Chris-Leef General Agency, Inc.
P.O. Box 3747 Shawnee Mission, KS. 66203
(913) 631-1232 (913) 631-1128 fax
(800) 548-0491 (800) 383-1235 fax
brokerage@chris-leef.com

APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.)
PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

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: ____________________

b. Principal business premise address ____________________
(Street) (County)

____
(City) (State) (zip)

c. ☐ Professional Corporation (for profit) ☐ Partnership
☐ Professional Corporation (non-profit) ☐ Professional Association
☐ Other (describe) ____________

d. Date established ____________________

e. Number of Employees: Full time ________ Part time _______ Seasonal ________ Total ________

f. Business, corporate or partnership name: ____________________

g. Name of all partners or members of the firm who provide professional services: ____________________

h. Professional societies or associations in which you are a member: ____________________

i. Please attach a copy of letterhead or other business stationery.

2. OPERATIONS

a. States Clinics are registered and licensed to practice: ____________________

If none, please explain.

b. Clinics professional specialty: ____________________

c. Do you maintain any beds for overnight occupancy? ☐ Yes ☐ No. If yes, also complete application form SM 271 of SM 68&

d. Total sq. ft. that you occupy (all locations): ____________________

e. Division of patients or clients:

(i) Hemodialysis	______%	(vii) Psychiatric	______%	(xiii) Bariatrics	______%
(ii) Holistic Medicine	______%	(viii) Drug Addicts	______%	(Xiv) Physical Rehabilitation	______%
(iii) Surgical	______%	(ix) Alcoholics	______%	(xv) Disability Evaluation	______%
(iv) Stress Testing	______%	(x) Obstetrical	______%	(xvi) Research or Experimental	______%
(v) Communicable	______%	(xi) Dental	______%	(xvii) Other ____________	______%
(vi) Family Planning	______%	(xii) Pediatric	______%	____________	100%

f. Does Clinic use a collection agency? ☐ Yes ☐ No
If yes, name of agency?
Does the agency have authority to file a collection suit on Clinics behalf? ☐ Yes ☐ No

g. Do owners, partners or directors, (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.

h. Do you own or operate any business other than that shown in question 1 a? ☐ Yes ☐ No
If yes, please attach detailed explanations of this activity.

i. 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 copy of ALL of the advertisements.

j. Names and locations of any hospitals or institutions Clinic use is in practice

3. PROFESSIONAL SERVICES

a. Do you perform:
(i) Acupuncture or acupuncture anesthesia? Explain: ☐ Yes ☐ No
(ii) Angiography/arteriagraphy/venography? Describe: ☐ Yes ☐ No
(iii) Catheterization (other than urinary or umbilical)? Describe: ☐ Yes ☐ No
(iv) Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? ☐ Yes ☐ No
(v) Injection of radioisotopes and/or use of irradiated substances? Describe ☐ Yes ☐ No
(vi) Radiation therapy and/or chemotherapy? Describe: ☐ Yes ☐ No
(vii) Psychiatric shock therapy? ☐ Yes ☐ No
(viii) Silicone injections? Describe-, ☐ Yes ☐ No
(ix) Spinal anesthesia (other than saddle blocks or caudals)? ☐ Yes ☐ No
(x) Laser treatment? Describe: ☐ Yes ☐ No
(xi) Experimental procedures or research testing? Describe in detail on separate sheet ☐ Yes ☐ No
(xii) Hypnosis? Describe ☐ Yes ☐ No

b. Do you perform:
(i) Norplant insertion/removals advise # yearly ☐ Yes ☐ No
(ii) Surgery other than incision of superficial boils or suturing superficial fascia? ☐ Yes ☐ No
(iii) Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker? ☐ Yes ☐ No
(iv) Tonsillectomies and/or adenoidectornies and/or caesarean sections? ☐ Yes ☐ No
(v) Cosmetic plastic surgery? Describe: ☐ Yes ☐ No
(vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles? ☐ Yes ☐ No
(vii) Hysterectomies? ☐ Yes ☐ No
(viii) Open reduction of fractures? Describe: ☐ Yes ☐ No
(ix) Surgery for weight reduction of patients? ☐ Yes ☐ No
(x) Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): ☐ Yes ☐ No
(xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: ☐ Yes ☐ No
(xii) Silicone implants? Describe: ☐ Yes ☐ No
(xiii) Sterilization procedures? Describe: ☐ Yes ☐ No
(xiv) Biopsies and/or endoscopies? List types performed: ☐ Yes ☐ No
(xv) Sex change operations? Describe and advise number yearly: ☐ Yes ☐ No
(xvi) Experimental surgery or surgical research? Describe in detail on separate sheet. ☐ Yes ☐ No
(xvii) Other surgery? Describe: ☐ Yes ☐ No

c. i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? ☐ Yes ☐ No
If yes, answer (ii) and (iii) below.

