EASTERN SPECIAL RISK
INSURANCE AGENCY
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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
Phone _____ _____
FAX _____

Application for a Premium Quotation (without obligation)

MEDICAL TESTING LABORATORY PROFESSIONAL LIABILITY MALPRACTICE
(including Comprehensive General Liability as an option)

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

SECTION A: General Information

1. Applicant _____ Phone_____ FAX _____
2. Mailing Address: _____ City: _____ State: _____ Zip Code: _____
3. Entity 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 Lab Director: _____
   Physician? ☐ Yes ☐ No Degrees held _____
6. Estimated Annual gross receipts: Last 12 Months $ _____ Next 12 Months $ _____
   Estimated Annual number of test performed: Last 12 Months # _____ Next 12 Months # _____
7. Number of employed staff (should include principals if active): _____Physicians _____ Nurses
   _____ Technicians/Technologists_____ Other Technicians _____ Phlebotomists_____Other (describe)
8. Any contracted physicians? ☐ 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
9. Does applicant ☐ own or ☐ lease premises? Does applicant occupy ☐ entire or ☐ portion of building? Is the applicant engaged in any business other than a laboratory? ☐ Yes ☐ No If yes, describe: _____
10. 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.)
11. 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)

12. Is the current carrier willing to renew? ☐ Yes ☐ No If not, why? _____
13. Loss History: (5 years)

Year	Amount Reserved	Amount Paid	Total Incurred

SECTION B: 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. Does the applicant provide services as other than a Clinical Laboratory? ☐ Yes ☐ No If yes, provide details. _____
   _____
2. Is the applicant licensed as a pathology laboratory? ☐ Yes ☐ No If yes, is the interpretation of test results or diagnosis provided on the applicant's letterhead? ☐ Yes ☐ No

3. Are specimens collected from patients at the applicant's premises? ☐ Yes ☐ No State the percentage of total annual tests from specimens collected at applicant's premises: _____% Describe the types of specimens collected at the applicant's premises: _____
_____

4. Are specimens received from outside sources? ☐ Yes ☐ No State percentage of total annual tests from specimens received from the following sources: _____ % Hospitals _____% Physicians' Offices _____ % Clinics_____ % Insurance Carriers _____ % Other

5. State the percentage of the laboratory's total annual tests performed in each category listed below. If no tests are performed in a category, please indicate ZERO.

_____ % Blood banking or blood storage	_____ % Testing for drugs of abuse	_____ % Pulmonary function/blood gas analysis
_____ % Plasmapherises procedures	_____ % HIV Testing	_____ % Cytology/Anatomical Pathology
_____ % Blood crossmatching	_____ % Amniotic fluid studies	_____ % Genetic studies
_____ % Blood Chemistry	_____ % Urine/fecal testing	_____ % Endoscopic studies
_____ % X-Ray services	_____ % Environmental testing	_____ % Immunodiagnostic studies
_____ % Magnetic resonance imaging	_____ % Rabies testing	_____ % Electrocardiogram
_____ % Ultrasound studies	_____ % Cerebrospinal fluid studies	_____ % Angiography

_____ % Other (describe)_____

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

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

8. Does the applicant follow the Center for Disease Control Guidelines regarding the handling of blood and blood products? ☐ Yes ☐ No

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

10. Are records of inspection, maintenance, testing and calibration of instruments maintained and updated by the applicant? ☐ Yes ☐ No
Indicate time intervals of calibration. _____

11. Is the applicant involved in any intravenous transfusions of blood or in the procurement of blood or blood products? ☐ Yes ☐ No If yes, attach a full description.

12. Is the applicant involved in any medical research? ☐ Yes ☐ No Genetic research? ☐ Yes ☐ No Drug research? ☐ Yes ☐ No
AIDS research? ☐ Yes ☐ No If yes, attach a full description of all research.

13. Is the applicant involved in the manufacturing, dispensing, or testing of any pharmaceuticals? ☐ Yes ☐ No If yes, attach a full description of this aspect of your operations.

14. Does the applicant manufacture and/or sell reagents? ☐ Yes ☐ No Laboratory equipment? ☐ Yes ☐ No Software? ☐ Yes ☐ No
If yes, attach a full description of products sold.

15. Is the applicant involved in any services open to the public (i.e. health fairs, shopping mall exhibits, mobile labs, testing units, etc.)? ☐ Yes ☐ No

If yes attach a full description of services.

SECTION C: X-Ray Operations

1. Is the applicant involved with X-Ray operations? ☐ Yes ☐ No If yes, complete all items in this section.

2. Are the X-rays done per a physician's request? ☐ Yes ☐ No

3. Who performs the X-rays?_____Who interprets the X-rays? _____

4. Are the actual X-rays sent to the requesting physician or just the report?_____

5. Are contrast media used on premises for patients? ☐ Yes ☐ No If yes, please indicate what media are used:_____
_____
What percentage is ionic type? _____% Do you have a patient questionnaire? ☐ Yes ☐ No If yes, please attach a copy to this application. (A credit may apply for adequacy.)

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

7. Describe the maintenance of X-Ray equipment done by the applicant's staff_____
By outside technicians_____

For each radiologist employed to review these X-Ray results, please attach a *Certificate of Insurance* evidencing Professional Liability Coverage

SECTION D: Cytology & Pathology

1. Is the applicant involved with any cytology or anatomical pathology? ☐ Yes ☐ No If yes, complete all items in this section.
2. Is this work done "in house" or by an outside lab. _____ If done by another lab, does the applicant obtain a Certificate of Insurance from that lab? ☐ Yes ☐ No If not, why not? _____
3. Is all this work done per a physician's request? ☐ Yes ☐ No
4. Does a physician on the applicant's staff review all test results? ☐ Yes ☐ No
5. Does anyone on the applicant's staff supply an interpretation of test results to a submitting physician? ☐ Yes ☐ No
6. Does anyone on the applicant's staff supply a diagnosis based on the interpretation of the test results to a submitting physician? ☐ Yes ☐ No
7. Does anyone on the applicant's staff supply a diagnosis based on the interpretation of the test results directly to a patient? ☐ Yes ☐ No
8. Does a physician review all abnormals and 10% of normals? ☐ Yes ☐ No

For each physician employed to review these tests, please attach a *Certificate of Insurance* evidencing Professional Liability coverage.

SECTION E: E.K.G.

1. Is the applicant involved with E.K.G. testing? ☐ Yes ☐ No If yes, complete all items in this section.
2. Are all E.K.G. tests performed per a physician's request? ☐ Yes ☐ No
3. Does a physician on the applicant's staff review all E.K.G. results? ☐ Yes ☐ No
4. Does anyone on the applicant's staff supply an interpretation of an E.K.G. test to a submitting physician? ☐ Yes ☐ No
5. Does anyone on the applicant's staff supply a diagnosis based on the interpretation of any E.K.G test to a submitting physician? ☐ Yes ☐ No
6. Does anyone on the applicant's staff supply a diagnosis based on the interpretation of any E.K.G. test directly to a patient? ☐ Yes ☐ No
7. Describe the E.K.G. equipment maintenance done by the applicant's staff _____
   Outside technicians _____

For each physician employed to review these tests, please attach a *Certificate of Insurance* evidencing Professional Liability coverage.

SECTION F: 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 or officer 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 or officer 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 Virginia, 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: _____