

ROBERT W. SCHMIDT & COMPANY
3505 North 124th Street
Brookfield, WI 53005-2489

**MISCELLANEOUS MEDICAL
PROFESSIONAL LIABILITY APPLICATION
(CLAIMS-MADE FORM)**

NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTATION ONLY. NO COVERAGE WILL BE EFFECTED UNTIL RECEIPT OF WRITTEN INSTRUCTION AND PREMIUM PAYMENT. ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION (AND ATTACHMENTS HERETO) AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS-MADE BASIS. THE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR DEFENSE EXPENSES. AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE APPLICABLE DEDUCTIBLE AMOUNT.

All Questions must be fully completed. If there is insufficient space to complete an answer, continue on a separate sheet of the Applicant's letterhead. If a Question is not applicable, state "N.A."

SECTION I – GENERAL INFORMATION:

1. Full Name of Applicant (include ALL Firm names, trade names or dba's under which the Applicant operates, including subsidiaries):

2. Address of Principal Office:

3. Internet Address:

4. List all states in which Applicant operates:

5. Does the Applicant have any other office locations? YES NO
If YES, list complete addresses on a separate sheet.

6. Applicant is a: Individual LLC Corporation: For profit Non-profit
 Partnership Joint Venture Other (specify): _____

Date Established: _____ (mm/dd/yy)

7. Has the name of the Applicant ever changed or has there been any acquisition, consolidation, dissolution, merger or any other change in business organization during the past five (5) years? YES NO
If YES, provide full particulars on a separate sheet, including all Firm names, in chronological order. Additionally, provide claims information (as per SECTION III) for all prior Firms.

8. During the coming twelve (12) months, does the Applicant contemplate offering any services not currently offered, or any mergers or acquisitions? YES NO
 If YES, please explain: _____

9. Professional Activities and Specialties:

- Home Healthcare Agency #Home Health Visits annually: _____
- Medical/Testing Laboratory # tests annually: _____
- Nurses Registry average length of placement: _____
- Out-Patient Medical Clinic #outpatient visits annually: _____
- Out Patient Mental Health Clinic #outpatient visits annually: _____
- Residential Healthcare Facility #Beds: _____
- Residential Mental Health Facility #Beds: _____
- Referral Agency # calls annually: _____
- Emergency Call Center/ Crisis Hotline #calls annually: _____

other: _____

10. State approximate % of gross income derived from the following (total should be 100%) :

- | | |
|--|----------------------------------|
| _____ % Alcohol Abuse Counseling | _____ % DUI classes |
| _____ % Drug Abuse Counseling | _____ % Inpatient Detox |
| _____ % Mental Health Counseling/Evaluations | _____ % Mental Health Group Home |
| _____ % Family Counseling | _____ % Hospice |
| _____ % Physical/Occupational/Speech Therapy | _____ % Halfway House |
| _____ % Blood/Urine Testing (Drug/Alcohol) | _____ % Supervised Living |
| _____ % Referrals | _____ % Adoption/Foster Care |
| _____ % Methadone Maintenance | _____ % Recreation Programs |
| _____ % Diagnostic Testing | _____ % Training |
| _____ % Pre-Employment Testing | |

_____ % other: _____

11. Does Applicant own (wholly or in part), operate, or administer any hospital, nursing home, assisted living facility or other institution where medical services are customarily rendered? Yes No
 If Yes, please provide details by separate attachment.

12. State sources and amounts of TOTAL GROSS REVENUE:

SOURCE	<u>Present Year</u>	<u>Previous Year</u>
Charitable Contributions:	\$ _____	\$ _____
Government Funding:	\$ _____	\$ _____
Fee for Service:	\$ _____	\$ _____
_____	\$ _____	\$ _____
TOTAL GROSS REVENUE:	\$ _____	\$ _____

Estimate of Total Gross Revenue for next Year: \$ _____

13. Staff:	<u>Employees</u>	<u>Independent Contractors</u>
Principals, Partners, Officers, Directors:	_____	_____
Registered Nurse:	_____	_____
LPN/LVN:	_____	_____
Nurse Anesth.:	_____	_____
Nurses Aides:	_____	_____
Certified Lab Tech./Technologist.:	_____	_____
Certified Medical Assistant :	_____	_____
EEG/EKG Tech./Technologist:	_____	_____
X-Ray Tech./Technologist:	_____	_____
Home Health Aide:	_____	_____
Medical Tech./Technologist:	_____	_____
Radiation Therapist:	_____	_____
Inhalation Therapist:	_____	_____
Speech Therapist:	_____	_____
Rehabilitation Therapist:	_____	_____
Physical Therapist	_____	_____
Physiotherapist:	_____	_____
Occupational Therapist:	_____	_____
Sports Medicine Therapist:	_____	_____
Phlebotomist:	_____	_____
Perfusionist:	_____	_____
Psychotherapist/Psychologist:	_____	_____
Social Worker:	_____	_____
Physicians Assistant:	_____	_____
Clerical/Administrative:	_____	_____
Other (specify): _____	_____	_____
TOTAL STAFF:	_____	_____

14. a) Are all above individuals licensed in accordance with all applicable state and federal regulations?
 Yes No If No, please attach explanation.
- b) Do you required any of the above individuals to maintain their own professional liability coverage?
 Yes No If Yes please list individuals and required limits:

If No, is coverage requested for above individuals? Yes No

15. Please attach explanation for any of the questions below answered "YES":

Has the applicant or have any of the above employees ever:

- a) Been the subject of disciplinary or investigative proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? Yes No
- b) Been convicted for an act committed in violation of any law or ordinance other than a traffic offense? Yes No
- c) 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
- d) Been treated for alcoholism or drug addiction? Yes No

- 16 Does applicant perform:
- a) Abortions? Yes No
 - b) Acupuncture or acupuncture anesthesia? Yes No
 - c) Angiography/Arteriography/Venography? Yes No
 - d) Biopsies or endoscopies? Yes No
 - e) Catheterization (other than urinary/umbilical)? Yes No
 - f) Circumcisions ? Yes No
 - g) Closed reduction of compound fractures? Yes No
 - h) Cosmetic or Plastic Surgery? Yes No
 - i) Cryosurgery? Yes No
 - j) Dermabrasion? Yes No
 - k) Excision of large cysts and/or deep-seated boils or carbuncles? Yes No
 - l) Hysterectomies? Yes No
 - m) Injection of radioisotopes and/or irradiated substances? Yes No
 - n) Insertions of temporary pacemakers? Yes No
 - o) Laser Treatments? Yes No
 - p) Liposuctions
 - q) Normal/High Risk Deliveries and/or Caesarian Sections? Yes No
 - r) open reduction of fractures? Yes No
 - s) Psychiatric shock therapy? Yes No
 - t) Radiation Therapy and/or Chemotherapy? Yes No
 - u) Sex change operations? Yes No
 - v) Silicone Injections or Implants? Yes No
 - w) Spinal Injections? Yes No
 - x) Sterilizations? Yes No
 - y) Surgery for weight reduction of patients? Yes No
 - z) Surgery other than incision of superficial boils or suturing superficial fascia? Yes No
 - aa) Tonsillectomies or Adenoidectomies? Yes No
 - bb) other Surgery (describe: _____) Yes No

17. Does the applicant perform hospital emergency room care:
- for its own regular patients? Yes No
- for patients not its own? Yes No
- if answer to b) is Yes, please specify the percent of time devoted to this work? _____ % and the number of hours devoted to this work _____ hrs.

18. Does the applicant prescribe drugs for weight reduction of patients? Yes No
Please list drugs prescribed on a separate attachment.
19. Do applicant or others administer anesthesia (other than topical or by means of local infiltration)? Yes No If Yes, please attach detailed explanation.
20. Does applicant maintain any beds for overnight occupancy? Yes No
If Yes, please include # beds licensed and type of care provided on separate attachment.

21. If application is a training school, complete the following or Not Applicable:

Profession for which student is being trained	Maximum # students per session	# of sessions per year	hrs that involve clinical settings	# of students	Qualifications of Faculty (MD.etc)
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22. Do you sell products? If so, what kind, please include brochures. If so, do any of them require a physician's prescription?

SECTION II - Current Insurance

23. General Liability: Carrier: _____ Term: _____

Limits: Occurrence: _____ Products/Co.Ops Agg: _____

General Agg: _____ Deductible: _____

Is coverage occurrence? Yes No Retroactive Date: _____

24. Professional Liability: (provide coverage for last 5 years)

Carrier	Limit	Deductible	Premium	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring coverage is claims made please provide Retroactive Date: _____

SECTION III - Claims History

25. Has any application for Professional Liability Insurance made on behalf of the applicant or any predecessor in business or present Partner, Officer of Principal ever been declined or has the insurance been cancelled or renewal refused? Yes No If Yes, please provide details by attachment.

26. Has any claim ever been made against the applicant or any of its employees? Yes No
 If Yes, please provide on separate attachment the following information for each situation or include currently values loss runs for last 5 years.

1) Claimant's name 2) date when claim was reported 3) date when the loss or damage occurred 4) allegations of claim including amount of damages alleged 4) Reserved or Paid Expenses; Reserved or Paid Indemnity. 5) Final Disposition.

27. Is the applicant aware of any circumstance, which may result in any claim against the applicant, or any predecessor in business or present Partner, Officer or Principal? Yes No If Yes, please provide details by separate attachment.

*******Please include along with this application: 1) Brochures 2) Currently valued loss runs if available**

Limits of Liability requested: _____ Deductible: _____

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Signature of Applicant (Principal, Partner or Officer) _____

Title: _____ Date: _____