

Quaker Special Risk

a division of Quaker Agency, Inc.
P.O. Box 1350 • Eatontown, New Jersey 07724
P: (732) 223-6666 • F: (732) 223-9072

APPLICATION FOR MEDICAL LABORATORIES, MEDICAL IMAGING CENTERS AND BLOOD PLASMAPHERESIS CENTERS 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.

I. GENERAL INFORMATION

1. (a) Full name of Applicant: _____
(b) Principal business premise address: _____
(Street) (County)

(City) (State) (Zip)
(c) Secondary locations: _____

(d) (i) Phone: _____ (ii) Fax: _____
(iii) E-Mail Address: _____ (iv) Website Address: _____
2. Number of employees including principals: Full-time ____ Part-time ____ Seasonal ____ Total ____
3. Date organized (MM/DD/YYYY): _____
4. Total square feet occupied by Applicant (all locations): _____
5. Applicant is a(n):
 individual corporation limited liability company partnership
 other _____
6. Applicant laboratory or center is: Mobile Stationary
7. State(s) in which the Applicant is licensed to practice: _____
8. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... Yes No
If Yes,
(a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... Yes No
(b) Provide the name and title of the Applicant's Privacy Officer. _____
Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

II. OPERATIONS

1. Provide a detailed description of the nature of operations, services and procedures provided: (Attach a copy of brochure, if available) _____

2. (a) Is the Applicant a Lab that is involved in drug testing? Yes No
If Yes, is the Applicant approved by National Institute on Drug Abuse (NIDA)? Yes No
(b) Is the Applicant a Medical Laboratory? Yes No
If Yes, is the Applicant CLIA approved? Yes No
If No to either of the above, provide a detailed explanation. _____
3. (a) Annual gross receipts for the last twelve months: \$ _____

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Estimated gross receipts for the next twelve month: \$ _____

(b) Number of tests performed last twelve months: _____

Estimated number of tests to be performed in the next twelve month: _____

(c) Number of patient contacts for the last twelve months: _____

Estimated number of patient contacts for the next twelve months: _____

4. Is the Applicant is a Medical Imaging Center?..... [] Yes [] No
If Yes, provide the number of tests for each of the following categories:

	Number of tests last 12 months	Anticipated number of tests for the next 12 months
Bone Density Scan		
CAT / CT Scan		
PET Scan		
MRI		
Mammograms		
Ultrasound		
X-Ray		
Other (describe)		

5. Is the Applicant under contract to or in the employ of any federal governmental entity? [] Yes [] No
If Yes, provide details. _____

6. Is the Applicant licensed in accordance with all applicable state and federal laws? [] Yes [] No
If No, provide details. _____

7. (a) Does the Applicant advertise its professional services in any manner other than a simple listing in a telephone directory? [] Yes [] No

(b) Is the Applicant associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? [] Yes [] No
If Yes to either of the above, provide details and a copy of all advertisements. _____

III. PROFESSIONAL ACTIVITIES AND SPECIALTY

1. Provide the percentage of services provided for:

Hospitals _____% Nursing Homes _____% Industrial Facilities _____% Vet Clinics _____%
Physicians' Offices _____% Other (describe) _____%

2. Is the Applicant involved in:

- (a) Services open to the public (health fairs, shopping mall exhibits, etc.)..... [] Yes [] No
- (b) Blood banking or cross matching [] Yes [] No
- (c) Medical, genetic, AIDS or drug research..... [] Yes [] No
- (d) Manufacturing, dispensing or testing pharmaceuticals [] Yes [] No
- (e) Use of injected or ingested materials [] Yes [] No
If Yes, provide details. _____
- (f) Use of any radioactive material other than used in x-ray equipment [] Yes [] No
- (g) Therapy or treatment procedures [] Yes [] No
- (h) Environmental analyses..... [] Yes [] No

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- (i) Manufacturer and/or sell laboratory equipment or supplies, reagents or software [] Yes [] No
- (j) Intravenous transfusions of blood or in the procurement of blood or blood products [] Yes [] No
- (k) Drug testing..... [] Yes [] No
If Yes, provide the percentage of Applicants gross receipts that are from drug testing. _____%
- (l) Testing for AIDS [] Yes [] No
If Yes, provide the percentage of Applicants gross receipts that are from testing for AIDS. _____%

If Yes to any of the above provide a full description. _____

- 3. (a) Provide percentage of specimens:
 - (i) Collected direct from patients by the Applicant: _____ %
 - (ii) Received by the Applicant from outside sources: _____ %
- (b) Describe the types of specimens collected: _____
- 4. Do the Applicant provide any services under contract?..... [] Yes [] No
If Yes, provide a details. _____

IV. STAFF

- 1. (a) Total number of professional employees employed by the Applicant: _____
- (b) Indicate by profession the number of individuals employed by the Applicant:
_____ Nurses _____ Physicians _____ X-Ray Technicians
_____ Phlebotomists _____ Technologies _____ Other Technician
_____ Other (describe) _____
- (c) If physicians are employed, is coverage being requested for employed physicians?..... [] Yes [] No
If Yes, submit an Application for Physicians & Surgeons Professional Liability Insurance for each physician requesting coverage.
If No, what Professional Liability Insurance limits of liability does the applicant request the physicians to carry? _____
- 2. (a) Total number of staff contracted by the Applicant: _____
- (b) Indicate by profession the number of individuals contracted by the Applicant:
_____ Nurses _____ Physicians _____ X-Ray Technicians
_____ Phlebotomists _____ Technologies _____ Other Technician
_____ Other (describe) _____
- (c) If physicians are contracted, is coverage being requested for contracted physicians? [] Yes [] No
If Yes, submit an Application for Physicians & Surgeons Professional Liability Insurance for each physician requesting coverage.
If No, what Professional Liability Insurance limits of liability does the applicant request the physicians to carry?

- 3. (a) Name and qualifications of the Applicant's Medical Director*: _____

- (b) Name and qualifications of the Applicant's Medical Review Officer (MRO)*: _____

* Attach a Curriculum Vitae (C.V.).

V. CLAIMS AND HISTORY

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1. Has the Applicant or any of its employees ever:
 - (a) Been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? [] Yes [] No
 - (b) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [] Yes [] No
2. Has the Applicant or any person proposed for this insurance had any professional license 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?..... [] Yes [] No
3. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance? [] Yes [] No
If Yes, how many? _____ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
4. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance? [] Yes [] No
If Yes, how many? _____ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.
5. 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?.. [] Yes [] No
If Yes, how many? _____ Complete a Shand Morahan & Company, Inc. Supplemental Claim form for each one.

6. List prior Professional Liability Insurance for each of the last (5) years, including the current year:
If None, check here. []

(a)	Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date
(1)	_____	_____	_____	_____	_____	_____
(2)	_____	_____	_____	_____	_____	_____
(3)	_____	_____	_____	_____	_____	_____
(4)	_____	_____	_____	_____	_____	_____
(5)	_____	_____	_____	_____	_____	_____

Attach a copy of the Declarations page for the most recent coverage.

 - (b) Does the policy for the current year allow the reporting of any incidents or circumstances that are likely to result in a claim?..... [] Yes [] No

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

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 Optional Extension Period option is exercised in accordance with the terms of the policy.

Shand Morahan & Company, 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 Shand Morahan & Company, Inc. receives notice is on file with Shand Morahan & Company, Inc. and is considered physically attached to and part of the of the policy if issued. Shand Morahan & Company, 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 Shand Morahan & Company, Inc., who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

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BROKER RISK SUMMARY (Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES: (Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE: (7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM: (Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: