EASTERN SPECIAL RISK
INSURANCE AGENCY
P.O. BOX 218
HARVARD, MASSACHUSETTS 01451
PHONE (978) 456-8200
WATS (800) 341-1110
FAX(978) 456-3245
CA License #0619313
specrisk@charter.net

Broker _____ Date _____
Address _____ Surplus lines licensee? ☐ Yes ☐ No If yes,
_____ indicate State, License No. and Expiration Date
Phone _____ _____
FAX _____ E-Mail _____

Application for a Premium Quotation (without obligation)
DIAGNOSTIC IMAGING CENTER PROFESSIONAL LIABILITY
(including General Liability as an option)

*This is an application for a **claims-made and reported** policy*

1. Applicant _____ Phone _____ FAX _____
2. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
3. Applicant is ☐ Individual ☐ Partnership ☐ Corporation ☐ Other (describe) _____
4. Date Business was Established: _____ (mo./day/yr.)
5. List States where applicant is licensed to practice: _____

   Name of Director: _____ Physician? ☐ Yes ☐ No Degrees Held _____
6. Annual gross receipts: Last 12 Months $ _____ Estimated Next 12 Months $ _____
7. Number of employed staff (should include principals if active): Physicians _____ Nurses _____ Phlebotomists _____
   Imaging Technicians/Technologists _____ Other Technicians _____ Other (describe) _____
   _____
8. Does applicant ☐ own or ☐ lease premises? Does applicant occupy ☐ entire or ☐ portion of building? Is the applicant engaged in any business other than an imaging center? ☐ Yes ☐ No If yes, describe:
9. Limits of liability desired: ☐ $300,000/$300,000 ☐ $500,000/$500,000 ☐ $1,000,000 /$1,000,000 ☐ $1.000,000/$3.000,000
   ☐ Other, specify limits: _____
   Will you require Prior Acts Coverage? ☐ Yes ☐ No If yes, indicate date (retroactive date) of Prior Acts coverage _____
   (This is the inception date of your first Claims-Made Policy, assuming you have been on uninterrupted Claims-Made coverage.)
10. List Professional Liability insurance carried for each of the past five years. If none, state NONE.

Company	Premium	Limits	Deductible (if any)	Eff/Exp. Dates	Claims-Made (Yes, No)

11. Is the current carrier willing to renew? ☐ Yes ☐ No If not, why? _____
12. Loss History - 5 years (If more space is needed, provide claim details on a separate sheet)

Year	Amount Reserved	Amount Paid	Total Incurred

Operations

Please attach a full written description of the applicant's operations, including annual reports, advertising brochures and explanatory pamphlets. If an adequate description of the applicant's operations is not attached, this application will not be processed.

1. Do you provide imaging services for hospitals? ☐ Yes ☐ No If yes, attach a copy of your contract with all hospital facilities.
2. Any contracted physicians working "in house"? ☐ Yes ☐ No How many? _____
   Do they carry Professional Liability Insurance? ☐ Yes ☐ No If yes, what limits of liability do they carry? $ _____
   Are Certificates of Insurance obtained from these physicians? ☐ Yes ☐ No Do these physicians provide an interpretation or diagnosis on the applicant's letterhead? ☐ Yes ☐ No If yes, how does the applicant entity separate itself from the radiologists? _____
   _____
3. Indicate the name of the outside radiological firm(s) which provide interpretation and diagnostic services in conjunction with your imaging facility.
   _____
   (If a contract(s) exists, attach it to this application.)
   Are certificates of insurance obtained from the radiological firm(s)? ☐ Yes ☐ No If no, why not? _____
   _____

4. Provide a breakdown by percentage of the tests performed in each of the following areas. If no tests are performed in each category, indicate ZERO.

	Number of Tests	Percentage of Total Tests (total should equal 100%)
A. Flat Film X-Ray		
B. Flat Film X-Ray (Mobile)		
B. Computed Tomography (CT Scans)		
C. Single Photon Emission CT (SPECT)		
D. Positron Emission Tomography (PET)		
E. Nuclear Medicine		
F. MRI Scans		
G. Ultrasound Scans		
H. Other (describe		
Total		100%

5. Is the applicant involved in any diagnostic testing other than imaging? ☐ Yes ☐ No If yes, describe _____

6. Does the applicant perform any Angiography or Arteriography? ☐ Yes ☐ No Directed Surgery? ☐ Yes ☐ No

7. Does the applicant provide any medical treatment? ☐ Yes ☐ No If yes, describe _____

8. Is the applicant's facility accredited? ☐ Yes ☐ No If yes, accredited by whom? _____

9. Are the lab personnel who are performing tests certified? ☐ Yes ☐ No If yes, by whom? _____

10. Are the lab personnel who are performing tests licensed? ☐ Yes ☐ No If yes, by whom? _____

ULTRASOUND - MRI QUESTIONNAIRE (Complete if applicable)

1. Are all tests performed at the request of a physician? ☐ Yes ☐ No If not, at whose request are tests performed? _____

2. Does a physician on the applicant's staff review all test results? ☐ Yes ☐ No

3. Does the applicant supply an interpretation of test results to a submitting physician on the applicant's letterhead? ☐ Yes ☐ No

4. Does anyone on the applicant's staff supply a diagnosis based on the interpretation of test results to a submitting physician? ☐ Yes ☐ No

5. Does anyone on the applicant's staff supply a diagnosis based on interpretation of the test results directly to a patient? ☐ Yes ☐ No

6 Does the applicant maintain a written, referenced, signed and dated procedures manual for all tests? ☐ Yes ☐ No

7. Is the applicant involved in any research? ☐ Yes ☐ No If yes, attach a full description of all research.

8.. Does the applicant manufacture and/or sell: Contrast Media? ☐ Yes ☐ No Medical Equipment? ☐ Yes ☐ No Software? ☐ Yes ☐ No
If yes, attach a full description of all products sold.

9. Is the applicant involved in any services open to the public (i.e. health fairs, shopping mall exhibits, mobile testing units, etc.)? ☐ Yes ☐ No
If yes, attach a full description of services.

10. Is there a noise cancellation system in the magnet area? ☐ Yes ☐ No

11. Is there an oxygen monitoring system in the magnet area? ☐ Yes ☐ No

12. Are all technicians/technologists trained in CPR? ☐ Yes ☐ No

13. How are patients screened for subcutaneous metals? _____
Possible adverse reaction to contrast media? _____
Attach a copy of all questionnaires used with respect to question 13. (A credit may apply for adequacy.)

14. Other than Gadolinium, are other contrast media used? ☐ Yes ☐ No If yes, what media? _____

15. Is any Level II ultrasound performed by the applicant? ☐ Yes ☐ No If yes, approximately how many annually? _____

16. Distance to the nearest hospital emergency room is _____ miles.

17. Does the applicant obtain informed consent prior to testing? ☐ Yes ☐ No If no, why not? _____
If yes, attach a copy of your informed consent agreement.

X-Ray/CT/PET/SPECT/NUCLEAR MEDICINE QUESTIONNAIRE

1. Are all tests performed at the request of a physician? ☐ Yes ☐ No If not, at whose request are tests performed? _____

2. Does a physician on the applicant's staff review all test results? ☐ Yes ☐ No

3. Does anyone on the applicant's staff supply an interpretation of test results to a submitting physician? ☐ Yes ☐ No

4. Does anyone on the applicant's staff supply a diagnosis based on the interpretation of test results to a submitting physician? ☐ Yes ☐ No

5. Does anyone on the applicant's staff supply a diagnosis based on the interpretation of test results directly to a patient? ☐ Yes ☐ No

6. Does the applicant maintain a written, referenced, signed and dated procedures manual for all tests? ☐ Yes ☐ No

7. Is the applicant involved in any research? ☐ Yes ☐ No If yes, attach a full description of all research.

8. Does the applicant manufacture and/or sell: Contrast Media? ☐ Yes ☐ No; Medical Equipment? ☐ Yes ☐ No; Software? ☐ Yes ☐ No If yes, attach a full description of all products sold.

9. Is the applicant involved in any services open to the public (i.e. health fairs, shopping mall exhibits, mobile testing units, etc.) ? ☐ Yes ☐ No If yes, attach a full description of services.

10. What contrast media are used? (Indicate by modality)_____

_____

11. Does the facility restrict contrast media to non-ionic types? ☐ Yes ☐ No If no, explain _____

_____

_____

12. How are patients screened for likelihood of adverse reaction to contrast media? _____

_____

Attach a copy of your screening form. (A credit may apply for adequacy.)

13. Are all technicians/technologists trained in CPR? ☐ Yes ☐ No

14. Does the applicant obtain informed consent prior to testing? ☐ Yes ☐ No If no, why not? _____

_____

If yes, attach a copy of your informed consent agreement.

Mobile Supplement (Complete if applicable)

1. Does the applicant own and/or operate any mobile units? ☐ Yes ☐ No If yes, please answer the following:
   a. What type?_____
   b. How many units? _____
   c. What services are performed?_____

   _____
   d. Who manufactured the truck(s) and/or trailers?_____
   e. Who installed the unit(s)?_____
   f. Who maintains the unit(s)? _____
      Attach a copy of the maintenance agreement(s)
   g. What is the radius of mobile operations?_____

Equipment Maintenance - Please attach an equipment inventory or list all diagnostic equipment valued at over $10,000

1. Are records of inspection, maintenance, testing and calibration of equipment updated by the applicant? ☐ Yes ☐ No Time intervals of inspections (weekly, monthly, etc.) _____

_____

2. Does the applicant adhere to manufacturer's direction for inspection and maintenance of screening/imaging equipment? ☐ Yes ☐ No If no, explain why.

_____

3. Describe equipment maintenance done by: a. Applicant's Staff _____

_____

   b. Outside Technicians _____

Warranty

1. Does the applicant have knowledge of, or reason to foresee, any circumstance which occurred prior to the date of this application which might result in a claim or suit being brought? ☐ Yes ☐ No If yes, give details in full _____

_____

2. Applicant agrees to report any claim or incident of which he/she receives knowledge **after** the signing of this application as a condition precedent to effecting coverage.

The undersigned owner, partner, officer, or administrator of the applicant, after inquiry declares that to the best of his or her knowledge the information contained in this application is true and correct and that this application shall be deemed a part of the policy as if annexed thereto.

_____

Signed Title Date

Must be signed by an owner, partner, officer or administrator of the applicant. Completion of this form does not bind coverage or obligate the applicant; however, should the quotation be acceptable, the information given above will be the basis of the contract. Application must be currently signed (within 45 days) and dated to consider for quotation. The policy being applied for is limited to only those claims that are first made against the insured while the policy is in force and which occur after the inception of the contract, unless Prior Acts coverage is included.

In Arkansas, Colorado, Florida, Hawaii, Kentucky, Maine, Minnesota, New Jersey, New Mexico, New York, Ohio, Oklahoma, Pennsylvania and Virginana, notice concerning false or fraudulent statements must be attached.

NOTICE REQUIRED BY CERTAIN STATES

NOTICE TO ARKANSAS APPLICATIONS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

NOTICE TO HAWAII APPLICANTS: "FOR YOUR PROTECTION, HAWAII LAW REQUIRES YOU TO BE INFORMED THAT PRESENTING A FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT IS A CRIME PUNISHABLE BY FINES OR IMPRISONMENT, OR BOTH."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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."

NOTICE TO MAINE AND VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO MINNESOTA APPLICANTS: "A PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "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, 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."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCLOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

NOTICE TO PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION SHALL UPON CONVICTION BE SUBJECTG TO IMPRISONMENT FOR UP TO SEVEN YEARS AND PAYMENT OF A FINE OF UP TO $15,000."

Signature: _____