

ADMIRAL INSURANCE COMPANY

1255 Caldwell Road
Cherry Hill, NJ 08034
Phone: 856-429-9200- Fax: 856-429-8611
Internet: <http://www.admiralins.com>

Medical Testing Laboratory
PROFESSIONAL LIABILITY APPLICATION

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. **Internet Address:** _____

3. **Address of Principal Office (street, city, state, zip)**

4. **List all states in which Applicant operates:**

5. A) **Does the Applicant have any other office locations?** YES NO

If YES, list complete addresses on a separate sheet.

B) **Does Applicant have a location at a hospital or other medical premises?** YES NO

If YES, does Applicant lease a distinct area? YES NO

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 (describe): _____

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

- | | |
|---------------------------------------|----------------------|
| _____ % Alcohol/Drug Testing | _____ % HIV (AIDS) |
| _____ % CT/CAT | _____ % Immunology |
| _____ % Cytology | _____ % MRI/fMRI |
| _____ % DNA | _____ % Occupational |
| _____ % Fertility/Pregnancy/Paternity | _____ % PET/SPECT |
| _____ % Hematology | _____ % STDs |
| _____ % Hepatitis | _____ % Sonography |
| _____ % Histology | _____ % ultrasound |
| _____ % other (describe) _____ | _____ % X-ray |
| _____ % other (describe) _____ | |
| _____ % other (describe)- _____ | |

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/RECEIPTS:

| SOURCE | This Year: _____ | Last Year: _____ |
|-----------------------------|------------------|------------------|
| Charitable Contributions: | \$ _____ | \$ _____ |
| Government Funding: | \$ _____ | \$ _____ |
| Fee for Service: | \$ _____ | \$ _____ |
| _____ | \$ _____ | \$ _____ |
| TOTAL GROSS REVENUE: | \$ _____ | \$ _____ |

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

13. Staff:

| | <i>Independent</i> | |
|---|--------------------|--------------------|
| | <i>Employees</i> | <i>Contractors</i> |
| A. Principals, Partners, Officers, Directors: | _____ | _____ |
| B. Registered Nurse: | _____ | _____ |
| C. LPN/LVN: | _____ | _____ |
| D. Nurse Anesth.: | _____ | _____ |
| E. Nurses Aides: | _____ | _____ |
| F. Certified Lab Tech./Technologist.: | _____ | _____ |
| G. Certified Medical Assistant : | _____ | _____ |
| H. EEG/EKG Tech./Technologist: | _____ | _____ |
| I. X-Ray Tech./Technologist: | _____ | _____ |
| J. Phlebotomist: | _____ | _____ |
| K. Medical Tech./Technologist: | _____ | _____ |
| L. Radiation Therapist: | _____ | _____ |
| M. Inhalation Therapist: | _____ | _____ |
| N. Physicians Assistant : | _____ | _____ |
| O. Social Worker | _____ | _____ |
| P. Clerical/Administrative | _____ | _____ |
| Q. : 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) Have any of the above individuals had their licenses/certifications revoked/suspended, voluntarily surrendered or cancelled? Yes No If YES, please attach explanation
- c) Do you require any above personnel 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" (include #tests/procedures & gross revenue):

- | | |
|---|--|
| a. Test result interpretation in applicant's (lab) name? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Consultation in Applicant's (lab) name? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Therapy or any treatment procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Blood Banking or blood/tissue storage | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Procurement of blood or its components? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Plasmapheresis procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Medical, Genetic or Drug research? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. any type of environmental analysis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Manufacture, testing or dispensing of pharmaceuticals? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Manufacture or sell laboratory equipment or supplies? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. experimental testing/procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. solely mobile services? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. any services at malls/shopping centers, health fairs etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. Intravenous transfusions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

16. What hours/days a week do you operate: _____

17. Does applicant utilize a procedural and quality control manual? Yes No
 If Yes, does applicant make sure that all employees have reviewed these? Yes No

18. Is lab inspected/certified/accredited by any governmental or medical association? Yes No
 If Yes, please list on separate attachment along the certifications/inspection dates.

19. Does applicant use a reference lab? Yes No
 If Yes, please answer the following:
- | | |
|----|---|
| a. | What are the expected annual receipts for the reference lab? \$ _____ |
| b. | Name of reference lab: _____ |
| c. | Does reference lab hold applicant harmless? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. | Does applicant obtain written proof of insurance with minimum limit of \$1,000,000, for reference lab? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. | Does applicant require reference lab to name them as an additional insured and obtain proof of same? <input type="checkbox"/> Yes <input type="checkbox"/> No |

20. Does applicant provide any service under contract? Yes No If Yes, please provide details or sample contract?

21. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? Yes No "Financial relationship means all ownership or investment interests, compensation arrangements, medical directorships with applicant".

If Yes, please provide details, including name of physicians, financial relationship and type of

referral.

22. Attach a list of all physicians providing service at this entity (employed or contracted) and include:

NAME, SPECIALTY, SERVICES, %OF OWNERSHIP, BOARD CERTIFIED, INSURANCE

CARRIER/LIMITS/EXPIRATION DATE, if LAB is Listed AS ADDITIONAL INSURED.

23. Have any employed or contracted personnel been subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? Yes No

24. Have any employed or contracted personnel been convicted of an act in violation of any law or ordinance other than a traffic accident? Yes No

25. Please list Professional Liability Policies covering applicant over the past 5 years:

| <u>Carrier</u> | <u>Expiration Date</u> | <u>Limits</u> | <u>Deductible</u> | <u>Annual Premium</u> |
|----------------|------------------------|---------------|-------------------|-----------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

If above policies were CLAIMS MADE please provide current RETROACTIVE DATE:)

26. Has any Professional or General Liability claim or suit been brought in the past 5 years against the applicant or any predecessor in interest? Yes No If Yes, please supply 5 years currently valued Carrier loss runs

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. Has applicant reported this circumstance/incident to their current carrier? Yes No

28. 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.

Please include along with this application any required attachments/questionnaires, copy of your brochure or advertisements and income statement & balance sheet for most currently completed fiscal year.

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: _____

Melanie Stevenson
1420 Fifth Avenue
Suite 425
Seattle, WA 98101
(206) 467-6511
FAX (206) 467-6557

Carolyn Grob, RPLU
1255 Caldwell Road
P.O. Box 5725
Cherry Hill, NJ 08034-3220
(856) 429-9200
FAX (856) 429-8611

Sharon S. Murray, RPLU
8911 Capital of TX Hwy.
Suite 3210
Austin, TX 78759-7267
(512) 795-0766
FAX (512) 795-0833

William Watts
6455 East Johns Crossing
Suite 240
Duluth, GA 30097
(770) 476-1561
Fax (770) 418-9597

X-RAY/Nuclear Medicine QUESTIONNAIRE

1. What testing substance are ingested or injected into the patients? _____

2. Is there a likelihood of adverse reaction to the substances used? _____

3. What emergency medical procedures have you established in the event of such reactions _____

4. Describe the system of delivery and disposal of radio-nuclides: _____

5. Indicate the frequency of testing of air and water discharge from the facility to ascertain federal standards of compliance: _____

6. What training is provided to your personnel? _____

7. Maintenance of equipment is provided by: In-house Manufacturer/Distributor
Contracted to outside firm
Other (describe) _____
- How often is equipment serviced: monthly quarterly BI-annual annually
8. Do you maintain records of your tests/procedures/scans? Yes No If Yes, please describe: _____

9. Are all tests/procedures/scans done per a physician request? Yes No
10. What personnel perform the test/procedure/scan? _____
Do procedures require two personnel to be with the patient at all times? Yes No
11. Who reports the interpretation of the test/procedure/scans etc.? _____
12. Are the x-rays/scans sent along with the report? Yes No
13. Are the x-rays/scans sent out under the name of the applicant or in the name of the Radiologist? _____
14. Number of annual patient contacts for all tests/scans/procedures/x-ray services: _____
15. Do employees wear nuclear sensitive badges which warn of potential nuclear problems? _____