ADMIRAL INSURANCE COMPANY
6455 East Johns Crossing, Suite 240
Duluth, GA 30097
Phone: 770-476-1561 — Fax: 770-418-9597
Internet: http://www.admiralins.com

MEDICAL LABORATORIES, MEDICAL IMAGING CENTERS & BLOOD PLASMAPHERESIS CENTERS
(TO BE USED WITH OUR PROFESSIONAL LIABILITY RENEWAL APPLICATION)

APPLICANT'S INSTRUCTIONS:
1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed & dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.
(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full Name of Applicant: _____

Business Phone: _____

b. Principal Business Address: _____

c. Secondary Locations: _____

_____

d. Total sq. ft. occupied by applicants (all locations): _____

e. [ ] Corporation [ ] Individual [ ] Partnership [ ] Other (describe) _____

Year established: _____ State where applicant is licensed to practice: _____

Limits, deductible & effective date requested:

_____ Per Claim _____ Agg. _____ Deductible

_____ Effective Date

2. OPERATIONS

a. Please describe fully the exact purpose of the operations, services and procedures provided (Attach copy of brochure if available): _____

_____

_____

b. (i) State annual gross receipts last 12 months: _____

Anticipated next 12 months: _____

(ii) Number of tests performed last 12 months: _____

Anticipated next 12 months: _____

(iii) Number of patient contacts last 12 months: _____

Anticipated next 12 months: _____

c. For medical imaging centers only, please indicate number of tests in each category annually:

MRIs _____ CT Scans _____ Mammograms _____ Ultrasounds _____

d. Are you under contract to or in the employ of any federal government entity? _____Yes _____No

If yes, Please attach an explanation.

e. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory?)

_____Yes _____No

If yes, please attach a detailed explanation and a copy of ALL of the advertisements.

f. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? _____Yes _____No

If yes, attach detailed explanation and a copy of ALL of the advertisements.

3. SERVICES

a. Service is provided for: Hospitals _____% Nursing Homes _____% Physicians' Offices _____%

Industrial Facilities _____% Other_____% (describe) _____

b. Are you involved in any: (If yes, please attach full description)

	Yes	No
Services open to the public (health fairs, shopping mall exhibits, etc.	_____	_____
Blood banking or cross matching	_____	_____
Medical, genetic, AIDS or drug research	_____	_____
Manufacturing, dispensing or testing pharmaceuticals	_____	_____
Use of injected or ingested materials	_____	_____
Use of any radioactive material other than normal x-ray equipment	_____	_____
Therapy or treatment procedures	_____	_____
Environmental analyses	_____	_____
Manufacturer and/or sell laboratory equipment or supplies, reagents software	_____	_____
Intravenous transfusions of blood or in the procurement of blood or blood products	_____	_____
Drug testing: If yes, _____% of your gross receipts	_____	_____
Testing for AIDS: If yes, _____% of your gross receipts	_____	_____

c. Specimens: _____% collected direct from patient by applicant; describe types of specimens collected:

_____

_____% received by applicant from outside source.

d. Do you provide any services under contract? _____Yes _____No

If yes, please attach an explanation.

4. STAFF

a. Total number of employees: _____ Professional _____

_____ Physicians _____Nurses _____X-ray Technicians

_____Technologies _____Phlebotomists _____Other Technicians (describe) _____

_____ Other (describe) _____

Do employed physicians carry their own professional liability insurance? _____Yes _____No

What limits of liability do they carry? _____

b. (i) Name and qualifications of Medical Director: _____

_____

(ii) Name and qualifications of Medical Review Officer (MRO): _____

_____

*Please attach Curriculum Vitae (C.V.)

c. (i) Are there any contracted physicians? _____Yes _____No

How many? _____

(ii) Do they carry professional liability insurance? _____Yes _____No

(iii) What limits of liability do they carry? $ _____

5. CLAIMS / HISTORY

	Yes	No
a. Have you or any of your employees ever: (If yes, please attach a full description)		
(i) been the subject of disciplinary or investigation proceedings or reprimand by an administrative or governmental agency, hospital or professional association?	_____	_____
(ii) been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
(iii) had any professional liability insurance cancelled, declined, refused, renewed or accepted only on special terms?	_____	_____
b. Are you licensed in accordance with all applicable state and federal laws?	_____	_____
(i) Approved by National Institute on Drug Abuse (NIDA) if lab is involved in drug testing?	_____	_____
(ii) CLIA approved?	_____	_____
If no to either of the above, provide detailed explanation.		
(iii) Have you or any of your employees had any professional licenses refused or suspended, reworked, renewal refused or accepted only on special terms or have you or any of your employees voluntarily surrendered any professional license?	_____	_____
c. Has any claim or suit for alleged malpractice been made against you and/or any of your employees?	_____	_____
d. Has any claim or suit for alleged malpractice been made against you and/or any of your employees that has NOT been reported to a prior Insurer?	_____	_____

e. Are you aware of any acts, errors, omissions or circumstances which may result in a _____ _____
malpractice claim or suit being made or brought against you and/or any of your employees?

If yes to any questions c – e above, please complete Supplemental Claim Information Form SM 174.

f. List prior professional liability insurance carried for each of the past 5 years. If none, check here [ ].

g. Attach a copy of the Declarations Page from your most recent coverage.

Insurance Co.	Limits of Liability	Premium	Incepton Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy form? Yes	No	Retroactive Date

NOTE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINS THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, 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 of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to Admiral Insurance Company.

_____

Signature of Applicant Title (Officer, partner, etc.) Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.