Quaker Special Risk a division of the Quaker Agency Inc.

APPLICATION FOR SPECIFIED
MEDICAL PROFESSIONS FOR
PROFESSIONAL LIABILITY
INSURANCE

(Claims Made Basics)
APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date 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 (include professional degree if applicant is an individual):

b. Principal business address:
(Please attach a list of additional office addresses)

c Number of Employees: Full time________. Part time__________. Seasonal___________. Total__________.

c. Business Phone: (   )______________________. Home Phone:
(   )____________________________.

d. Date of Birth:_______________________.

Place of Birth:__________________________.

Are you a U.S. citizen?_____Yes_____No. If No, your status, date of entry into USA:

e. square feet of total office space (all locations):

f. Your practice:

[ ] Solo practitioner (unincorporated)
[ ] Solo practitioner (incorporated)
[ ] Partnership
[ ] Professional Association
[ ] Professional corporation (for profit)
[ ] Professional corporation (non-profit)
[ ] Employee of___________________________..
(Give name of employer)
[ ] Other (please describe)____.

g. Formal business, corporate or partnership name:

h. Please list the names of all partners or members of your professional association/corporation who provide professional Services:

i. Please attach a copy of your letterhead.

2. EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training		Degree or Certification Attained
	From	To	
	From	To	
	From	To	

(i) Where have you practiced your profession during the last ten years?

In ________________________ From ________________________ To________________________.

In ________________________ From ________________________ To________________________.

In ________________________ From ________________________ To________________________.

2. EDUCATION/EXPERIENCE(Individual Applicant Only) (CONTD.)

(ii) Have you ever failed any professional licensing or specialty organization examination?
If yes, please attach a detailed explanation including the dates and location. [ ] YES [ ] NO

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation.

b. Please indicate your professional specialty (CHECK ONE):

[ ] Chiropractor
[ ] Counselor (Describe) ______________________.
[ ] Dental Hygienist
[ ] Hearing Aid Fitter
[ ] Home Health Care Agcy.
[ ] Inhalation Therapist
[ ] Laboratory Technician
[ ] Medical Personnel Pool
[ ] Naprapath
[ ] Nurse, Licensed Practical
[ ] Nurse, Registered
[ ] Nurses, Registry
[ ] Occupational Therapist
[ ] Optician
[ ] Optometrist
[ ] Orthotist
[ ] Perfusionist
[ ] Pharmacist
[ ] Physical Therapist
[ ] Psychologist
[ ] Social Worker
[ ] Speech Therapist
[ ] Veterinarian
[ ] Visiting Nurse Assoc.
[ ] X-ray Technician
[ ] Other (Specify) ______________________.

c. Please indicate the sources and amounts of actual and projected revenue:

SOURCE	Amount This Fiscal Year	Amount Next Fiscal Year
(i) Charitable Contributions:	$________________	$________________.
(ii) Government Funding:	$________________	$________________.
(iii) Fee of Services:	$________________	$________________.
(iv) Other:____________	$________________	$________________.
TOTAL GROSS REVENUE	$________________	$________________.

d. Please provide the number of patient or client visits:

Type of Visit	**Number Visits Last 12 Months**	**Number of Visits Next 12 Months**
Clinic	________________	________________.
Laboratory	________________	________________.
Other (specify)____________	________________	________________.
TOTAL NUMBER OF VISITS	________________	________________.

e. Please specify any professional societies or associations in which you are a member:

f. Are you associated with or do you work for a physician or surgeon? [ ] Yes [ ] No

If yes, please give the name and the specialty of the physician:

g. Please give the approximate percentage of time spent in the following work locations:

________ % Administrative Office ________% Laboratory ________% Hospital Ward (specify)

________ % Classroom ________% Operating Room ______________________________.

________ % Emergency Dept of Hospital ________ % Outpatient Clinic ________% Professional Office (specify profession)

________% Nursing Home ________% Patient's Home ______________________________.

________ % Other (specify)____.

3. APPLICANT PRACTICE (CONTD.)

h. Please indicate the approximate division of your patients or clients among:

Hemodialysis	________ %	Psychiatric	________%	Bariatrics	________%
Holistic Medicine	________ %	Drug Addicts	________%	Physical Rehabilitation	________%
Surgical	________ %	Alcoholics	________%	Disability Evaluation	________%
Stress Testing	________%	Obstetrical	________%	Research or Experimental	________ %
Communicable	________%	Dental	________%	____________________	________%
Family Planning	________%	Pediatric	________ %	____________________	________%

i. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

TYPE OF PROFESSION	NO.	TYPE OF PROFESSION	NO.
Inhalation Therapists	________________	Opticians	______________.
Laboratory Technicians	________________	Optometrists	______________.
Nurse Anesthetists	________________	Perfusionists	______________.
Nurses, Licensed Practical	________________	Pharmacists	______________.
Nurse Practitioner	________________	Physiotherapists	______________.
Nurses, Registered	________________	Social Workers	______________.
Speech Therapists	________________	Other (please specify)	______________.

j. Are all of the above individuals licensed in accordance with applicable state and federal regulations? [ ] Yes [ ] No
If no, please attach an explanation.

4. APPLICANT PROCEDURES

	YES	NO
a. Do you render professional services directly to patients?	[ ]	[ ]

If yes, please describe in detail and indicate the extent of supervision by others.

Description of Professional Services	**Percent of Time Supervised**	**Qualifications of Supervisor**
______________________________	________%	______________.
______________________________	________%	______________.
______________________________	________%	______________.
______________________________	________%	______________.

b. Do you render professional services that do not involve contact with a patient? [ ] [ ]
If yes, please describe these services in detail.

c. (I) Do you perform or assist in any surgical procedures? [ ] [ ]

(ii) Please list ALL surgical procedures performed (including minor surgery):____.

____.

____.

(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? [ ] [ ]
If yes, please attach a detailed explanation.

(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? [ ] [ ]
If yes, please attach a detailed explanation.

4. APPLICANT PROCEDURES (CONTD.)

d. Do you perform radiation therapy? [ ] [ ]

e. Do you perform psychiatric shock therapy? [ ] [ ]

f. Do you compound in bulk, manufacture or wholesale medicine? [ ] [ ]
If yes, please provide a detailed explanation.

g. (I) Do you perform veterinary services? [ ] [ ]
If yes, please indicate the approximate division of your work among the following categories.

_______________% Greyhounds _________________% Thoroughbreds

_______________% Animals valued over $5,000.

Please attach an explanation including the frequency and the type(s) of animals treated.

h. (ii) Do you administer artificial insemination? [ ] [ ]
If yes, please answer the following questions:

(i) What type(s) of animals are involved?____.

(ii) Are you responsible for the storage of the semen? [ ] [ ]

If yes, please explain.____.

____.

(iii) What percent of your practice is involved with artificial insemination? _________%

i. Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action? [ ] [ ]
If yes, please attach a detailed explanation.

5. PERSONNEL

a. Please list the number and type of independent contractors who provide professional services on your behalf.
IF NONE, STATE NONE.

NO.	Type of Profession	NO.	Type of Profession	NO.	Type of Profession
____________	Inhalation Therapists	____________	Laboratory Technicians	____________	Nurse Anesthetists
____________	Nurses, Licensed Practical	____________	Nurse Practitioner	____________	Nurse, Registered
____________	Opticians	____________	Optometrists	____________	Perfusionists
____________	Pharmacists	____________	Physiotherapists	____________	Social Workers
____________	Speech Therapists	____________	Other (specify)________________.		

b. Do you supervise any individuals who are not your own employees? [ ] Yes [ ] No
If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these Individuals.

c. Please indicate by profession the number of individuals you supervise.

NO	Type of Profession	NO	Type of Profession
____________	Physicians	____________	Laboratory technicians
____________	X-ray technicians	____________	Other (please specify):____________.

6. APPLICANT AFFILIATIONS

	YES	NO
a. Do you own or operate any business other than that shown in Question 1(a) above? If yes, please give details on a separate sheet.	[ ]	[ ]
b. Are you employed by any individual or entity other than that shown in Question 1(a) above? If yes, please attach an explanation describing details of your responsibilities.	[ ]	[ ]
c. Are you under contract to any individual or entity other than that shown in Question 1(a) above? If yes, please attach an explanation including the details of your responsibilities. If your contract contains a hold-harmless agreement, a copy of the contract must be attached.	[ ]	[ ]
d. Are you employed by or under contract to any government entity? If yes, please attach an explanation including the details of your responsibilities.	[ ]	[ ]
e. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? If yes, please attach a copy of ALL of your advertisements.	[ ]	[ ]
f. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? If yes, please attach a detailed explanation and copy of ALL of your advertisements.	[ ]	[ ]
g. Do you own (wholly or in part), operate, or administer any hospital., nursing home or other institutions where medical services are customarily rendered? If yes, please give details including the name, location, size and number of beds.	[ ]	[ ]

h. If you have a training school, please complete the following. Attach a separate sheet if needed.

Specify Profession For Which Students Are Being Trained	**Max. No. Of Students Per Session**	**No. of Sessions Per Year**	**% of Time Involved in Clinical Setting**	**Number of Faculty**	**Qualifications of Faculty (e.g. MD, RN, PhD, etc.)**

i. (i) Do you use a collection agency? If yes, please state the name of the agency	[ ]	[ ]
(ii) Does the agency have the authority to file a collection suit at its discretion?	[ ]	[ ]

7. APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any "YES" answers)	YES	NO
a. Have you or any of your employees:		
(i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	[ ]	[ ]
(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	[ ]	[ ]
(iii) Ever been treated for alcoholism or drug addiction?	[ ]	[ ]

7. APPLICANT HISTORY/CLAIMS (CONTD.)

(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? [ ] [ ]

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? [ ] [ ]

b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Policy Insurance Carrier	Policy Number	Limits of Liability	Deductible (If any)	Premium	Inception Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	

c. Year 2000: YES NO

(i) Does your computer system store a four-digit year? [ ] [ ]

(ii) If NO, please attach a description of corrective measure taken and the date upon which you anticipate the problem will be solved.

(iii) Are you, in the course of your business, involved in working to solve the year 2000 problem as a consultant/advisor or as a part of your employment? [ ] [ ]

(iv) If YES, what percentage of your work is involved?____________________%

d. Has any claim or suit been brought against you and/or any of your employees? [ ] [ ]
If yes, a Supplemental Claim Information Form must be completed for each claim or suit.

e. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? [ ] [ ]
If yes, please give details on a separate sheet.

*NOTICE 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 AGAINST 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 the Insurers, that I 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 Shand Morahan & Company, Inc., Underwriting Manager for the 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.

Quaker Special Risk a division of the Quaker Agency Inc.

FAX

NAME:____
COMPANY:____
ADDRESS:____
STATE, ZIP:____
DATE:____
NUMBER OF PAGES(incl. Cover):____
* FAX TO:____

PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST YOU.

* Click the link below for a list of our offices and current fax numbers.

http://www.qsr-insurance.com/qsr-fax.html

ADDITIONAL COMMENTS: