

Ten Parkway North, Deerfield, IL 60015 (847) 572-6000 Fax (847) 572-6137 Underwriting Manager

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

If you obtained this application at www.markelshand.com, please submit this application through your local insurance professional.

## APPLICATION FOR CLINICS (MEDICAL, DENTAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER) PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

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

<u>I.</u>	GE	NERAL INFORMATION				
1.	(a)	Full name of Applicant:				
	(b)	Principal practice address:				
	` ,			(Street)		(County)
		(City)		(State)		(Zip)
	(c)	Location: Stand alone	_ Hospital	School	Correctional Facility	Other
	(d)	(i) Phone:				
		(ii) E-Mail Address:		(iii) Website	Address:	
	(e)	Date Established: Attached a proforma busine		applicant is newly	established.	
2.	App	olicant is a:				
	[ ] professional corporation				[ ] joint venture	
	[ ] limited liability company			[ ] professional association		
	[]	other			[ ] partnership	
<ol> <li>4.</li> </ol>	Doe inst	me(s) of all partners or members any owner, partner or directly itution where medical service es, provide details, including	ector operate os are rendered	or administer, wh?	nolly or in part, any hospita	al, nursing home or other
5.	Priv If You (a) (b)	he Applicant a "Covered Entracy Rule?es,  Has the Applicant implement Provide the name and title of Business Associate Agree	nted procedure	s to comply with	the HIPAA Privacy Rule?	[ ]Yes [ ]No
		eement we will recognize.	nent is availab	ole at <u>www.man</u>	Neightand.com.	only Business Associate
II.	OP	ERATIONS				
1.	Day	s/hours of operation:				
2.	(a) (b)	Provide the name and spec Does the Applicant's Medical Is	al Director have	e direct patient c	ontact?	[ ]Yes [ ]No

ა.	Applicant's professional specialty:				
4.	Provide the percentage of patients	s/clients:			
5.	Bariatrics% Communicable Disease% Correctional Medicine% Dental% Disability Evaluation	Holistic medicine Obstetrical Oncology Pain Management Pediatric Physical Rehabilitation Psychiatric Research or Experimental  is registered and licensed to operate	% % % % %	Sleep Disorders Stress Testing Students Substance Abuse Surgical Urgent Care	% %
	• •				
^				in annualism	
6.	Name(s) and location(s) of any no	espital or medical facility that the App	ilicant refe	ers in practice:	
7.	ever been limited, revoked, suspe	registration or certification, or certific nded, refused, cancelled or voluntari	ily surrenc	dered?	[ ] Yes [ ] No
8.		tion memberships held by Applicant	-	and include a copy of	the most recent
9.	Does the Applicant participate in a	any state patient compensation fund?	?		[ ] Yes [ ] No
10.		he Federal Tort Claims Act ("FTCA") es are provided under the FTCA?			[ ] Yes [ ] No
11.		mployees or independent contractors il, detention center, prison, etc.?			[ ]Yes [ ]No
12.	Applicant's Gross Revenues:				
		<u>Last Twelve Months</u>	-	Next Twelve Months	
	Fee for Service	\$		\$	
	Medicare/Medicaid Funds	\$		\$	
	Research	\$		\$	
	Other (describe)	\$		\$	
	TOTAL GROSS REVENUES	\$		\$ <u></u>	
13.	Number of outpatient/client visits:	Last Twelve Months	,	Next Twelve Months	
	Clinics	·	,		
	Laboratory				
	X-ray/Imaging	<del></del>			
	Pharmacy TOTAL VISITS:				
	NOTE: If Applicant provided servi	ces for correctional facilities, provide	number o	of inmates:	
14.	Does the Applicant maintain any b	peds for overnight occupancy:			
	(a) On the Applicant's premises' If Yes, (i) No. of beds:	?e and an explanation including protoc			[]Yes[]No

STAFF Indicate the number of professional employee	es, indeper	dent contrac	ctors and vol	unteers. If N	one, state N	one.
	Emplo		Indepe	endent actors		nteers
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures						
Physicians: Minor surgery or obstetrical procedures not constituting major surgery						
Anesthesiologists						
Obstetrics-Gynecologists						
Oncologists						
Ophthalmologists						
Urologists						
Dentists						
Chiropractors						
Nurse Anesthetists						
Nurse Practitioners						
Optometrists						
Pharmacists						
Physician Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Other(describe):						
NOTE: If the Applicant requires any of the ab individual.	ove to be I	nsureds, sub	omit a separa	ate application	on for each s	uch
Are all of the above persons licensed in according to the state of the	rdance with	applicable	state and fed	deral regulati	on?[ ]	Yes [ ] N
Do all professional staff maintain a Profession If Yes, what are the minimum limits of liability \$each claim / \$	that the A	oplicant requ			[ ]	Yes [ ] N
PROFESSIONAL SERVICES						
Does the Applicant's employees or independe  (a) Perform any minor surgery other than in and superficial fascia?	cision of bo	oils and supe			[ ]	Yes [ ]I

	(c)	Perform abortions and/or menstrual extractions?			[ ] 140
		If the Applicant provides pregnancy termination complete a Supplement for Abortion Centers (			
	(d)	Perform any experimental procedures or research testing?	_	-	
		If Yes, are they FDA approved?	[	] Yes	[ ] No
		If No, attach a description.			
	(e)	Perform any chelation therapy services?	[	] Yes	[ ] No
		If Yes, explain:	_		
	(f)	Administer anesthesia other than topical or local infiltration?	]	] Yes	[ ]No
	( )	If Yes, attach detailed explanation.	•	-	
	(g)	Use drugs for weight reduction for patients?	1	1 Yes	[ ]No
	(3)	If Yes, attach list of drugs used and percentage of practice devoted to weight reduction;	٠	•	
		frequency and duration of prescriptions or weight reduction drugs and quantity dispensed.			
	(h)	Administer any methadone treatment?	Г	1 Yes	[ ] No
	(,	If Yes,	Г	1.00	[ ].(0
		(i) Provide the number of treatments during the:			
		Last 12 months Next 12 months			
	(:)	(ii) Attach a description of treatment and controls used.		1 \/	r 1 N I -
	(i)	Provide teleradiology services?	[	] Yes	[ ]NO
		If Yes, provide description of services and for whom services are provided.			
	(j)	Offer professional advice to the public via the internet, newspapers or broadcasts?	[	] Yes	[ ]No
		If Yes, provide details.			
	(k)	Advertise professional services in any manner other than a simple listing in a telephone director	•		
			[	] Yes	[ ] No
		If Yes, attach a copy of all advertisements.			
2.	Doe	es the Applicant use a collection agency:	Г	1 Yes	[ ] No
	If Ye		Г	1 100	[ ]140
	(i)	Name of agency:			
	(ii)	Does the agency have authority to file a collection suit on behalf of the Applicant?	— ,	1 Vac	I INo
	(11)	boes the agency have authority to life a collection suit on behalf of the Applicant:	[	1 163	[ ]140
<b>V</b> .	CLA	AIMS AND HISTORY			
1.	Hac	the Applicant or any of its employees ever:			
١.	Has				
	(2)				
	(a)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing,	г	1 Vac	r 1No
		Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?	[	] Yes	[ ] No
	(a) (b)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic	_	-	
		Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?	_	-	
		Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic	_	-	
		Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.	_	-	
		Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional	[	] Yes	[ ] No
	(b)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.	[	] Yes	[ ] No
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	(b)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms or	[ [	] Yes	[ ] No
	(b)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms on has the Applicant or any of its employees voluntarily surrendered any professional license?	[ [	] Yes	[ ] No
	(b) (c)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms of has the Applicant or any of its employees voluntarily surrendered any professional license?	[ [ ,	] Yes	[ ] No
2.	(b) (c) (d)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms of has the Applicant or any of its employees voluntarily surrendered any professional license?	[ [ , r	] Yes	[ ] No
2.	(b) (c) (d)	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms of has the Applicant or any of its employees voluntarily surrendered any professional license?	[ [ , r	] Yes	[ ] No
2.	(b) (c) (d) Has	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms of has the Applicant or any of its employees voluntarily surrendered any professional license?	[ [ , r	] Yes	[ ] No
2.	(b) (c) (d) Has for till f Ye	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?	[ , r [	] Yes	[ ] No
2.	(b) (c) (d) Has for tilf Ye	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?	[ , , r [ [	] Yes ] Yes ] Yes	[ ] No
2.	(b) (c) (d) Has for tilf Ye Has for til	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?	[ [ [	] Yes ] Yes ] Yes	[ ] No
2.	(b) (c) (d) Has for tilf Ye Has for til	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?	[ [ [	] Yes ] Yes ] Yes	[ ] No
2.	(b) (c) (d) Has for tilf Ye Has for til	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?	[ [ [	] Yes ] Yes ] Yes	[ ] No
	(b) (c) (d) Has for till f Yes	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license?  If Yes, provide details.  If Yes, provide details.  If any claim or suit for malpractice ever been made against the Applicant or any person proposed his insurance?  If yes, how many?  If yes, provide details or suit for malpractice ever been made against the Applicant or any person proposed his insurance?  If yes, provide details or suit for malpractice ever been made against the Applicant or any person proposed his insurance that has not been reported to the Applicant's current or prior insurer?	[ , , , , , , , , , , , , , , , , ,	] Yes ] Yes ] Yes	[ ] No
2. 3.	(b) (c) (d)  Has for the lif Year for the lif Year list the list t	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms ohas the Applicant or any of its employees voluntarily surrendered any professional license?  If Yes, provide details.  If yes, provide details.  If yes, provide details.  If yes, provide of the Applicant or any person proposed this insurance?  If yes any claim or suit for malpractice ever been made against the Applicant or any person proposed this insurance that has not been reported to the Applicant's current or prior insurer?  If yes, provide details.  If yes, provide details yes provided on the provided or any professional license?  If yes, provide details.	[ , , ,[ ,	] Yes ] Yes ] Yes ] Yes	[ ] No [ ] No [ ] No
	(b) (c) (d) Has for tilf Ye for tilf Ye	Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?  Been convicted for an act committed in violation of any law or ordinance including traffic offenses?  If Yes, provide details.  Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders?  If Yes, provide details.  Had any professional license or license to prescribe or dispense narcotics been denied limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license?  If Yes, provide details.  If Yes, provide details.  If any claim or suit for malpractice ever been made against the Applicant or any person proposed his insurance?  If yes, how many?  If yes, provide details or suit for malpractice ever been made against the Applicant or any person proposed his insurance?  If yes, provide details or suit for malpractice ever been made against the Applicant or any person proposed his insurance that has not been reported to the Applicant's current or prior insurer?	[ , , ,[ ,	] Yes ] Yes ] Yes ] Yes	[ ] No [ ] No [ ] No

its his	predecessors, subsid	iaries, affiliates, five years?	employees a	and/or for any other	r person or entity propos	sed for
	ist prior Professional L None, check here. [	•	e for each of	the last five (5) year	ars, including the currer	nt year:
In		Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	
<u>-</u> -						
7. Li	•	-	each of the	last five (5) years,	including the current ye	
In		Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	
_						
_						
_						
_						
VI. G	ENERAL LIABILITY	(To be complete	d by the App	olicant if applying fo	r General Liability)	
1. C	complete the following	for each of the A	Applicant's fa	icilities:	Describe Assiltant	l. <b>T</b> l
	ocation lumber Name of Faci	ility Addres		Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	
<u>1</u>						
2						
<u>3</u>						
2. C	complete the following	for each of the A	Applicant's lo	cations:		
		Location 1	Lo	ocation 2	Location 3	Location 4
S	quare Footage*					
Y	ear Built					
Y	ear Remodeled					
N	umber of Stories					
	ype of Construction rame, brick, concrete)					
	ercentage of Building occupied by Applicant					
	other occupants? Yes/No)					
*	nclude square footage	e of parking facili	ities if owned	d or rented by the A	applicant.	
3. A	re all of the Applicant's	s locations equip	ped with:			
	• •		-			[ ]Yes [ ]No
(k (c	) At least two clearly	y marked exits o	n each floor'	?		[ ]Yes [ ]No

	(d)	Automatic fire alarm system connected to a local fire department?	] Yes	3 [	] No
	(e)	Smoke detectors?	] Yes	3 [	] No
	(f)	Emergency electrical system?	] Yes	s [	] No
	(g)	Heat sensors?	] Yes	s [	] No
	(h)	Fire escape(s)?	-	_	-
	(i)	Posted emergency evacuation procedures?			
	(j)	Properly maintained fire extinguishers?			
	•		1	٠.	1
		y of the above are answered No, provide details by attachment.			
4.		s the Applicant have a written safety program in place?	] Yes	} [	] No
5.	Doe	s the Applicant have written procedures for incident reporting?[	] Yes	3 [	] No
6.	Doa	ny of the Applicant's locations have any:			
	(a)	Exposure to flammables, explosive, chemicals?	] Yes	s [	] No
	(b)	Catastrophe exposure?	] Yes	s [	] No
	(c)	Exposure to radioactive materials?	] Yes	s [	] No
7.		ny of the Applicant's operations involve storing, treating, discharging, applying, disposing, or sporting hazardous materials?[	1 Yes	s ſ	1 No
0		s the Applicant sell or lease any medical equipment or products to patients/clients or others in	,		,
8.	con	s the Applicant sell of lease any medical equipment of products to patients/clients of others in lection with Applicant's operation?[ s, Total Annual Sales	] Yes	š [	] No
		Total Annual/Lease Rental Receipts \$			
0	Daa	·			
9.		s the Applicant:		_	
	(a)	Loan or rent machinery or equipment to others?			
	(b)	Own any elevators or escalators?	-	_	-
	(c)	Own or rent any parking facility?	_	_	_
	(d)	Provide any recreational facility? [			
	(e)	Have a swimming pool on the premises?			
	(f)	Sponsor any sporting or social events?	] 168	> [	] 140
10.		any claim for General Liability ever been made against any person(s) or entity(ies) proposed	1 \/ -		1 1 1 -
		nis insurance?[	] Yes	3 [	] NO
	Pro	s, answer the following: ide three year loss history for claims under \$100,000 Loss and Expense and ten years for claims \$ ter. Attach further sheets if needed.	\$100,0	00 :	and
	9,00	Amount Amount of	Ope	n (C	))
	Da	te of Date Claim Description of Loss Expenses	-	or (	-,
		urrence Made of Loss Reserved Reserved	Close		C)
		and Paid and Paid		`	,
11.	ls (a	re) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or	situatio	on v	vhich
		result in a General Liability claim, such that would fall under the proposed insurance?[			
	If Y	s, provide details for each incident.			
	_				

### **VII. ADDITIONAL INFORMATION**

As part of this Application attach the following:

- 1. A CV of Medical Director including specialty and board certification.
- 2. Five (5) years of currently valued Professional Liability Insurance and General Liability Insurance claim runs from current and prior insurers or complete a Supplemental Claim Information form (SM6236) for each claim.
- 3. A list of any activities or procedures performed that are not otherwise described in this Application.

- 4. Credentialing, Risk Management protocols.
- 5. Most recent annual financial statements, both a balance sheet and a revenue and expense statement. If the Applicant is newly established attached proforma financial statements.
- 6. Complete an Additional Insured Supplement for any additional insured that coverage is being requested for under General Liability Coverage.

#### **NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY**

Must be signed by the Applicant within 60 days of the proposed effective date.

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Extended Reporting Period option is exercised in accordance with the terms of the policy.

Markel Shand, Inc. or the Company is authorized to make any inquiry in connection with this application. Signing this application does not bind 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 Markel Shand, Inc. receives notice is on file with Markel Shand, Inc. and is considered physically attached to and part of the policy if issued. Markel Shand, Inc. 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 Markel Shand, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

#### WARRANTY

I/We warrant to 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 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 Markel Shand, Inc. or the Company, Ten Parkway North, Deerfield, Illinois 60015.

Notice to 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.

ADDITIONAL EXPLANATIONS

ADDITIONAL EXPLANATIONS



# BROKER RISK SUMMARY (Medical Malpractice and Specified Medical)

	OUNT NAME:		
	Address City, State, Zip States of Licensure New or Renewal for M	arkel Shand	
	RIPTION OF SERVICE de management experie		
CURR	ENT INSURANCE PRO	OGRAM:	
	Name of Carrier:		
	Limito		
	Limits:	Deductible:	Premium:
	Expiration Date:		Retro Date:
	Expiration Date:		

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:

(Including Credentialing/hiring protocols)

**DATE QUOTE NEEDED:**