

**ADMIRAL INSURANCE COMPANY**

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**Non-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. a)Internet Address: \_\_\_\_\_ b)Phone Number: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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. Services Breakdown**

<b>NON ENVIRONMENTAL SERVICES</b>	<b>YES</b>	<b>NO</b>	<b>%</b>
<b>Soil/Geotechnical Non environmental</b>			
<b>Mechanical Equipment/parts</b>			
<b>Construction Materials</b>			
<b>Chemical</b>			
<b>Food</b>			
<b>Explosives</b>			
<b>Metalurgy</b>			
<b>Aircraft/Aerospace products/equipment</b>			
<b>Other non-environmental (describe):</b>			

<b>ENVIRONMENTAL SERVICES</b>			
<b>a. Air Quality</b>			
<b>b. Asbestos</b>			
<b>c. Lead</b>			
<b>d. landfill</b>			
<b>e. mold</b>			
<b>f. Potable Water</b>			
<b>g. Waste Water</b>			
<b>h. UST</b>			
<b>i. Soil</b>			
<b>j. other environmental(describe):</b>			

<b>Total for all should equal</b>			<b>100%</b>
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**10. What % of above services is related to:**

- a. Forensic \_\_\_\_\_%    Product Development: \_\_\_\_\_%    Maintenance Contracts: \_\_\_\_\_%  
 Final Production Research: \_\_\_\_\_%    Quality Control: \_\_\_\_\_%
- b. What percent of overall testing is non-destructive? \_\_\_\_\_%

11. Do you perform testing for parent company(ies), affiliates, subsidiaries or other associated entities? YES NO

If Yes, please provide details on separate attachment, include revenue derived.

12. Do you interpret test results as well as make recommendations based on the test results? YES NO

13. Do you have a Quality Control or Quality assurance program in effect? YES NO

Please attach the table of contents from your QA/Qc program.

14. State amounts of TOTAL GROSS REVENUE/RECEIPTS:

	<u>This Year:</u> _____	<u>Last Year:</u> _____
<b>TOTAL GROSS REVENUE:</b>	\$ _____	\$ _____

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

15. Staff:

	<u>Employees</u>	<u>Independent Contractors</u>
A. Principals, Partners, Officers, Directors:	_____	_____
B. Professionals :	_____	_____
C. Administrative:	_____	_____
<b>TOTAL STAFF:</b>	_____	_____

16. 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:

\_\_\_\_\_  
\_\_\_\_\_

17. 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.

18. Does applicant provide any service under contract? YES NO If Yes, please provide details or sample contract?

19. 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:)

- 20. 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
- 21. 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
- 22. 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.

23. PLEASE INCLUDE THE FOLLOWING WITH THIS APPLICATION:

- Sample Test Report
- Sample Contract
- Income Statement & Balance Sheet for current completed fiscal year
- Brochure/Advertisement

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 no 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: \_\_\_\_\_