(ii) List ALL surgical procedures performed (including minor surgery): ______

(iii) Do you administer anesthesia (other than topical or local infiltration)? ☐ Yes ☐ No
If yes, please attach detailed explanation.

d. Do you perform hospital emergency room care for patients not your own? ☐ Yes ☐ No
If yes, please attach explanation and also advise the number "patient contact" hours MONTHLY by you:
(i) Emergency Room Physicians ______ hrs. (iii) Nurses ______ hrs
(ii) Paramedics ______ hrs. (iv) Other ______ ______ hrs

e. Do you use drugs for weight reduction or patients? ☐ Yes ☐ No
If yes, attach list of drugs used and percentage of practice devoted to weight reduction, frequency and duration of prescriptions or weight reduction drugs', and quantity dispensed.

f. Do you administer any methadone treatment? ☐ Yes ☐ No
If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months ______, Next 12 months ______

g. Number of annual x-ray exposures: for diagnosis ______, for treatment ______

h. If x-ray treatment is given, what qualifications are required of the staff? ______

i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity. ☐ Yes ☐ No

j. Attach detailed description of any additional activities and/or procedures which you performed.

4. STAFF

a. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE

		Employees and Volunteers	Independent Contractors			Employees and Volunteers	Independent Contractors
(i)	Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	______	______	(xi)	Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	______	______
(ii)	Physicians: Minor surgery or obstetrical procedures not constituting major surgery	______	______	(xii)	Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet	______	______
(iii)	Proctologists, Ophthalmologists and Urologists	______	______	(xiii)	Unlicensed Interns	______	______
(iv)	General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	______	______	(xiv)	Dentists (no oral surgery)	______	______
(x)	Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	______	______	(xv)	Orthodontists	______	______
(vi)	Oral Surgeons	______	______	(xvi)	Podiatrists	______	______
(vii)	Nurse Anesthetists	______	______	(xvii)	Chiropractors	______	______
(viii)	Optometrists, Opticians	______	______	(xviii)	RN, LPNs	______	______
(ix)	Pharmacists	______	______	(xix)	Other ______	______	______
(x)	Perfusionists	______	______	(xx)	______	______	______

NOTE If you require any of the above to be Named Insureds, please submit separate application for each such individual.

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation? ☐ Yes ☐ No
If no, please attach explanation.

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS

(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association? ☐ Yes ☐ No

(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

(iii) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

(iv) 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? ☐ Yes ☐ No

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

d. Do you supervise any individual other than your own employees? ☐ Yes ☐ No
If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals. ______________________________

____

Also, indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
______	Physicians	______	______________
______	X-ray Technicians	______	______________
______	Laboratory Technician	______	______________

5. REVENUES

a. Please state sources and amounts of total revenue:

Source	This Fiscal Year	Next Fiscal Year
(i) Charitable Contributions	$__________	$__________
(ii) Government Funding	$__________	$__________
(iii) Fee for Service	$__________	$__________
(iv) Other __________	$__________	$__________
TOTAL GROSS REVENUE	$__________	$__________

b. Please provide number of outpatient visits.

Type of Visit	Last 12 Months	Next 12 Months
Clinics	__________	__________
Laboratory	__________	__________
Emergency Room	__________	__________
__________	__________	__________
__________	__________	__________
TOTAL NO. OF VISITS	__________	__________

c. If you have a training school, please complete the following. Attach separate schedule 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 (i.e., MID, RN. PhD etc.)
__________	__________	__________	__________	__________	__________
__________	__________	__________	__________	__________	__________
__________	__________	__________	__________	__________	__________

6. AFFILIATIONS

a. Are you associated with any agency or organization that engages in any kind of advertising for or solicitation of patients? ______ ☐Yes ☐No
If yes, please attach detailed explanation and a copy of ALL of the advertisements.

b, Are you employed by any individual or entity other than that shown in Question 1 (a) ? ______ ☐Yes ☐No
If yes, please attach explanation.

c. Are you under contract to any individual or entity other than that shown in Question 1 (a)? ______ ☐ Yes ☐No
If this contract contains a hold-harmless agreement, copy of contract must be attached.

d. Are you in the employ of or under contract to any federal governmental entity? ______ ☐Yes ☐No

7. HISTORY/CLAIMS

a. Has any claim or suit been brought against you and/or any of your employees? ______ ☐Yes ☐No
If yes, a supplemental claim information form must be completed for each claim or suit.

b. 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? ______ ☐ Yes ☐No
If yes. please give details on separate sheet.

c. Please list general liability insurance carried for each of the past three years. IF NONE, STATE NONE.

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

* 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 to the Insurer, 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.

______________________________ Name of Applicant

______________________________ Title (Officer, partner, etc.)

______________________________ Signature of Applicant

______________________________ 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.

Agent: ______________________________

Address: ______________________________

____