SHAND MORAHAN & COMPANY, INC.
MARKEL®
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

MEDICAL LABORATORIES, MEDICAL IMAGING CENTERS AND BLOOD PLASMAPHERESIS CENTERS PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S 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 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: _____ Business Phone: ( ) _____

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

_____
(City) (State) (Zip)

c. Secondary locations: _____

d. Total sq. ft. occupied by applicant (all locations): _____

e. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____

f. [ ] Corporation [ ] Individual [ ] Partnership [ ] Other (describe)
Year established: _____ State where applicant is licensed to practice: _____
Is Laboratory or Center [ ] Mobile [ ] Stationary

g. Limits, deductible and effective date requested:_____ (per claim) _____ (agg.) _____ Deductible

2. OPERATIONS

a. Please describe fully the exact purpose of the operations, services and procedures provided. (Attach copy of brochure, if available.):

b. (i) State annual gross receipts last 12 months $_____
Anticipated next 12 month $_____
(ii) Number of tests performed last 12 months _____
Anticipated next 12 months _____
(iii) Number of patient contacts last 12 months _____
Anticipated next 12 months _____

c. For medical imaging centers only, please indicate number of tests in each category annually:

MRIs ____ CT scans ____ Mammograms ____ Ultrasounds ____ Other _____ (describe) _____

d. Are you under contract to or in the employ of any federal governmental entity? ..... [ ] Yes [ ] No
If yes, please attach explanation.

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 detailed explanation and a copy of ALL of the advertisements.

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, attach detailed explanation and a copy of ALL of the advertisements.

g. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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._____

Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

3. SERVICES

a. Service is provided for: Hospitals _____% Nursing Homes_____% Industrial Facilities _____%
Physicians' Offices _____% Other _____% (describe) _____

b. Are you involved in any: (If yes, please attach full description)

Services open to the public (health fairs, shopping mall exhibits, etc. ..... [ ] Yes [ ] No
Blood banking or cross matching ..... [ ] Yes [ ] No
Medical, genetic, AIDS or drug research ..... [ ] Yes [ ] No
Manufacturing, dispensing or testing pharmaceuticals ..... [ ] Yes [ ] No
Use of injected or ingested materials ..... [ ] Yes [ ] No
Use of any radioactive material other than normal x-ray equipment ..... [ ] Yes [ ] No
Therapy or treatment procedures ..... [ ] Yes [ ] No
Environmental analyses ..... [ ] Yes [ ] No
Manufacturer and/or sell laboratory equipment or supplies, reagents or software ..... [ ] Yes [ ] No
Intravenous transfusions of blood or in the procurement of blood or blood products ..... [ ] Yes [ ] No
Drug testing: If yes, _____% of your gross receipts ..... [ ] Yes [ ] No
Testing for AIDS: If yes, _____% of your gross receipts ..... [ ] Yes [ ] No

c. Specimens: _____% collected direct from patient by applicant; describe types of specimens collected: _____

_____

_____% received by applicant from outside sources.

d. Do you provide any services under contract? ..... [ ] Yes [ ] No
If Yes, please attach explanation.

4. STAFF

a. Total number of employees: _____ Professional _____

_____ Physicians _____ Nurses _____ X-Ray Technicians
_____ Technologies _____ Phlebotomists _____ Other Technicians
_____ Other (describe) _____

Do employed physicians carry their own professional liability insurance? ..... [ ] Yes [ ] No
What limits of liability do they carry? $_____

b. (i) Name and qualifications of Medical Director:* _____

_____

(ii) Name and qualifications of Medical Review Officer (MRO):* _____

_____

*Please attach Curriculum Vitae (C.V.).

c. (i) Are there any contracted physicians? ..... [ ] Yes [ ] No
How many? _____

(ii) Do they carry professional liability insurance? ..... [ ] Yes [ ] No

(iii) What limits of liability do they carry? $_____

5. CLAIMS/HISTORY

a. Have you or any of your employees ever: (If Yes, please attach full description.)

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

(ii) been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ..... [ ] Yes [ ] No

(iii) had any professional liability insurance canceled, declined, refused, renewal or accepted only on special terms? ..... [ ] Yes [ ] No

b. Are you licensed in accordance with all applicable state and federal laws? ..... [ ] Yes [ ] No

(i) Approved by National Institute on Drug Abuse (NIDA) if lab is involved in drug testing? ..... [ ] Yes [ ] No

(ii) CLIA approved? ..... [ ] Yes [ ] No

If no to either of the above, provide detailed explanation.

(iii) Have you or any of your employees had any professional licensed refused, suspended, revoked, renewal refused or accepted only on special terms or have you or any of your employees voluntarily surrendered any professional license? ..... [ ] Yes [ ] No

c. Has any claim or suit for alleged malpractice been brought against you and/or any of your employees? ..... [ ] Yes [ ] No

d. Has any claim or suit for alleged malpractice been made against you and/or any of your employees that has NOT been reported to a prior Insurer? ..... [ ] Yes [ ] No

e. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you and/or any of your employees? ..... [ ] Yes [ ] No

If Yes to any questions, c - e above, please complete Supplemental Claim Information Form SM 174.

f. (i) List prior professional liability insurance carried for each of the past five years. If none, check here [ ].

(ii) Attach a copy of the Declarations Page from your most recent coverage.

Insurance Co.	Limits of Liability	Premium	Inception Exp. Mo./Day/+-Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retroactive Date
					[ ]	[ ]	
					[ ]	[ ]	
					[ ]	[ ]	
					[ ]	[ ]	
					[ ]	[ ]	

* 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 Shand Morahan & Company, Inc., Underwriting Manager for the Company.**

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 Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier:_____

Limits:_____ Deductible:_____ Premium:_____

Expiration Date: _____ Retro Date: _____

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

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

DATE QUOTE NEEDED: