Admiral INSURANCE GROUP
a Berkley Company

MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I - GENERAL INFORMATION

1) Full Name of Applicant:
(Include all DBAs and subsidiaries seeking coverage under the policy for which you are applying)

2) Mailing & Location Address (If multiple locations, include an attachment with a complete list of locations)
Mailing:
Location:

3) Website Address(es) (if applicable):

4) Date Established (mm/dd/yy):

5) Type of Entity: ☐ Corporation ☐ Partnership ☐ Professional Association ☐ Sole Proprietor
☐ Government Entity ☐ Other (please describe):

6) Description of Operations:

7) Is this entity owned by, associated with or controlled by any other entity or are you part of a franchise? ◯ Yes ◯ No
If yes, describe:

8) Are any of your services provided in, or under contract to a facility or entity that you own, operate or are somehow affiliated with? ◯ Yes ◯ No
If yes, describe:

9) Does the Applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? Yes No

If yes, provide complete details including name of entity, your ownership interest or contractual relationship, and information on their insurance program(s):

10) Within the next 12-month period, does the applicant plan to:

a. Obtain another operation or entity? Yes No

b. Add to the number of employees? Yes No

c. Expand the number of locations? Yes No

d. Eliminate current services or add new services? Yes No

e. Operate in other states? Yes No

If yes to any of the above questions, describe:

11) Organization Accreditations/Certifications/Licensures:

a. Accredited:

b. Certified:

c. Licensed:

d. Has the applicant's accreditation, certification or license been suspended or revoked? Yes No

If yes, describe:

SECTION II – EXPOSURES [PROFESSIONAL ACTIVITIES & SPECIALTIES]

12) Describe in detail all of your professional services and indicate the percentage of gross receipts/revenues derived from each activity:

Description of Professional Services	Percentage of Revenue
	%
	%
	%
	%

13) Does your practice include Pain Management? Yes No

If yes, specify the percentage of your practice derived from Prescription Only Pain Management. %

14) Does your practice include prescribing of opioids? Yes No

If yes, provide the following details:

a. Specify the percentage of your practice derived from opioid prescriptions: %

b. Do you fully comply with the CDC Guideline for Prescribing Opioids? Yes No
https://www.cdc.gov/drugoverdose/prescribing/guideline.html

c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? Yes No

d. Do you also dispense the opioids? Yes No

15) Complete all sections that apply:

	Revenue	# of Outpatient Visits	# of Inpatient Beds	# of Non-Emergency Transports	# of Emergency Transports	# of Students
Next 12 Months						
Last 12 Months						
Two Years Ago						

16) Provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of the Applicant:

	Employee or Volunteer	Independent Contractors	Insured on Own Med Mal Policy	Current Carrier & Limits of Liability
Physicians (no surgery)			Yes No	
Physicians (surgical)			Yes No	
Physicians Assistants			Yes No	
Surgical Technicians			Yes No	
Certified Nurse Anesthetists			Yes No	
Nurse Practitioners			Yes No	
Registered Nurses			Yes No	
LPNs or Nurse Aides			Yes No	
X-Ray Technicians			Yes No	
Medical Assistants			Yes No	
Optometrists			Yes No	
Opticians			Yes No	
Pharmacists			Yes No	
Pharmacy Technicians			Yes No	
Chiropractors			Yes No	
Massage Therapists			Yes No	
Laboratory Technicians			Yes No	
Paramedics			Yes No	
EMTs			Yes No	
Social Workers			Yes No	
Aestheticians			Yes No	
Other:			Yes No	

17) Do you require all of your independent contractors to carry Professional Liability? Yes No

If no, describe:

18) Are all of the above noted employees and independent contractors licensed in accordance with applicable state and federal regulations? ◯ Yes ◯ No
If no, describe:

19) Do you have a Medical Director? ◯ Yes ◯ No

If yes, provide the following details:

a. What is the name of your Medical Director?

b. What is the specialty of your Medical Director?

c. Does the Medical Director have direct patient care? ◯ Yes ◯ No

If yes, does the Medical Director carry a medical malpractice policy? ◯ Yes ◯ No
What limits of liability are carried and what is the name of the insurance carrier?

d. Does the Medical Director have supervisory duties over allied healthcare professionals? ◯ Yes ◯ No

If yes, describe:

e. Are you seeking coverage for the Medical Director's direct patient care under this policy? ◯ Yes ◯ No

If yes, provide a physician's application.

20) Has the applicant or any of the above employees and/or independent contractors:

a. Ever been subject to a disciplinary or investigative proceeding or been reprimanded by a government or administrative agency, hospital or professional association? ◯ Yes ◯ No

b. Ever been convicted of a criminal act other than traffic offenses? ◯ Yes ◯ No

c. Ever been treated for alcoholism or drug addiction? ◯ Yes ◯ No

d. Ever had any professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered such license? ◯ Yes ◯ No

If yes to any of the above questions, describe:

21) Does the Applicant administer any of the following?

a. Methadone treatment? ◯ Yes ◯ No If yes, how many slots?

b. Suboxone treatment? ◯ Yes ◯ No If yes, how many slots?

c. Vivitrol treatment? ◯ Yes ◯ No If yes, how many slots?

22) Does the Applicant administer detoxification treatment? ◯ Yes ◯ No
If yes, how many patients annually?

23) Do you offer rapid detoxification under anesthesia? ◯ Yes ◯ No
If yes, how many patients annually?

24) Is anesthesia (other than topical or by means of local infiltration) administered by, for or at the Applicant's facility? ◯ Yes ◯ No

If yes, what percentage of procedures require general anesthesia? %

What procedures require general anesthesia?

Who administers the general anesthesia?

25) Does the Applicant sell any products? Yes No

If yes, answer the following questions and include product brochures.

What kinds of products?

Do any of these products require a physician's prescription? Yes No

Do you label any of these products in your own name? Yes No

26) Does the Applicant have a training school or provide internships? Yes No

If yes, answer the following questions:

a. What profession or topic are the students being trained on?

b. How many students are trained per year?

c. Does their training include clinical training involving direct patient care? Yes No

If yes, are you requesting coverage for students under this policy? Yes No

d. What are the qualifications of the faculty providing the training?

27) Does the Applicant participate in any clinical trials? Yes No

If yes, describe:

SECTION III – RISK MANAGEMENT

28) Explain your Quality Assurance and Risk Management Program:

29) Are background checks performed on all employees, independent contractors and volunteers? Yes No

If yes, what level or type of criminal background checks?

County State Federal Sexual Offender Registry

If no, describe:

30) Are all employees, independent contractors and volunteers screened for drugs and alcohol? Yes No

If yes, how often are screens performed?

31) How are patients referred to the Applicant?

32) Do you have a policy to prevent sexual abuse or allegations of sexual abuse? Yes No

If yes, describe and advise how often it is reviewed:

SECTION IV – NETWORK SECURITY AND DATA PRIVACY PROCEDURES

33) Please describe security measures and procedures used to protect private data:

34) Do you have a formal documented security policy? Yes No
If yes, are all employees required to read, receive and understand the security policy? Yes No

35) Do you have a full time Chief Information Officer responsible for security of private information? Yes No

36) Do you utilize encryption for data stored and data transmitted? Yes No

37) Are your computer systems and networks actively monitored for security breaches? Yes No

If yes, by whom?

38) Have you ever experienced a security breach, data loss or denial of service attack? Yes No

If yes, describe:

SECTION V – ADDITIONAL COVERAGES INFORMATION

39) Do you publish or broadcast any material other than for your own advertising activities? Yes No

If yes, describe:

40) Do you develop or sell software to third parties for a fee? Yes No

If yes, describe:

41) Do you do medical billing services for others for a fee? Yes No

If yes, do you have a separate Professional Liability policy for these services? Yes No
Describe:

42) Do you do your own medical billing? Yes No

If no, who does your medical billing?

43) What percentage of your revenues are from services that are private pay? %

44) Are you subject to HIPAA regulation ? Yes No

45) Are you HIPAA compliant? Yes No

SECTION VI – COVERAGE HISTORY

46) Provide the following information as respects the last five years of PROFESSIONAL LIABILITY coverage beginning with the most current coverage: (If none, state NONE)

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

47) Please provide the following information as respects the last five years of GENERAL LIABILITY coverage beginning with the most current coverage: (If none, state NONE)

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

48) Are you interested in a quote for General Liability? ◯ Yes ◯ No

If yes, complete the GL Section of this application.

SECTION VII – CLAIMS HISTORY

49) Has any application for professional liability insurance made on behalf of the Applicant, any predecessors in business or present partners ever been declined, cancelled or have any policies been non-renewed? ◯ Yes ◯ No

If yes, provide details including name of carrier and date:

50) Has any claim ever been made against the Applicant or any of its employees? ◯ Yes ◯ No

If yes, complete a Supplemental Claim Information Form for each and every claim.

51) Is the applicant aware of any errors, omissions, circumstances or incidents which may result in a claim being made against them or their employees, or are there any claims that have not yet been reported? ◯ Yes ◯ No

52) Have any of the Applicant's employee(s) or independent contractors been the subject(s) of alleged or actual incidents regarding sexual abuse or molestation or child abuse/neglect? ◯ Yes ◯ No

If yes, provide details on a separate attachment.

SECTION VIII – GL SECTION

A) Complete the following for each of the Applicant's facilities:

Location	Name of Facility	Address	Description of Facility	Does the Applicant Manage a Garage? (Y/N)	Is There an Adjacent Exposure? (Y/N)

Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percent of Building Occupied by the Applicant	%	%	%	%
Other Occupants? (Yes/No)				

**Include square footage of parking facilities if owned or rented by the Applicant.*

B) Are all of the Applicant's locations equipped with:

1. Complete sprinkler system? Yes No
2. At least two clearly marked exits on each floor? Yes No
3. Self-closing fire doors on each floor? Yes No
4. Automatic fire alarm system connected to a local fire department? Yes No
5. Smoke detectors? Yes No
6. Emergency electrical system? Yes No
7. Heat sensors? Yes No
8. Fire escape(s)? Yes No
9. Posted emergency evacuation procedures? Yes No
10. Properly maintained fire extinguishers? Yes No

If any of the above questions are answered **No**, provide details on a separate attachment.

Please attach the following information:

- 5 years currently valued carrier loss runs
- A complete roster of physicians that are contracted with your facility
- Copies of informed consent documents

RESET SAVE PRINT EMAIL

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: 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 for the purpose of defrauding or attempting to defraud the 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.

Applicable in FL and OK: 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 (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: 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 and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: 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 or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.