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 Testing Laboratory PROFESSIONAL LIABILITY APPLICATION (Claims Made Form)

NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTATION ONLY. NO COVERAGE WILL BE EFFECTED UNTIL RECEIPT OF WRITTEN INSTRUCTION AND PREMIUM PAYMENT. ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION (AND ATTACHMENTS HERETO) AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS-MADE BASIS. THE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR DEFENSE EXPENSES. AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE APPLICABLE DEDUCTCIBLE AMOUNT.

All Questions must be fully completed. If there is insufficient space to complete an answer, continue on a separate sheet of the Applicant's letterhead. If a Question is not applicable, state "N.A."..

SECTION I – GENERAL INFORMATION:

1. Full Name of Applicant (include ALL Firm names, trade names or dba's under which the Applicant operates, including subsidiaries): ____________________

____

____

____

2. Internet Address:____________________

3. Address of Principal Office (street, city, state, zip)

____

____

____

4. List all states in which Applicant operates:

____

____

____

5. A) Does the Applicant have any other office locations? _____YES _____NO
   If *YES*, list complete addresses on a separate sheet.
   B) Does Applicant have a location at a hospital or other medical premises?_____YES _____NO
   If *YES,* does Applicant lease a distinct area? _____YES _____NO

6 Applicant is a: [ ] Individual [ ] LLC Corporation: [ ] For profit [ ] Non-profit
[ ] Partnership [ ] Joint Venture Other (specify): ____________________

Date Established: ________________(mm/dd/yy)

7 Has the name of the Applicant ever changed or has there been any acquisition, consolidation, dissolution, merger or any other change in business organization during the past five (5) years? _____YES _____NO
If *YES*, provide full particulars on a separate sheet, including all Firm names, in chronological order. Additionally, provide claims information (as per SECTION III) for all prior Firms.

8. During the coming twelve (12) months, does the Applicant contemplate offering any services not currently offered, or any mergers or acquisitions? _____YES _____NO
If *YES*, please explain: ____________________

9. Professional Activities and Specialties (describe):____

____

____

____

10. State approximate % of gross income derived from the following (total should be 100%):

_____% Alcohol/Drug Testing
_____% CT/CAT
_____% Cytology
_____% DNA
_____% Fertility/Pregnancy/Paternity
_____% Hematology
_____% Hepatitis
_____% Histology
_____% HIV (AIDS)
_____% Immunology
_____% MRI/fMRI
_____% Occupational
_____% PET/SPECT
_____% STDs
_____% Sonography
_____% ultrasound
_____% X-ray
_____% other (describe)____

11. Does Applicant own (wholly or in part), operate, or administer any hospital, nursing home, assisted living facility or other institution where medical services are customarily rendered? _____YES _____NO

If *Yes*, please provide details by separate attachment.

12. State sources and amounts of TOTAL GROSS REVENUE/RECEIPTS:

SOURCE	This Year:______	Last Year:__________
Charitable Contributions:	$_____________________	$_________________________
Government Funding:	$_____________________	$_________________________
Fee for Service:	$_____________________	$_________________________
Other: ____________________	$_____________________	$_________________________
TOTAL GROSS REVENUE:	$_____________________	$_________________________

Estimate of Total Gross Revenue for Next Year: $____

13. Staff:

		Employees	*Independent Contractors*
A.	Principals, Partners, Officers, Directors:	__________	__________
B.	Registered Nurse:	__________	__________
C.	LPN/LVN:	__________	__________
D.	Nurse Anesth.:	__________	__________
E.	Nurses Aides:	__________	__________
F.	Certified Lab Tech./Technologist.:	__________	__________
G.	Certified Medical Assistant:	__________	__________
H.	EEG/EKG Tech./Technologist:	__________	__________
I.	X-Ray Tech./Technologist:	__________	__________
J.	Phlebotomist:	__________	__________
K.	Medical Tech./Technologist:	__________	__________
L.	Radiation Therapist:	__________	__________
M.	Inhalation Therapist:	__________	__________
N.	Physicians Assistant :	__________	__________
O.	Social Worker:	__________	__________
P.	Clerical/Administrative:	__________	__________
Q.	Other (specify): __________________________	__________	__________
	TOTAL STAFF:	__________	__________

14. a) Are all above individuals licensed in accordance with all applicable state and federal regulations?
_____YES _____NO If *No*, please attach explanation.

b) Have any of the above individuals had their licenses/certifications revoked/suspended, voluntarily surrendered or cancelled? _____YES _____NO If *YES* , please attach explanation

c) Do you require any above personnel to maintain their own professional liability coverage?
_____YES _____NO If YES, please list individuals and required limits:

____

____

If No, is coverage requested for above individuals? _____YES _____NO

15. Please attach explanation for any of the questions below answered "YES" (include #tests/procedures & gross revenue):

a. Test result interpretation in applicant's (lab) name?	_____YES	_____NO
b. Consultation in Applicant's (lab) name?	_____YES	_____NO
c. Therapy or any treatment procedures?	_____YES	_____NO
d. Blood Banking or blood storage	_____YES	_____NO
e. Procurement of blood or its components?	_____YES	_____NO
f. Plasmapheresis procedures?	_____YES	_____NO
g. Medical, Genetic or Drug research?	_____YES	_____NO
h. any type of environmental analysis?	_____YES	_____NO
i. Manufacture, testing or dispensing of pharmaceuticals?	_____YES	_____NO
j. Manufacture or sell laboratory equipment or supplies?	_____YES	_____NO
k. experimental testing/procedures?	_____YES	_____NO
l. solely mobile services?	_____YES	_____NO
m. any services at malls/shopping centers, health fairs etc.?	_____YES	_____NO
n Intravenous transfusions?	_____YES	_____NO

16. What hours/days a week do you operate:____

17. Does applicant utilize a procedural and quality control manual? _____YES _____NO

If Yes, does applicant make sure that all employees have reviewed these? _____YES _____NO

18. Is lab inspected/certified/accredited by any governmental or medical association? _____YES _____NO

If Yes, please list on separate attachment along the certifications/inspection dates.

19. Does applicant use a reference lab? _____YES _____NO

If Yes, please answer the following:

a. What are the expected annual receipts for the reference lab? $______________________

b Name of reference lab:____

____

c. Does reference lab hold applicant harmless? _____YES _____NO

d. Does applicant obtain written proof of insurance with minimum limit of $1,000,000, for reference lab? _____YES _____NO

e. Does applicant require reference lab to name them as an additional insured and obtain proof of same? _____YES _____NO

20. Does applicant provide any service under contract? _____YES _____NO

If Yes, please provide details or sample contract?

21. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? _____YES _____NO "Financial relationship means all ownership or investment interests, compensation arrangements, medical directorships with applicant".

If Yes, please provide details, including name of physicians, finanical relationship and type of referral.

22. Attach a list of all physicians providing service at this entity (employed or contracted) and-include: NAME, SPECIALTY, SERVICES, %OF OWNERSHIP, BOARD CERTIFIED, INSURANCE CARRIER/LIMITS/EXPIRATION DATE, if LAB is Listed AS ADDITIIONAL INSURED.

23. Have any employed or contracted personnel been subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? _____YES _____NO

24. Have any employed or contracted personnel been convicted of an act in violation of any law or ordinance other than a traffic accident? _____YES _____NO

25. Please list Professional Liability Policies covering applicant over the past 5 years:

Carrier	Expiration Date	Limits	Deductible	Annual Premium

If above policies were CLAIMS MADE please provide current RETROACTIVE DATE:)_______________________________

26. Has any Professional or General Liability claim or suit been brought in the past 5 years against the applicant or any predecessor in interest? _____YES _____NO If Yes, please supply 5 years currently valued Carrier loss runs

27. Is the applicant aware of any circumstance, which may result in any claim against the applicant, or any predecessor in business or present Partner, Officer or Principal? _____YES _____NO If *Yes*, please provide details by separate attachment. Has applicant reported this circumstance/incident to their current carrier? _____YES _____NO

28. Has any application for Professional Liability Insurance made on behalf of the applicant or any predecessor in business or present Partner, Officer of Principal ever been declined or has the insurance been cancelled or renewal refused? [] Yes [] No If *Yes*, please provide details by attachment.

Please include along with this application any required attachments/questionaires, copy of your brochure or advertisements and income statement & balance sheet for most currently completed fiscal year.

Limits of Liability requested:___________________________ Deductible:___________________________

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 no the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements 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 (Principal, Partner or Officer)____

Title: ____

Date: ____

X-RAY/Nuclear Medicine QUESTIONAIRE

1. What testing substance are ingested or injected into the patients?___________________________________
____

2. I s there a likelihood of adverse reaction to the substances used?___________________________________
____

3. What emergency medical procedures have you established in the event of such reactions?_____________
____
____

4. Describe the system of delivery and disposal of radio-nuclides:___________________________________
____
____

5. Indicate the frequency of testing of air and water discharge from the facility to ascertain local, state and federal standards of compliance:____
____

6. What training is provided to your personnel?____
____
____
____

7. Maintenance of equipment is provided by: In-house _____ Manufacturer/Distributor _____
Contracted to outside firm _____ Other (describe)____

How often is equipment serviced: monthly_____ quarterly _____ bi-annual_____ annually _____

8. Do you maintain records of your tests/procedures/scans? _____YES _____NO If Yes, please describe:____
____

9. Are all tests/procedures/scans done per a physician request? _____YES _____NO

10. What personnel perform the test/procedure/scan?____
Do procedures require two personnel to be with the patient at all times? _____YES _____NO

11. Who reports the interpretation of the test/procedure/scans etc.?____________________________________

12. Are the x-rays/scans sent along with the report? [] Yes [] No

13. Are the x-rays/scans sent out under the name of the applicant or in the name of the Radiologist?____

14. Number of annual patient contacts for all tests/scans/procedures/x-ray services:____

15. Do employees wear nuclear sensitive badges which warn of potential nuclear problems?______________