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Medical Testing Laboratories Liability Application

Applicant's Name _____
Mailing Address _____

Location _____

Agent Name _____
Address _____

PROPOSED EFFECTIVE DATE:
From _____ To _____
12:01 A.M., Standard Time at the address of the Applicant

LIMITS OF LIABILITY REQUESTED		
COVERAGE	EACH OCCURRENCE	AGGREGATE
COMBINED SINGLE LIMIT	\$ '000	\$ '000

PLEASE ANSWER ALL QUESTIONS-IF THEY DO NOT APPLY, INDICATE 'NOT APPLICABLE'

1. Applicant is: Individual Corporation Partnership Joint Venture
 Limited Liability Company Other (Specify): _____

2. State annual gross receipts for the last 12 months: _____ Anticipated next 12 months: _____

3. State number of patient contacts in the last 12 months: _____ Anticipated next 12 months: _____

4. State the number of tests performed in the last 12 months: _____ Anticipated next 12 months: _____

5. Briefly describe your location including square feet occupied: _____

6. Fully describe your operations, including types of specimens handled. Attach copy of brochure if available.
Attach separate sheets if additional space is needed.

Description of Operations: _____

7. Check areas of activity that your facility is involved with:

Activity	Yes	No	Number of Tests Performed	% of Gross Receipts
Diagnostic services-if yes, describe	<input type="checkbox"/>	<input type="checkbox"/>		
X-Ray services	<input type="checkbox"/>	<input type="checkbox"/>		
Test result consultation for another lab	<input type="checkbox"/>	<input type="checkbox"/>		
AIDS or HIV testing	<input type="checkbox"/>	<input type="checkbox"/>		
Blood banking or blood storage	<input type="checkbox"/>	<input type="checkbox"/>		
Plasmapheresis procedures	<input type="checkbox"/>	<input type="checkbox"/>		

Check areas of activity that your facility is involved with (continued):

Activity	Yes	No	Number of Tests Performed	% of Gross Receipts
Therapy or treatment procedures-if yes, describe	<input type="checkbox"/>	<input type="checkbox"/>		
Drug testing	<input type="checkbox"/>	<input type="checkbox"/>		
Pap smears	<input type="checkbox"/>	<input type="checkbox"/>		
Cytology	<input type="checkbox"/>	<input type="checkbox"/>		
EKG testing	<input type="checkbox"/>	<input type="checkbox"/>		
MRI's Cardiac Monitoring, Stress Testing, CAT Scans, Sonograms, Mammography	<input type="checkbox"/>	<input type="checkbox"/>	By type.-	By type.-

8. Number of cytologists on staff: _____

9. Years in business: _____

10. Is applicant owned by or operated at a hospital, whether main location or branch? Yes No

11. Total number of employees: _____

12. Number of employees (please categorize, i.e., physicians, pathologists, interns, x-ray technicians, lab technicians, radiologist technicians, RN, LPN, LVN, clerical, etc.):

Full-time	Part-time	Functions

13. Are the applicant, partners and employees all currently licensed? Yes No
 Has your license ever been revoked or canceled? Yes No If yes, please explain: _____

If any of the following answers are "yes," details must be provided (i.e., specific tests performed, number of tests performed, per year, percentage of gross annual receipts).

14. Are you involved in cytogenetics or analyzing amniotic fluids? Yes No

15. Are you involved in PSA analysis? Yes No

16. Are you involved in alpha fetoprotein analysis? Yes No

17. Are you involved in any medical, genetic or drug research? Yes No

18. Are you involved in the manufacturing, dispensing or testing of pharmaceuticals? Yes No

19. Do you manufacture and/or sell laboratory equipment or supplies? Yes No

20. Do you perform any types of environmental analysis? Yes No

21. Are you involved in any services open to the public (health fairs or shopping mall exhibits)? Yes No

Do you utilize any mobile units or own/operate any portable laboratory equipment? Yes No

22. Do you send tests to reference labs? Yes No If yes, please state percent of receipts: _____

Reference lab name: _____

Location: _____

Are you contractually held harmless? Yes No

Do you have proof of their professional liability insurance with limits at least equal to yours? Yes No

Are you named as an additional insured on their policy? Yes No

23. Attach sample billing document reflecting tests performed.

24. Identify exact names, addresses and relationship (ownership holdings) of all entities to be insured:

Exact Entity	Name	Address	% of Ownership

25. Identify all physicians involved in laboratory, by name and function served:

Name	Type of Doctor	% of Ownership	Specific Duties in Lab Operations

If applicant is owned by a practicing physician, does applicant occupy same or contiguous space? Yes No

Percentage of gross receipts derived from physician's personal practice: %.

26. Identify all independent contractors used by laboratory, by name and function served:

Name	Type of Operations Conducted	Specific Duties in Lab Operations

Are certificates of insurance obtained from all independent contractors? Yes No

Are applicants named as an additional insured on the independent's policy? Yes No

Are certificates of insurance so designated? Yes No

Are there any contractual agreements between the applicant and independent contractors? Yes No

Do the contracts contain a hold harmless agreement in the applicant's favor? Yes No

27. If any independent contractors are physicians, Certificates of Insurance from the professional liability insurance carrier for doctors will be required. Please list below:

Name of Doctor	Insurance Carrier	Insurance Limit	Expiration Date

28. Has any professional or general liability claim or suit been brought against you in the past five years?
 Yes No

If yes, please provide the following:

Name	Description of Loss	Amount Paid or In Reserves

29. Has any company canceled, declined or refused to issue similar insurance? (Not applicable in Missouri.)
 Yes No

If yes, please explain: _____

Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.

Year	Company	Pol. #	Premium	Losses Paid	Losses Reserved	Description

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

APPLICANT'S SIGNATURE _____ DATE _____
 (Must be signed by a principal or officer in the firm.)

NAME OF CONTACT FOR INSPECTION OR PREMIUM AUDIT _____ PHONE NUMBER _____

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

ANSWER ALL QUESTIONS-IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE