapist**	__________	__________	__________
M.	**Inhalation Therapist**	__________	__________	__________
N.	**Physicians Assistant**	__________	__________	__________
O.	**Social Worker**	__________	__________	__________
P.	**Clerical/Administrative**	__________	__________	__________
Q.	**Other (specify): __________________________**	__________	__________	__________
	____	__________	__________	__________
	TOTAL STAFF:	__________	__________	

***Please attach copies of declarations pages for all of the above that carry their own insurance.**

17. **Are all of the above individuals licensed in accordance with all applicable state and federal regulations?**
___ Yes ___ No If No, please provide details____

a) Have any of the above individuals had their license/certification revoked/suspended, voluntarily surrendered or cancelled? ___ Yes ___ No If Yes, please provide details.__________________________________
____

b) Have any of the above individuals been the subject of disciplinary or investigative proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ___ Yes ___ No If Yes, please provide details.____

c) Have any of the above individuals been convicted of an act in violation of any law or ordinance other than a traffic accident? ___ Yes ___ No If Yes, please provide details.____
____

18. **Do you offer any of the following services? If Yes, please attach a detailed explanation.**

a. Therapy or any treatment procedures	**___ Yes ___ No**
b. Blood banking or blood storage	**___ Yes ___ No**
c. Procurement of blood or its components	**___ Yes ___ No**
d. Plasmapheresis procedures	**___ Yes ___ No**
g. Medical, Genetic or Drug research	**___ Yes ___ No**
h. Manufacture, testing or dispensing of pharmaceuticals	**___ Yes ___ No**
i. Manufacture or sell laboratory equipment or supplies	**___ Yes ___ No**
j. Experimental testing or procedures	**___ Yes ___ No**
k. Mobile services: If Yes, what percentage: ______%	**___ Yes ___ No**
l. Any services at malls/shopping centers, health fairs etc.	**___ Yes ___ No**
m. Intravenous transfusions	**___ Yes ___ No**

19. **What hours/days a week do you operate:____**

20. **Does applicant utilize a procedural and quality control manual? ___ Yes ___ No**
If Yes, does applicant make sure that all employees have reviewed these? ___ Yes ___ No

21. **Is lab inspected/certified/accredited by any governmental or medical association? ___ Yes ___ No**
If Yes, which association? ____

22. **Does applicant use a reference lab? ___ Yes ___ No**
If Yes, please answer the following:
- **a.** **What % of your tests are sent to reference lab?____________________________________**
- **b** **Name of reference lab:____**
- **c.** **Does reference lab hold applicant harmless? ___ Yes ___ No**
- **d.** **Does applicant obtain written proof of insurance with minimum limit of $1,000,000, for reference lab? ___ Yes ___ No**
- **e.** **Does applicant require reference lab to name them as an additional insured and obtain proof of same? ___ Yes ___ No**

23. **Does applicant provide any service under contract? ___ Yes ___ No If Yes, please provide details and copy of contract. ____**

24. **Please list Professional Liability coverage for the last five years beginning with the most current coverage:**

Carrier	Limits	Deductible	Premium	Policy Term	Retro Date

25. **Has any Professional Liability claim or suit been brought against the applicant or any of its employees? ___ Yes ___ No If Yes, please complete the Supplemental Claim Information Form attached to this application for each and every claim. Please attach five years of currently valued company loss runs.**

26. **Is the applicant aware of any circumstance which may result in any claim against them or their employees? ___ Yes ___ No If Yes, please provide full details including names of parties involved, dates and allegations.**

27. **Has any application for Professional Liability Insurance made on behalf of the applicant ever been declined or has their insurance been cancelled or renewal refused? ___ Yes ___ No If Yes, please provide details.________________**

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell no the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

______________________________________ __________________________
Signature of Applicant **Date**

Please attach the following documents to this application:
- **C.V. or Resumes on physicians and principals**
- **Five years of currently valued company loss runs**
- **Marketing or advertising brochures**

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for every claim)

1. **Name of applicant/named insured:** ____
____

2. **Name of other parties or defendants named in suit:** ______________________________
____
____

3. **Data of alleged error or occurrence, or contact date:** _____________________________

4. **Data claim was made:** ____

5. **Name of claimant:** ____

6. **Name of Insurance Company handling your claim:** ___________________________

7. **Present status of claim or final disposition:** _______________________________
____
____

   Circle One: CLOSED OPEN

8. **Defense costs paid to date inclusive of any deductible:** ________________________

9. **If closed, total loss paid, inclusive of any deductible:** _________________________

10. **If claim is open or pending, what are the insurers reserves?**
    Defense: ______________________ **Loss:** ______________________

11. **Description of case and events including allegations and assessment of liability:** ________
____
____
____
____
____

12. **Claimants last settlement demand:** ______________________________________

______________________ ______________________
Date **Signature**