Corporation, Partnership or Other Legal Entity Application

Please legibly print all responses in full. If more room is required than is provided here, please respond at the end of this application or supplement it with additional pages, along with any and all other requested documents.

1. Full Legal Name of Entity (including all dba's and subsidiaries seeking coverage):

2. Mailing and Location Address (if multiple addresses include an attachment with all locations):

3. Date Established: ______________________

4. Type of Entity: Corporations
Partnership
Individual
Other: ____________________

5. Is this entity owned by, associated with or controlled by any other entity? Yes No If yes, give details:

6. Requested coverage:

Limits of Liability:

___ $100,000 / $300,000
___ $200,000 / $600,000
___ $250,000 / $750,000
___ $500,000 / $ 1 Million
___ $1 Million / $3 Million
___ Other: ____

Effective Date: ___________________

What is the retroactive date on you current policy? ____________________

7. Professional Activities and Specialty:

Ambulance Service Ground Air
Cosmetic Aesthetics Clinic (Med-Spa)
Dental Practice
Drug and Alcohol Treatment
Home Healthcare Agency
Kidney Dialysis Center
Laser Vision Correction Center
Medical Clinic
Medical Staffing
Methadone Clinic
Mental Health Services
Nurse Registry
Pharmacy
Radiology (Teleradiology Yes No)
Residential Care Facility
Social Services
Surgery Center
Other (Provide Details)

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8. State the approximate division of patients:

____% Substance Abuse – Drug or Alcohol
____% Cosmetic or Elective
____% Counseling
____% Communicable Diseases
____% Dental
____% Dialysis
____% Family Planning
____% Holistic or Alternative Medicine
____% General Medicine

____% Developmentally Disabled
____% Obstetric
____% Pediatric
____% Psychiatric
____% Research or Experimental
____% Geriatric
____% Surgical
____% Other (Provide Details)
____

9. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

	Employees Or Volunteer	Independent Contractor	Insured On Own Med Mal Policy
Physicians (no surgery)	_____	_____	Yes No
Physicians (surgery)	_____	_____	Yes No
Physicians Assistant	_____	_____	Yes No
Surgical Technicians	_____	_____	Yes No
Certified Nurse Anesthetists	_____	_____	Yes No
Nurse Practitioner	_____	_____	Yes No
Registered Nurse	_____	_____	Yes No
LPN's or Nurse Aids	_____	_____	Yes No
X-ray Technicians	_____	_____	Yes No
Medical Assistants	_____	_____	Yes No
Optometrists	_____	_____	Yes No
Opticians	_____	_____	Yes No
Pharmacists	_____	_____	Yes No
Pharmacy Technicians	_____	_____	Yes No
Chiropractors	_____	_____	Yes No
Message Therapists	_____	_____	Yes No
Laboratory Technicians	_____	_____	Yes No
Paramedics	_____	_____	Yes No
EMT's	_____	_____	Yes No

	Employees Or Volunteer	Independent Contractor	Insured On Own Med Mal Policy
Social Workers	_____	_____	Yes No
Aestheticians	_____	_____	Yes No
Perfusionists	_____	_____	Yes No
Occupational Therapists	_____	_____	Yes No
Physical Therapists	_____	_____	Yes No
Speech Therapists	_____	_____	Yes No
Other: _______________	_____	_____	Yes No
Total Staff:	_________		

****Please attach copies of declarations pages on all individuals that carry their own medical malpractice.**

If you have a Medical Director, provide name, specialty and CV:

Are Medical Director's duties administrative only? Yes No

Does Medical Director provide direct patient care? Yes No

What medical malpractice limits is Medical Director required to carry? ____

10. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes No
If No, Please attach a detailed explanation.

11. Has the applicant or any of the above employees and/or independent contractors:
Please attach explanation for any of the questions below answered "Yes":

A. Ever been the subject of disciplinary or investigated proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association?	Yes	No
B. Ever been convicted for an act committed in ciolation of any law or ordinance other than a traffic offense?	Yes	No
C. Ever been treated for alcoholisms or drug addiction?	Yes	No
D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only of special terms or even voluntarily surrendered same?	Yes	No

12. Does the applicant perform any of the following non-surgical procedures or treatment?

Acid or chemical peels	Yes	No
Solution Strength ______ If over 30%, is this done by licensed MD	Yes	No
Acupuncture	Yes	No
Angiography, Artiography, Venography	Yes	No
Botox Injections	Yes	No
Catheterization (other than urinary or umbilical)	Yes	No
Closed reduction of compound fractures	Yes	No
Collagen injections	Yes	No
Electrolysis	Yes	No
Laser Treatment (non-surgical) If yes, which of the following:	Yes	No
Hair Removal		
Skin Resurfacing		
Tattoo Removal		
Other: ____		
Lipodissolve	Yes	No
Mesotherapy	Yes	No
Microdermabrasion	Yes	No
Pain Management (non-surgical)	Yes	No
Permanent Makeup Application	Yes	No
Psychiatric choch therapy	Yes	No
Radiation Therapy and/or Chemotherapy	Yes	No
Sclerotherapy	Yes	No
Silicone Injection	Yes	No

