212 Key Drive
Madison, MS 39110
(866) 386-4136
Fax: (601) 707-1044
www.continentalbrokers.biz

APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS FOR PROFESSIONAL LIABILITY INSURANCE (Claims Made Basis)

APPLICANTS 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 (include professional degree if applicant is an individual):_____

_____

b. Principle business premise address:_____
(Street) (County)

_____
(City) (State) (Zip)

Please attach a list of additional office addresses

c. Number of Employees: Full Time____ Part Time_____ Seasonal_____ Total_____

d. Business Phone:_____ Home Phone:_____

e. Date of Birth:_____ Place of Birth:_____

Are you a US citizen [ ] Yes [ ] No. If No, your status, date of entry into USA:_____

f. Square feet of total office space (all locations):_____

g. Your practice:

[ ] Solo Practitioner (unincorporated)
[ ] Solo Practitioner (incorporated)
[ ] Partnership
[ ] Professional Association
[ ] Other (please describe)_____
[ ] Professional Corporation (for profit)
[ ] Professional Corporation (non profit)
[ ] Employee of _____
(Give name of employer)

h. Formal business, corporate or partnership name:

i. Please list the names of all partners or members of your professional association/corporation who provide professional services: _____

_____

j. Please attach a copy of your letterhead.

k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule?..... [ ] Yes [ ] No

If yes,
(i) Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ... [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer _____

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2. EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From_____To_____	_____
_____	From_____To_____	_____
_____	From_____To_____	_____

(i) Where have you practised your profession during the last ten years?
In _____ From_____To_____
In _____ From_____To_____
In _____ From_____To_____

(ii) Have you ever failed any professional licensing or specialty organization examination?.....
[ ] Yes [ ] No
If yes, please attach a detailed explanation including the dates and location.

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _

_____

b. Please indicate your professional speciality (CHECK ONE):

[ ] Chiropractor
[ ] Counselor (describe) _____
[ ] Dental Hygienist
[ ] Hearing Aid Fitter
[ ] Home Health Care Agency
[ ] Inhalation Therapist
[ ] Laboratory Technician
[ ] Medical Personnel Pool
[ ] Naprapath
[ ] Nurse, Licensed Practical
[ ] Nurse, Registered
[ ] Nurses Registry
[ ] Occupational Therapist
[ ] Optician
[ ] Optometrist
[ ] Orthotist
[ ] Perfusionist
[ ] Pharmacist
[ ] Physical Therapist
[ ] Psychologist
[ ] Social Worker
[ ] Speech Therapist
[ ] Veterinarian
[ ] Visiting Nurse Association
[ ] X-ray Technician
[ ] Other (Specify) _____

c. Please indicate the sources and amounts of actual and projected revenue:

Source	Amount this Fiscal Year	Amount next Fiscal Year
(i) Charitable Contributions	$_____	$_____
(ii) Government Funding	$_____	$_____
(iii) Fee for Services	$_____	$_____
(iv) Other_____	$_____	$_____
Total Gross Revenue	**$**_____	**$**_____

d. Please provide the number of patient or client visits:

Type of Visit	Number of Visits Last 12 Months	Number of Visits Next 12 Months
Clinic	_____	_____
Laboratory	_____	_____
Other (specify)_____	_____	_____
Total Number of Visits	_____	_____

e. Please specify any professional societies or associations in which you are a member: _____

_____

f. Are you associated with or do you work for a physician or surgeon? ..... [ ] Yes [ ] No
If yes, please give the name and the specialty of the physician: _____

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g. (i) Do you perform veterinary services? ..... [ ] Yes [ ] No
If yes, please indicate the approximate division of your work among the following categories.
_____ % Greyhounds _____ % Thoroughbreds
_____ % Animals valued over $5,000
Please attach an explanation including the frequency and the type(s) of animal treated.

h. Do you administer artificial insemination? ..... [ ] Yes [ ] No
If yes, please answer the following questions:
(i) What type(s) of animals are involved?_____
(ii) Are you responsible for the storage of semen? ..... [ ] Yes [ ] No
If yes, please explain_____
_____
(iii) What percent of your practise is involved with artificial insemination? _____ %

i. Are you responsible for identifying contagious diseases in your locality and/or for recommending remedial action? ..... [ ] Yes [ ] No
If yes, please attach a detailed explanation.

4. PERSONNEL

a. Please list the number and type of independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.

No.	Type of Profession	No.	Type of Profession	No.	Type of Profession
____	Inhalation Therapists	_____	Laboratory Technicians	_____	Nurse Anesthetists
_____	Nurses, Licensed Practical	_____	Nurse Practitioner	_____	Nurse, Registered
_____	Opticians	_____	Optometrists	_____	Perfusionists
_____	Pharmacists	_____	Physiotherapists	_____	Social Workers
_____	Speech Therapists	_____	Other (specify)_____		

b. Do you supervise any individuals who are not your own employees? [ ] Yes [ ] No.
If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

c. Please indicate by the number of individuals you supervise.

No.	Type of Profession	No.	Type of Profession
____	Physicians	____	Laboratory Technicians
____	X-ray technicians	____	Other (please specify)

1. APPLICANT AFFILIATIONS

a. Do you own or operate any business other than that shown in Question 1(a) above? ……
[ ] Yes [ ] No. If yes, please give details on a separate sheet.

b. Are you employed by any individual or entity other than that shown in Question 1(a) above? ……
[ ] Yes [ ] No. If yes, please give details on a separate sheet.

c. Are you under contract to any individual or entity other than that shown in Question 1(a) above? ……
[ ] Yes [ ] No. If yes, please attach an explanation describing details of your responsibilities. If your contract contains a hold harmless agreement, a copy of the contract must be attached.

d. Are you employed by or under contract to any government entity?.....
[ ] Yes [ ] No. If yes, please attach an explanation of your responsibilities.

e. 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 advertisements.

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f. 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 a detailed explanation and a copy of ALL of your advertisements.

g. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered?)? [ ] Yes [ ] No. If yes, please give details including the name, location, size and number of beds.

_____
_____
_____

h. If you have a training school, please complete the following. Attach a separate sheet if needed.

Specifiy Profession For Which Students Are Being Trained	Max. No. Of Students Sessions Per Session	No. of Involved in Per Year	% Of Time Number of Clinical Setting	Qualifications (e.g. MD, RN, PhD)

(i) Do you use a collection agency? …….. [ ] Yes [ ] No
If yes, please state the name of the agency
(ii) Does the agency have the authority to file a collection suit at its discretion? ....[ ] Yes [ ] No

2. APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

a. Have you or any of your employees:

(i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?.....[ ] Yes [ ] No

(ii) Ever been convicted for an act commited 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 refusals or accepted only 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

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b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Policy Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception MM/DD/YY	Expiration MM/DD/YY	Was this a Claims Made Policy Y/N	Retro Date

c. 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.

d. 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 a separate sheet.

*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 Catlin Underwriting Agencies Ltd.

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.

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BROKER RISK SUMMARY
(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Catlin

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM

Names of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSUANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: