Lancet Indemnity, RRG

Physician Owned, Managed and Directed

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APPLICATION FOR PARAMEDICS, EMTs, NURSE PRACTIONERS, AMBULANCE SERVICES AND PHYSICIANS'/SURGEONS' ASSISTANTS 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 READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

WARNING- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance of files a 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.

PART I – ALL APPLICANTS MUST COMPLETE:

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1. APPLICANT INFORMATION

a. (i) Full Name of Individual Applicant: _____ Professional Degree: _____
(ii) Date of Birth: _____ Place of Birth: _____
b. (i) Principal business premise address: _____
(Street) (County)
_____
(City) (State) (Zip)
(ii) Other Business Location: _____
(iii) Square feet of total office space (all locations): _____
(iv) Number of Employees: Full time _____ Part time _____ Total _____
(v) Business Phone: (____) _____ Home Phone (___) _____ Email: _____

c. If you practice **other than** as an **employee** OR an **unincorporated solo practitioner**:
(i) Formal business, corporate or partnership name: _____
(ii) List the names of all partners or members of your professional association/corporation who provide professional services:_____
_____
_____
(iii) Attach a copy of your letterhead

d. 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 _____

2. APPLICANT PRACTICE

a. Your Practice:

_____Solo Practitioner (unincorporated) _____ Professional Corporation (for profit)
_____Solo Practitioner (incorporated) _____ Professional Corporation (non-profit)
_____Partnership _____ Employee of _____ (give name of employer)
_____Other (Describe) _____

b. Please list all states where you are licensed to practice:

_____
_____

If NONE, please attach an explanation.

c. Please indicate your professional specialty (CHECK ONE):

_____ Ambulance Service _____ Nurse Practitioner _____ Surgeon's Assistant
_____ Emergency Medical Technician _____ Paramedic _____ Other (specify)___
_____ Nurse Anesthetist _____ Physician's Assistant

d. Please give the approximate percentages of time spent in the following work locations:

_____ % Administrative Office _____ % Laboratory _____ % Hospital Ward (specify)
_____ % Ambulance _____ % Operating Room
_____ % Classroom _____ % Outpatient Clinic ____% Professional Office
_____ % Emergency Dept. of Hospital _____% Laboratory (specify profession)
_____ % Nursing Home _____ % Patient's Home _____% Other (specify)

e. Please indicate the approximate division of your patients or clients among:

Hemodialysis	_____%	Psychiatric	_____%	Bariatrics	_____%
Holistic Med.	_____%	Drug Addicts	_____%	Physical Rehabilitation	____%
Surgical	_____%	Alcoholics	_____%	Disability Evaluation	_____%
Stress Testing	_____%	Obstetrical	_____%	Research or Experimental	____%
Communicable	_____%	Dental	_____%	_____	_____%
Family Planning	_____%	Pediatric	_____%	_____	_____%
					100%

f. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE.

_____ Emergency Medical Technicians _____ Physicians' Assistants
_____ Nurse Anesthetists _____ Surgeons' Assistants
_____ Nurse Practitioners
_____ Paramedics

g. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ____ yes ____ no

If no, please attach an explanation.

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

Source	Amount This Fiscal Year	Amount Next Fiscal Year
(i) Charitable Contributions:	$_____	$_____
(ii) Government Funding:	$_____	$_____

(ii) Fee for Service: $_____ $_____
(iv) Other: _____ $_____ $_____
TOTAL GROSS REVENUE: $ _____ $_____

i. Number of patient encounter last 12 months _____ and/or patient tests carried out _____.
(NOTE: "Patient encounters" refers to the number of visits – not the number of patients.

j. Number of estimated patient encounters next 12 months ____ and/or patient tests carried out ___.
(NOTE: "Patient encounters" refers to the number of visits – not the number of patients.

3. APPLICANT HISTORY (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS)

a. Have you or any of your employees:
(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ___yes ___no
(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ___yes ___no
(iii) Ever been treated for alcoholism or drug addiction? ___yes ___no
(iii) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ___yes ___no
(iv) Ever had any insurance company of Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice Insurance? ___yes ___no

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

Insurance Carrier	Policy #	Limits of Liability	Deductible (if any)	Premium	Inception Exp. Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form
							___ Yes ___ No
							___ Yes ___No
							___ Yes ___No
							____Yes ___No

c. If prior professional liability insurance was on a claims made basis, please indicate the retroactive exclusion date of coverage. _____

4. PERSONNEL

a. Please list the number and type of independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.
_____ Emergency Medical Technicians
_____ Nurse Anesthetists
_____ Nurse Practitioners
_____ Paramedics
_____ Physician's Assistants
_____ Surgeon's Assistants

b. Do you supervise any individuals who are not your own employees? If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals. ___yes ___no

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

Number	Type of Professions	Number	Type of Profession	Number	Type of Profession
_____	Emergency Medical Technicians	_____	Nurse Practitioners	_____	Surgeon's Assistant
_____	Laboratory Technicians	_____	Nurses, Registered		

_____ Nurse Anesthetists _____ Paramedics
_____ Nurses, Licensed Practical _____ Physician's Assistants

5. APPLICANT PROCEDURES

a. Do you render professional services directly to patients? ___yes ____no
If yes, please describe these services in detail and indicate whether you are supervised and by whom.

Detailed Description of Professional Services	**% of Time Supervised**	**Title of Supervisor**
_____	_____%	_____
_____	_____%	_____
_____	_____%	_____

b. Do you render professional services that do not involve contact with a patient? ___yes ____ no
If yes, please describe these services in detail. _____
_____
_____

c. Do you administer any anesthesia? ____yes ____no
If yes, please explain and indicate whether you are supervised and by whom. _____
_____
_____

d. (i) Do you perform or assist in any surgical procedure(s)? ____ yes ___no
If yes, please answer (ii) below.
(ii) Please list ALL surgical procedures performed (including minor surgery):_____
_____
_____
(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? ____ yes ___no
If yes, please attach a detailed explanation.
(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? ____yes ____no
If yes, please attach a detailed explanation.

e. (i) Do you perform radiation therapy? ____yes ___no

f. Do you prescribe or dispense any drugs without the countersignature of a physician? ____ yes ___no
If yes, please provide a detailed explanation.
_____
_____

6. APPLICANT AFFILIATIONS

a. Are you associated with or do you work for a physician or surgeon? ___yes ___no
If yes, please give the name and specialty of the physician: _____

b. Do you own or operate any business other than that shown in Question 1(a) above? ___yes ___no
If yes, please attach an explanation, including details of your responsibilities.

c. Are you employed by an individual other than that shown in Question 1(a) above? ___yes ___no

If yes, please attach an explanation, including details of your responsibilities.

d. Are you under contract to any individual other than that shown in Question 1(a) above? ___yes ___no
If yes, please attach an explanation, including details of your responsibilities. If this contract contains a hold-harmless agreement, please attach a copy of the contract.

e. Are you employed by or under contract to any government entity? ___yes ___no
If yes, please attach an explanation, including details of your responsibilities.

f. Are you under contract to any governmental entity ____yes ___no
If yes, please attach an explanation, including details of your responsibilities.

g. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)?
If yes, please attach a copy of ALL of your advertisements. ___yes ___no

h. Are you associated with any agency or organization that engages in advertising for, or solicitation of patients? If yes, please attach a detailed explanation and a copy of ALL relevant advertisements. ___yes ___no

7. CLAIMS

a. Has any claim or suit been brought against you and/or any of your employees? ____ yes ___no
If yes, please complete a supplemental claim information form for each claim or suit.

b. 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? If yes, please provide details on a separate sheet. ___yes ___no

8. PROFESSIONAL SOCIETIES

a. Please indicate membership in professional societies or associations: _____
_____
_____

PART II – INDIVIDUAL APPLIANTS ONLY, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. CITIZENSHIP

a. Are you a U.S. citizen? If no, please indicate your status and date of entry into the U.S.A. ___yes ___no

2. EDUCATION

a. Describe your professional training:

Institution (Name & Address)	Years of Training	Degree or Certification Attained
_____	From_____ To_____	_____
_____	From_____ To_____	_____
_____	From_____ To_____	_____
_____	From_____ To_____	_____

3. EXPERIENCE

Where have you practiced your profession during the last ten years?

a. Prior Experience – From: _____ To:_____ Location: _____
Practice Activity: _____

b. Prior Experience – From: _____ To:_____ Location: _____
Practice Activity: _____

c. Prior Experience – From: _____ To:_____ Location: _____
Practice Activity: _____

d. Have you ever failed any professional licensing or specialty organization examination? ___yes ___no
If yes, please attach a detailed explanation, including dates and location.

PART III – PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY IF A QUOTATION IS REQUESTED TO COVER A GROUP OF PARAMEDICS OR EMERGENCY MEDICAL TECHNICIANS AND/OR THE EMPLOYER. THESE QUESTIONS ARE TO BE COMPLETED BY THE ADMINISTRATOR OR BUSINESS MANAGER, AND THE APPLICATION MUST BE SIGNED BY SAME.

1. SERVICE BOUNDARY

What is the radius of operations of the ambulance service? _____

2. ANNUAL NUMBERS

a. Please state the annual number of patient encounters (the number of patients transported by the ambulance service):
Last 12 months: _____ Estimated next 12 months: _____

b. Please state the annual number of calls for emergencies:
Last 12 months: _____ Estimated next 12 months: _____

c. Please state the annual number of calls for transporting patients to and from a hospital or other institution that are not accident cases:
Last 12 months: _____ Estimated next 12 months: _____

* 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.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the insurer, that I understand and accept the notice stated above 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 authorize the release of claim information from any prior insurer to Lancet Indemnity, RRG and their affiliates.**

_____	_____
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.

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, AND ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY. MAKE ADDITIONAL COPIES AS NECESSARY.

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SUPPLEMENTAL CLAIM INFORMATION

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 READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION. (PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be complete by Applicant who has been in any claim or suit aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

1. Applicant Name: _____

2. Claimant Name: _____

3. Name of Individual(s) at your firm/Company involved in Claim; _____

4. Indicate whether: _____ Claim/Suit: _____Incident

5. Date of alleged error: _____Date claim made against applicant: _____

6. Additional defendants: _____

7. Current Disposition of claim:

   ____ DISMISSED (Action dropped without any payment to claimant or Statue of Limitations has expired)
   ____ ABANDONED (no activity from claimant for over 3 years)
   ____ WON by defense
   ____ Won by claimant Total Paid $ _____ Amount Paid on your behalf $ _____
   Indicate whether: ____ Court Judgment, or ____ Out of court settlement
   ____ OPEN Claimant's settlement demand $ _____
   Defendant's offer for settlement? $ _____ Insurer's loss reserve $ _____

8. Name of Insurer: _____

9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
   a. Alleged act, error or omission upon which Claimant bases claim: _____
   _____
   b. Description of cases and events: _____
   _____
   c. Description of the type and extent of injury or damage allegedly sustained: _____
   _____

d. If a medical claim provide type of injury claimed:
____ Emotional Only ____ Temporary Disability ___ Death ___ Cosmetic
____ Permanent Disability ____ Other (describe)

10. Explain what action has been taken by you to prevent recurrence of the same type of claim. _____
_____

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

_____ _____
Name of Applicant Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date

* Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.

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STATEMENT OF NO KNOWN CLAIMS / LOSSES

(This statement must be completed, signed and returned with the completed application)

My signature below confirms that:

1. I have no known losses or claims that have not been reported to my prior insurance carrier.

2. I have no knowledge or information relating to a MEDICAL INCIDENT which could reasonably result in a claim that has NOT been reported to a prior insurance carrier.

3. I have no knowledge of ANY REQUEST FOR MEDICAL RECORDS which might result in a claim.

4. I have no knowledge or information relating to service or service on a Board which might result in claim.

5. No prior professional liability carrier has REFUSED coverage for, or DECLINED to accept a report of a medical incident, threat of a claim, letter of intent, and adverse result notice or attorney contract.

Signature _____ Date _____

Printed _____