ADMIRAL INSURANCE COMPANY 6455 E. Johns Crossing, Suite 240 Duluth, GA 30097 Phone: 770-476-1561 Fax: 770-418-9597 http://www.admiralins.com	APPLICATION FOR MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY INSURANCE (CLAIMS MADE)

1. Full Name of Applicant: _____

_____

(Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. Mailing and Location Address: _____

_____

(If multiple addresses include an attachment with a complete schedule of all locations)

3. Website Address (if applicable): _____

4. Date Established: _____

5. Type of Entity: ___Corp ___ Partnership ___ Individual ___ Other: _____

6. Is this entity owned by, associated with or controlled by any other entity? _____ Yes _____ No If Yes, please give details.

_____

7. PROFESSIONAL ACTIVITIES AND SPECIALTY: Check All that Apply

_____ Ambulance Service __ Ground __ Air
_____ Day Spa/Medical Spa
_____ Dental Practice
_____ Drug and Alcohol Treatment
_____ Group Home (Elderly)
_____ Group Home (Non-Elderly)
_____ Home Healthcare Agency
_____ Independent Living (Elderly)
_____ Independent Living (Non-Elderly)
_____ Kidney Dialysis Center
_____ Laser Vision Correction Center
_____ Medical Clinic
_____ Methadone Clinic
_____ Medical Staffing
_____ Mental Health Services
_____ Nurses Registry
_____ Pharmacy
_____ Radiology (Teleradiology Y or N circle)
_____ Residential Care Facility
_____ Services to Nursing Homes/Assisted Living
_____ Social Services
_____ Surgery Center
_____ Other (Please provide details): _____
_____
_____
_____

Full Description of Services Rendered: _____
_____
_____
_____
_____

8. State the approximate division of applicants patients:

_____% Alcoholics
_____% Cosmetic or Elective
_____% Counseling/Family Planning
_____% Communicable
_____% Dental
_____% Dialysis
_____% Drug Addicts
_____% Holistic or Alternative Medicine
_____% Medical
_____% Mentally Retarded
_____% Obstetrical
_____% Pediatric
_____% Psychiatric
_____% Research or Experimental
_____% Senile or Elderly
_____% Surgical
_____% Other (Please provide details): _____
_____
_____

9. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

	Employee	Independent Contractor	Insured On Own Med Mal Policy	Limits Required
Physicians (no surgery)	_____	_____	____ Yes ____ No	_____
Physicians (surgical)	_____	_____	____ Yes ____ No	_____
Physician Assistants	_____	_____	____ Yes ____ No	_____
Surgical Technicians	_____	_____	____ Yes ____ No	_____
Certified Nurse Anesthetists	_____	_____	____ Yes ____ No	_____
Nurse Practitioners	_____	_____	____ Yes ____ No	_____
Registered Nurses	_____	_____	____ Yes ____ No	_____
LPN's or Nurse Aides	_____	_____	____ Yes ____ No	_____
X-Ray Technicians	_____	_____	____ Yes ____ No	_____
Medical Assistants	_____	_____	____ Yes ____ No	_____
Optometrists	_____	_____	____ Yes ____ No	_____
Electrologist	_____	_____	____ Yes ____ No	_____
Opticians	_____	_____	____ Yes ____ No	_____
Pharmacists	_____	_____	____ Yes ____ No	_____
Pharmacy Technicians	_____	_____	____ Yes ____ No	_____
Chiropractors	_____	_____	____ Yes ____ No	_____
Massage Therapists	_____	_____	____ Yes ____ No	_____
Laboratory Technicians	_____	_____	____ Yes ____ No	_____
Paramedics	_____	_____	____ Yes ____ No	_____
EMT's	_____	_____	____ Yes ____ No	_____
Social Workers	_____	_____	____ Yes ____ No	_____
Aestheticians	_____	_____	____ Yes ____ No	_____
Perfusionists	_____	_____	____ Yes ____ No	_____
Therapists/Counselors	_____	_____	____ Yes ____ No	_____
Administrators	_____	_____	____ Yes ____ No	_____
Psychologists	_____	_____	____ Yes ____ No	_____
Accupuncturists	_____	_____	____ Yes ____ No	_____
Other:_____	_____	_____	____ Yes ____ No	_____

***Please attach copies of declarations pages on all individuals that carry their own medical malpractice.**

***If you have a Medical Director, provide name, specialty and C.V.:**

a) Are Medical Director's duties administrative only? _____Yes_____No
b) Does Medical Director provide direct patient care? _____Yes_____No
c) What medical malpractice limits is Medical Director required to carry?_____

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

11. Has the applicant or any of the above employees and/or independent contractors: YES NO
If Yes, please attach a detailed explanation.

(a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? _____ _____
(b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? _____ _____
© 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? _____ _____

12. Check the hiring procedures that apply or are performed by this operation:

_____ Criminal Background Checks
_____ Reference Checks
_____ Questioning of employees in their previous involvement as defenders in professional malpractice litigation
_____ Verification of certification or professional licensing
_____ Drug, alcohol and sexual abuse screening or testing

13. Does the applicant perform any of the following non-surgical procedures or treatment?	YES	NO	Est. Annual Procedures
(a) Acid or chemical peels? (Specify solution strength)	_____	_____	_____
(b) Acupuncture?	_____	_____	_____
© Angiography, arteriography or venography?	_____	_____	_____
(d) Botox Injections (Advise who performs)	_____	_____	_____
(e) Catheterization (other than urinary or umbilical?)	_____	_____	_____
(f) Closed reduction of compound fractures?	_____	_____	_____
(g) Dermal Filler Injections (Advise type, who performs)	_____	_____	_____
(h) Electrolysis (Advise who performs)	_____	_____	_____
(i) Laser Treatments (non-surgical)? If Yes, which of the following:	_____	_____	_____
_____ Hair Removal			_____
_____ Skin Resurfacing			_____
_____ Tattoo Removal			_____
Other:_____			_____
(j) Mesotherapy (Advise who performs)	_____	_____	_____
(k) Microdermabrasion? (Advise who performs)	_____	_____	_____
(l) Pain management (non-surgical)?	_____	_____	_____
(m) Permanent Makeup Application? (Advise who performs)	_____	_____	_____
(n) Psychiatric shock therapy?	_____	_____	_____
(o) Radiation Therapy and/or Chemotherapy?	_____	_____	_____
(p) Sclerotherapy? (Advise who performs)	_____	_____	_____
(q) Lipo-Dissolve, Lipostabil, Lipolysis or LipoShape (Advise who performs)	_____	_____	_____

NOTE: THESE PROCEDURES WILL NOT BE COVERED UNLESS PERFORMED BY A TRAINED PHYSICIAN OR PHYSICIAN'S ASSISTANT.)

14. Does the applicant perform any of the following surgical procedures?	YES	NO	Est. Annual Procedures
(a) Abortions? If Yes, please answer the following:	_____	_____	_____
What is the maximum trimester?_____			
What methods?_____			
How many per month?_____			
(b) Biopsies and/or endoscopies? If Yes, list types performed._____	_____	_____	_____
_____			
(c) Circumcisions?	_____	_____	_____
(d) Cosmetic Plastic Surgery? If Yes, what percentage of practice?_____%	_____	_____	_____
(e) Cryosurgery?	_____	_____	_____
(f) Deliveries? (If Yes, C-Sections? _____ Yes _____ No)	_____	_____	_____
(g) Dilation and curettage?	_____	_____	_____
(h) Gastric bypass surgery or other stomach banding procedures for weight loss?	_____	_____	_____
(i) Hysterectomies?	_____	_____	_____
(j) Minor surgical procedures only?	_____	_____	_____
(k) Major surgical procedures?	_____	_____	_____
(l) Mastectomies or lumpectomies?	_____	_____	_____
(m) Neurosurgery?	_____	_____	_____
(n) Organ transplant surgery?	_____	_____	_____
(o) Orthopedic surgery other than spinal?	_____	_____	_____
(p) Penile lengthening or enhancement surgery?	_____	_____	_____
(q) Sex change operations or sexual reassignment surgery?	_____	_____	_____
(r) Spinal surgery?	_____	_____	_____
(s) Surgical podiatry?	_____	_____	_____
(t) Vasectomies?	_____	_____	_____

*Please attach a complete list of all surgical procedures performed at this facility.

15. Does the applicant administer methadone treatment? _____ Yes _____ No If Yes, how many slots?_____
16. Does the applicant administer detoxification treatment? _____ Yes _____ No (How many patients annually? _____)
    Do you offer rapid detoxification under anesthesia? _____ Yes _____ No (How many patient annually? _____)
17. Does the applicant maintain any beds for overnight occupancy? _____ Yes _____ No
    If Yes, what is the total number of beds? _____
18. Does the applicant provide services to Nursing Homes or Assisted Living Centers? _____ Yes _____ No
    If Yes, please provide description of the services, and the percentage (%) of total revenue derived from these services:
19. Is anesthesia (other than topical or by means of local infiltration) administered at the applicant's facility?
    _____ Yes _____ No If Yes, how many procedures per year require general anesthesia? _____

20. If the applicant has or is a training school, please provide the following: (attach separate sheet if more room needed)

Profession for which students are being trained	Max # of students per session	# of sessions per year	% of time in clinical setting	# of faculty	Qualification of Faculty (MD, RN, PHD)
			%		
			%		

21. State sources and amounts of total revenue:

	Last 12 months	Estimate for next 12 months
Charitable Contributions	$	$
Government Funding	$	$
Fee for service	$	$
Sales or Lease of Medical Products	$	$
Other:	$	$
Total Gross Revenues:	$	$

22. Please provide the number of annual patient encounters or client visits:

	Last 12 months	Estimate for next 12 months
Outpatient Visits		
Surgical Procedures (not included in above)		
Perfusion, Autotransfusion – Case Load		
Pharmacy – Number of Prescriptions		
If any Compounding, advise %	%	%
Other:		

23. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage:

Carrier	Limit	Deductible	Premium	Policy Term	Retroactive Date

24. Is the applicant currently insured under a Commercial General Liability policy? _____ Yes _____ No If Yes, please attach a copy of the declarations page.

25. Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? _____ Yes _____ No If Yes, please provide complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program.

26. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? _____ Yes _____ No If Yes, please provide details including name of carrier and dates_____

27. Has any claim ever been made against the applicant or any of its employees? Yes _____ No _____
If Yes, how many?_____ Please complete the Supplemental Claim Information Form at the end of this application for each and every claim.

28. Is the applicant aware of any circumstances which may result in any claim against them or their employees?
_____ Yes _____ No If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident._____

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 nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement 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 or Authorized Representative **Date**

Please attach the following documents to this application:

- **Resumes or CV's on principals and partners**
- **Copies of brochures, marketing or advertising materials**
- **Five years of currently valued company loss runs**
- **Information on disciplinary actions, license revocations, etc.**
- **Copy of most current declarations page**

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each 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**