13. Does the applicant perform and of the following surgical procedures?

Abortions If Yes, please answer the following:	Yes	No
What is the maximum trimester? ______________________________		
What methods? ______________________________		
How many per month? ______________________________		
Bariatric Surgery If Yes, attach a list of types performed	Yes	No
Biopsies	Yes	No

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Circumcisions	Yes	No
Colonoscopies or Endoscopies	Yes	No
Cosmetic Plastic Surgery If Yes, what percentage of practice? _____________	Yes	No
Cryosurgery	Yes	No
Deliveries Yes No If Yes, C Sections?	Yes	No
Dilation and curettage	Yes	No
Hysterectomies	Yes	No
Mino surgical procedures only	Yes	No
Major surgical procedures	Yes	No
Mastectomies or lumpectomies	Yes	No
Neurosurgery	Yes	No
Organ transplant surgery	Yes	No
Orthopedic surgery other than spinal	Yes	No
Penile lengthening or enhancement surgery	Yes	No
Sec change operations or sexual reassignment surgery	Yes	No
Spinal surgery	Yes	No
Surgical podiatry	Yes	No
Vasectomies	Yes	No
Other ____		

14. Does the applicant administer methadone treatment? Yes No
    If Yes, how many slots? ____________

15. Does the applicant administer detoxification treatment? Yes No
    How many patients annually? ____________

16. Does the applicant maintain any beds for overnight occupancy? Yes No
    If Yes, what is the total number of beds? ____________

17. Does the applicant provide services to Nursing Home or Assisted Living Centers? Yes No
    If Yes, please provide description of the services and the percentage (%) of these services:

18. Is anesthesia (other than topical or by means of local infiltration) administered at the applicants facility? Yes No
    If Yes, what percentage of procedures required general anesthesia? ________

19. Does the applicant sell any products? Yes No
    If Yes, please include product brochures.
    What find of products? ____________________________________
    Do any of these products require a physicians prescription?
    Do you re-label these products in your own name?

20. Please provide the number of annual patients encounter or client visits:

	Last 12 months	Estimate for next 12 months
Outpatient Visits (non-surgical)	____________	____________

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Surgical Procedure (not including above) ____________ ____________
Other ____________________________________ ____________ ____________

21. Please provide the following information as respects the last five years of professional liability coverage beginning with the most current coverage: (If None, state NONE)

Carrier	Limit	Deductable	Premium	Policy Term

22. What is the retroactive date on you current policy? ____________________

23. Is the applicant currently insured under a Commercial General Liability policy? Yes No
If Yes, please attach copies of declaration page.

24. Does the applicant own, operate or manage an business other than the one(s) described in this application for which you are applying for coverage? Yes No
If Yes, please provide complete details, including name of entity, your ownership interests or contractual relationship and information on their insurance program.

25. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? Yes No
If Yes, please provide details including name of carrier and dates.

26. Has any claim ever been made against the applicant or any of its employees? Yes No
If Yes, please complete the supplemental claim information form with your submission.

27. Is the applicant aware of any circumstances which mat result in any claims against tem or their employees? Yes No
If Yes, please provide full details on each incident including name of partied involved, date of treatment and current status of incident.

28. Does the applicant have a Risk management and Risk Control Program in place? Yes No
Who is responsible for the Program? ____
Title: ______________________________ Contact email: ____
Phone Number: ____________________________

FRAUD WARNING

ANY PERSON WHI KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AND APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION OF A MATERIAL NATURE, MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICANTS REPRESENTATIONS, WARRENTIES AND AUTHORIZATIONS

I understand that no coverage will be bound until after Lancet Indemnity RRG has reviewed this completed application and formally bound the requested coverage.

I understand that no insurance will be provided for: 1) any claim known to the applicant prior to the effective date of this insurance, whether or not reported to any prior insurer; or 2) any claim that may arise out of any incident known to the applicant prior to the effective date of this insurance, whether or not reported to any prior insurer.

I specifically represent and warrant to Lancet Indemnity RRG that the information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this application or that might be material to the acceptance of the risk described to the underwriter in this application. I further agree that any false or misleading statement in this application shall be ground for the insurer to cancelled and void coverage at its sole and absolute discretion. I understand that a photocopy or facsimile of this application will serve as if it were the original.

I authorize the release of any underwriting and/ or claim information (and release from any and all liability for the provision of information) from all prior and current insures, all professional societies or associations, any state licensing authority, or any hospitals or healthcare institutions, to Lancet Indemnity RRG, and it subsidiaries or agents.

I agree to cooperate with the risk manage department of Lancet Indemnity RRG, and it subsidiaries or agents, and to supports its efforts to enhance the quality of patient care.

____ ________________

Signature Title Date

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