PROFESSIONAL LIABILITY
APPLICATION FOR ALLIED AND MISCELLANEOUS SERVICES

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.
If the answer is NONE, state NONE;
If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A).
If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET.
NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): _____

1.2 Mailing Address: _____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office _____/_____ Fax _____/_____

1.6 Person to contact for survey: Name _____

Title _____

1.7 Year entity established: _____

1.8 Entity is ___ Individual ___ Corporation
___ Partnership ___ Professional Association/Corporation
___ Other. (Describe) _____

1.9 Entity is ___ For Profit ___ Non-Profit. Describe source of funds: _____

_____

1.10 If an individual, What is your profession? _____as _____Employee or _____Student
How many years have you been practicing?_____
In which branch of profession do you specialize?_____

1.11 Name, address and type of operation of employer, or school, if student:_____

_____

_____

Is your employer/employment by or through a registry or temporary employment? ___ Yes ___ No
agency? ___ Yes ___ No

1.12 Proposed effective date _____

1.13 Requested Limits of Liability (if available):
Professional Liability $ _____/$_____
General Liability $ _____ each occurrence
$ _____ general aggregate

1.14 Annual Gross Receipts: Estimated next twelve months - $ _____
Last twelve months - $ _____

1.15 Total Premises Square Footage Occupied by Applicant: _____

1.16 List applicant entity's memberships in professional organizations: _____

_____

1.15 Is the applicant eligible for certification or accreditation? ___ Yes ___ No

If yes, is applicant certified and/or accredited? ___ Yes ___ No

If no, explain the reason._____

_____

PART II. EXPOSURES

2.1 Service is licensed as _____

2.2 Describe the nature of insured's operation including types of services rendered and activities conducted: _____

_____

_____

2.3 What was your total number of patient/client visits last year?_____ Estimated next year?_____

2.4 Breakdown of patient services:

___% AIDS	___% Alcoholic	___% Bariatric
___%Communicable	___% Dental	___% Disability
___% Drug Addiction	___% Emergency Medical	___% Family Planning
___% General Exams	___% Gynecological	___% Hemodialysis
___% Holistic Medicine	___% Major Surgery	___% Minor Surgery
___% Nutritional (Diet)	___% Obstetric	___% Occupational Medical
___% Optometry/Ophthalmology	___% Orthopedic	___% Pediatric
___% Psychiatric	___% Rehabilitative Therapy	___% Research/Experimental
___% Stress Testing	___% Substance Abuse	___% Other(describe)_____

2.5 Are any of the following performed?

Administer anesthesia (general or local)?	___ Yes ___ No
Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)?	___ Yes ___ No
Cardiac Catheterization	___ Yes ___ No
Diagnostic tests	___ Yes ___ No
Chemotherapy	___ Yes ___ No
X-Rays	___ Yes ___ No
Radiation Therapy	___ Yes ___ No
Reduction of Fracture	___ Yes ___ No
Shock Therapy	___ Yes ___ No
Prescribe medication	___ Yes ___ No
Obstetric procedures	___ Yes ___ No

For all "yes" answers, give detailed description on separate page or back of application.

2.6 Total number of all staff _____

Total payroll or remuneration paid last year (E&C): $_____ Estimated payroll or remuneration next year (E&C): $_____

If you contract for services of any outside health care staff, breakdown total estimated annual payments to contractors by professional category. _____

_____

_____

2.7 Do you desire coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ___ Yes ___ No

Do you require:

a) contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ___ Yes ___ No
If yes, indicate minimum limits required. _____

b) employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ___ Yes ___ No

If yes, indicate minimum limits required. _____

2.8 Number of Professional Staff: E = Employed; C = Contracted

Show total number of hours of client service provided by all categories of staff: _____

E	C		Annual Hours	E	C	
___	___	Aestheticians	_____	___	___	EEG or EKG Operators
___	___	Aides or Orderlies	_____	___	___	Electrologists
___	___	Audiologists	_____	___	___	Hearing Aid Fitters
___	___	Chiropractors	_____	___	___	Inhalation/Respiratory Therapists
___	___	Dentists	_____	___	___	Laboratory Technicians
___	___	Dental Hygienists/Technicians	_____	___	___	LPN'S
___	___	Dental Assistants	_____	___	___	Massage Therapists
___	___	Dietitians/Nutritionists	_____	___	___	Medical Technicians
___	___	Nurse Anesthetists	_____	___	___	Physio/Physical Therapists
___	___	Nurse Midwives	_____	___	___	Podiatrists
___	___	Nurse Practitioners	_____	___	___	Prosthetic Device Fitters
___	___	Occupational Therapists	_____	___	___	Psychologists/Psychotherapists
___	___	Optometrists	_____	___	___	RN'S
___	___	Opticians	_____	___	___	Social Workers
___	___	Paramedics or EMT's	_____	___	___	Speech Therapists
___	___	Pharmacy Technicians	_____	___	___	X-Ray or Radiologist Techs
___	___	Physicians or Surgeons*	_____	___	___	X-Ray or Radiologist Therapists
___	___	Physician Assistants	_____	___	___	Other, describe _____

* Attach list and indicate specialty.

2.9 Give name of Administrator/Supervisor and describe his/her training and experience.

_____

2.10 Do you sell any products? ___ Yes ___ No
If yes, describe and indicate estimated annual sales for each. _____

_____

2.11 Do you rent or otherwise provide any equipment or products to others? ___ Yes ___ No
If yes, describe and indicate estimated annual receipts for each. _____

_____

_____

2.12 Describe any "fund raising" or other special events activities conducted. _____

_____

2.13 Does the applicant maintain any beds for overnight occupancy? Yes No
If yes, indicate the number _____, type _____ and the number of patient days the last 12 months ____.

2.14 Do you provide any of the following services:

A) Blood Bank/Plasma Centers ___ Yes ___ No
B) Cemeteries/Funeral Homes/Morticians ___ Yes ___ No
C) Medical Arts Schools and Colleges ___ Yes ___ No
D) Pharmacies ___ Yes ___ No
E) Nursing Homes ___ Yes ___ No

IF YES, complete the appropriate supplement application.

PART III. RISK MANAGEMENT

3.1 Name, qualifications and number or years of experience of the Medical Director:
Name Title Experience/Training Association Membership

_____

_____

3.2 Does your Agency have a written credentializing policy and procedure for all individual's associated with or practicing within the Applicant? ___ Yes ___ No

3.3 Do you conduct pre-employment screening and investigation? ___ Yes ___ No

3.4 Do you prepare job descriptions and instructional manuals for your staff? ___ Yes ___ No
If so, enclose a copy of each.

3.5 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ___ Yes ___ No

3.6 Are patients' accepted for health care services only upon a written plan of treatment established by an attending physician? ___ Yes ___ No
Explain any exceptions:

_____

_____

_____

3.7 Are you equipped with an emergency 24 hour telephone call line for all of staff and patients? ___ Yes ___ No

3.8 Do you enter into any contractual agreements (other than lease of premises agreements)? ___ Yes ___ No
If yes, attach explanation.

3.9 Does the applicant advertise its services other than an ordinary local telephone directory listing? ___ Yes ___ No
If yes, please attach a copy of each advertisement.

3.10 Do you require staff to report all incidents (accidents) which might result in a liability claim and are records of such reports kept on file by you? ___ Yes ___ No
If not, are you agreeable to instituting this procedure? ___ Yes ___ No

3.11 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws?
If no, attach explanation of any exception.

3.12 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ___ Yes ___ No
b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ___ Yes ___ No
c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ___ Yes ___ No

IF THE ANSWER TO ANY OF 3.12 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

3.13 Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home healthcare operations.
_____None _____Description Attached

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date?_____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date?_____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?
___ Yes ___ No If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary).
_____
_____
_____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?
___ Yes ___ No If yes, describe the event and indicate the reason for anticipation of a claim.
_____
_____
_____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or

private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

Date	Applicant/Title

MEDICAL SPA SUPPLEMENTAL APPLICATION

NOTE: SUPPLEMENT MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK..

1. Provide the percentage of the applicant's patients/clients in the following categories:

_____ % Beauty Shop (nails, hair, etc)
_____ % Dental
_____ % Massage
_____ % Medical Spa/Anti-Aging
_____ % Research/Experimental
_____ % Holistic
_____ % Surgical
_____ % Weight Control
_____ % Other (describe) _____
100 % TOTAL

Age of Patients/Clients
_____ % Under 12 years old
_____ % 12 to 18 years old
_____ % Greater than 18 years old
_____ % Substance Abuse
100 % TOTAL

2.1 Indicate the estimated annual number for each of the following procedures that is performed and **attach a training certificate, CV, client selection protocol and informed consent** for each procedure performed.

Proceedure	Name and Qualification of the person that this procedure is performed by	Is Training Certificate Attached? (Yes/No)	Is CV Attached? (Yes/No)	Is Client Selection Protocol Attached? (Yes/No)	Is Informed Consent Attached? (Yes/No)	Estimated Annual Number of Proceedures
Acne Blue Light Treatment						
Botox Injections						
Chemical Peels (specify solution strength)						
Electrolysis						
Hair Transplants						
Laser hair removal						
Laser Skin Treatment (specify type)						

Massage						
Microderm Abrasion						
Other Injections (specify type)						
Permanent Make-Up						
Other (please describe)						

2.2 Are any of the procedures listed above in response to Q2.1 performed by a physician or dentist? _____ Yes _____ N
If Yes, do all physicians and dentists carry Professional Liability with equal or greater limits? _____ Yes _____ N

3. Do you use drugs for weight reduction or patients? _____ Yes _____ N

If yes, list the drugs used and percentage devoted to weight reduction, as well as the frequency and duration of prescriptions or weight loss drugs and quantity dispensed

_____
_____

4. If X-ray treatment is given, what qualifications are required of the staff performing this procedure?

_____
_____

5. Have you or any of your employees:
   a) Ever been treated for alcoholism or drug addiction?
   b) Ever had any state professional or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or evervoluntarily surrendered same?
   c) Ever had any insurance company or Lloyds's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?

6. Do you supervise any individual other than your own employees? _____ Yes ___ No
If yes, please provide explanation of responsibilities and relationships to the entity which employs these individuals.

_____
_____
_____
_____
_____

_____ _____
Date Applicant Signature / Title