Chaucer

APPLICATION FOR ALLIED HEALTH PROFESSIONAL AND GENERAL LIABILITY INSURANCE

1. NAME OF APPLICANT: _____

2. MAILING ADDRESS: _____
(If multiple name and locations, please attach list)

_____ PHONE NO. _____

3. a) DATE ESTABLISHED Corp._____ Partnership Prof. Assoc. _____ Individual _____

b) In what states is the applicant registered and licensed to practice? _____

4. Is the firm engaged in, owned by, associated with or controlled by any other business? ____ if yes, give detail

_____

_____

_____

5. State approximate division of applicant's patient among:

a) Alcoholics	(%)		
b) Counseling/ Family Planning	(%)	k) Obstetrical	(%)
c) Communicable	(%)	l) Pediatric	(%)
d) Dental	(%)	m) Psychiatric	(%)
e) Drug Addicts	(%)	n) Research	(%)
f) General	(%)	o) Senile or Aged	(%)
g) Hemodialysis	(%)	p) Stress Testing	(%)
h) Holistic medicine	(%)	q) Surgical	(%)
i) Medical	(%)	r) Tubercular	(%)
j) Mentally Retarded	(%)	s) Other_____	(%)

6. a. List the number and type of applicant's employees and volunteers: If None, State None.

Number	Type of Profession		
a)_____	EMT's	j)_____	Paramedics
b)_____	Inhalation Therapists	k)_____	Perfusionists
c)_____	Laboratory Technicians	l)_____	Pharmacists
d)_____	Nurse Anesthetists	m)_____	Physicians - Minor Surgery
e)_____	Nurses, Licensed Practical	n)_____	Physicians - No Surgery
f) _____	Nurse Practitioner	o) _____	Physiotherapists
g)_____	Registered Nurses	p)_____	Social Workers
h)_____	Opticians	q)_____	Speech Therapists
i)_____	Optometrists	r)_____	Other

b. List the number and type of independent contractors who provide professional services on behalf of the applicant. IF NONE, STATE NONE._____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations
_____ Yes _____ No If no, attach explanation.

7. PROFESSIONAL ACTIVITIES AND SPECIALTY

Please check all that apply:

GENERAL

_____ Acupuncture Clinic
_____ Acupuncturist
_____ Adult Day Care
_____ Alcohol / Drug Rehab (Adults Only)
_____ Ambulance Services (NON EMERG ONLY)
_____ Artificial Limb Clinic
_____ Audiologist
_____ Case Management
_____ Community Health Clinic (non-surgical)
_____ Consultant
_____ Counselor
_____ Diagnostic Imaging / X-ray
_____ Diagnostician
_____ Dialysis Center - Hemo
_____ Dialysis Center - In Home Peritoneal
_____ Dialysis Center - Peritoneal
_____ Durable medical equipment - Sales
_____ EMT
_____ Halfway House
_____ Health and Fitness Center
_____ Hearing Aid Fitter
_____ Home Health Agencies
_____ Home Health Aide
_____ Imaging Tech
_____ LVN / LPN
_____ Massage Therapist
_____ Medical Clinic
_____ Medical Clinic -LVN
_____ Medical Clinic - Counseling
_____ Medical Clinic - Nurse Practitioner
_____ Medical Clinic - Physician
_____ Medical Clinic RN / PT
_____ Medical Director
_____ Medical Lab Tech
_____ Medical Lab All Other
_____ Medical Lab - DNA Testing
_____ Medical Lab - Drug Testing
_____ Medical Lab - Fertility Testing
_____ Medical Personnel Services - Home Health
_____ Medical Personnel Services - Staff Relief

_____ Mental Health Clinics
_____ Mental Health Tech
_____ Nurse
_____ Nurse Practitioner
_____ Nurse Aide
_____ Occupational Therapist
_____ Occupational Therapist Assistant
_____ Ocularist
_____ Oncology Treatment
_____ Optical - related establishments
_____ Optical Goods Stores
_____ Optometrist
_____ Pastoral Counselor
_____ Pharmacy - non prescription
_____ Pharmacy - prescription
_____ Phlebotomist
_____ Physical Therapy Assistant
_____ Physical Therapy Clinic
_____ Physician Assistant (no surgery exposures)
_____ Physician Assistant (surgery exposures)
_____ Pregnancy Center
_____ Psychiatric Social Worker
_____ Psychologist
_____ Radiation Therapy Technician
_____ Respiratory Therapist
_____ School for Handicapped
_____ Sheltered Workshops
_____ Speech Therapist
_____ Speech / Language Pathologist
_____ Surgical Technician
_____ Surgicenter
_____ Surgicenter - w/ Anesthe
_____ Surgicenter - w/out Anesthe
_____ Testing Services
_____ Testing Services (specimen collection only)
_____ Ultrasound Technician
_____ Veterinarian
_____ X Ray Technician

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MEDICAL SPA SPECIALTIES

Please check all treatments that apply

_____	Laser / LED Treatments	_____	Laser Hair Stimulation
_____	Laser Hair Removal (skin types I -IV only)	_____	Tattoo Removal
_____	Varicose Vein treatments	_____	Sclerotherapy
_____	Age Spot Removal	_____	Medical strength peels (skin types I-IV only)
_____	Rosaceas Treatment	_____	Facials / peels and microdermabrasion
_____	Wrinkle Reduction	_____	Teeth Whitening
_____	Acne Treatment	_____	Henna Tattoo
_____	Mesotherapy	_____	Tattooists
_____	Pigment Removal	_____	Other - please state below _____

_____

_____

_____

_____

If any Medical Spa Specialties have been checked, please complete the Medical Spa Supplemental Application

8. ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:	YES	NO
Has the applicant or have any of the above employees:		
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	a)_____	_____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	b)_____	_____
c) Ever been treated for alcoholism or drug addiction?	c)_____	_____
d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	d)_____	_____

9. Number of Ground Ambulances _____
Number of Air Ambulances _____
Radius of Services _____
Number of Emergency Calls _____
Number of Non-Emergency Calls

If the applicant uses hired /non-owned automobiles, please complete the Non Owned Auto Supplemental Application

	YES	NO
10. Does the applicant perform:	a)_____	_____
a. Acupuncture or acupuncture anesthesia? Explain:_____	b)_____	_____
b. Anglography / Arteriography/ Venography? Describe:_____		
c. Catherterization (other than urinary or umbilical)? Describe procedure:	c)_____	_____
d. Closed reduction of compound fractures and / or Normal Deliveries and/or Dermabrasion?	d)_____	_____
e. Injection of radioisotopes and / or use of irradiated substances? Describe:_____	e)_____	_____
f. Radiation Therapy and/or Chemotherapy? Describe: _____	f)_____	_____
g. Psychiatric shock therapy?	g)_____	_____
h. Silicone injections/ Describe: _____	h)_____	_____
i. Spinal Anesthesia (other than saddle blocks or caudals)?	i)_____	_____
j. Laser treatment? Describe: _____	j)_____	_____
k. Botox injections	k)_____	_____
l. Chelation Therapy / Describe_____	l)_____	_____

11. Does the applicant perform any:	a)_____	_____
a. Surgery other than incision of superficial boils or suturing superficial fascia?		
b. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers?	b)_____	_____
	c)_____	_____
c. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections?	d)_____	_____
d. Cosmetic Plastic Surgery? Describe _____		
_____	e)_____	_____

e. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? f)_____ _____
f. Hysterectomies? g)_____ _____
g. Open reduction of fractures? Describe:_____ h)_____ _____
h. Surgery for weight reduction of patients?
i. Abortions and / or menstrual extractions? Describe (include trimester, i)_____ _____
method and number of abortions performed per month): j)_____ _____
j. Silicone Implants? Describe: _____ k)_____ _____
k. Sterilization Procedures? Describe:_____ l)_____ _____
l. Biopsies and/or endoscopies? List types performed:_____ m)_____ _____
m. Sex change operations? Describe and advise the number performed
per year: _____ n)_____ _____
n. Other Surgery? Describe: _____

12. Does the applicant perform hospital emergency room care?
a) for its own regular patients? _____ Y b) for patients not its own? _____ Yes _____ No
c) If answer to (b) is yes, please specify: the percentage of its time devoted to this work= _____% the number of hours per month devoted to this work= _____ hrs.

13. Does the applicant use drugs for weight reduction of patients? ___ Yes _____ No If yes, list drugs used and advise: Percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant. _____

_____

14. Does the applicant administer any methadone treatment? _____ Yes _____ No If yes, please complete the methadone supplementary application.

15. Is anesthesia (other than topical or by means of local infiltration) admistered by either applicant or others? _____Yes _____ No If yes, attach detailed explanation

16. Does the applicant maintain any beds for overnight occupancy? _____Yes _____ No, If yes, number of licensed beds by location: _____

_____

17. State the number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom treatment is given and number of procedures: _____

_____

18. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? _____Yes _____ No If yes, give details, including name, location size and number of beds. _____

_____

_____

19. State sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
		$_____
A. Charitable contributions	$_____	$_____
B. Government Funding	$_____	$_____
C. Fee for Services	$_____	$_____
D. _____	$_____	$_____
E._____	$_____	$_____
TOTAL GROSS REVENUE	$_____	

20. Number of patient encounters last 12 months _____ and / or patient tests carried out _____
(Note:"patient encounters" refers to number of visits - not number of patients.)

21. Number of estimated patient encounters next 12 months _____ and/or patient tests carried out_____
(Note:"patient encounters" refers to number of visits - not number of patients.)

22. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

If expiring insurance is a claims made policy, what is the retroactive date? _____

23. Is the Applicant currently insured under a Commercial General Liability Policy? Yes _____ No_____ If yes, please give details:

Insurance Company	Type of Coverage	BI	PD	Limits From	To

24. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?
_____ Yes _____ No If yes, please give details :_____

25. Has any claim ever been made against the firm or any of its employees? Yes_____ No_____ If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

26. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? Yes_____ No_____ If yes, please give full details on the same basis as item 24.

27. Has any insurer cancelled or refused to renew any similar insurance during the past five years? _____

28. Limits of Liability requested _____ Deductible _____

29. Desired term of policy: From _____ To _____

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____

Please Print Title

Signature: _____

Name Date

Name of Insurance Agent or Broker _____

Please Print Title

Signature: _____

Name Date