SHAND MORAHAN & COMPANY, INC.
MARKEL®

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
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APPLICATION FOR PARAMEDICS, EMT'S, NURSE ANESTHETISTS, NURSE PRACTITIONERS, AMBULANCE SERVICES AND PHYSICIANS' AND 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)

PART I - ALL APPLICANTS MUST COMPLETE:

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 Locations: _____

(iii) Square feet of total office space (all locations): _____

(iv) Number of Employees: Full time _____ Part time _____ Total _____

(v) Business Phone: (____) _____ Home Phone: (____) _____

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._____

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.

2. APPLICANT PRACTICE

a. Your Practice:

_____ Solo Practitioner (unincorporated)
_____ Solo Practitioner (incorporated)
_____ Partnership
_____ Professional Association
_____ Other (Describe)_____

_____ Professional Corporation (for profit)
_____ Professional Corporation (non-profit)
_____ Employee of _____
(give name of employer)

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
[ ] Emergency Medical Technician
[ ] Nurse Anesthetist
[ ] Nurse Practitioner
[ ] Paramedic
[ ] Physician's Assistant
[ ] Surgeon's Assistant
[ ] Other (specify) _____

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

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

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

Hemodialysis	_____%	Psychiatric	_____%	Bariatrics	_____%
Holistic Medicine	_____%	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 NONE.

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

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

i. Number of patient encounters 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

(iv) 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

(v) Ever had any insurance company or 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 Number	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
							[ ]	[ ]
							[ ]	[ ]
							[ ]	[ ]
							[ ]	[ ]

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
_____ Physicians' Assistants
_____ Surgeons' 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 Profession	Number	Type of Profession	Number	Type of Profession
_____	Emergency Medical Technicians	_____	Nurse Practitioners	_____	Surgeons' Assistants
_____	Laboratory Technicians	_____	Nurses, Registered	_____	
_____	Nurse Anesthetists	_____	Paramedics	_____	
_____	Nurses, Licensed Practical	_____	Physicians' 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	Percent 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

(ii) Psychiatric shock 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 or entity 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 governmental 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.....[ ] Yes [ ] No
telephone directory)? If yes, please attach a copy of ALL your advertisements.

h. Are you associated with any agency or organization that engages in advertising for, or solicitation.....[ ] Yes [ ] No
of, patients? If yes, please attach a detailed explanation and a copy of ALL relevant advertisements.

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..... [ ] Yes [ ] No
brought against you or any of your employees? If yes, please provide details on a separate sheet.

8. PROFESSIONAL SOCIETIES

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

_____

_____

PART II - INDIVIDUAL APPLICANTS 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 _____	_____
_____		

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 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 authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Ten Parkway North, Deerfield, Illinois 60015**.

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.

MARKEL®
SHAND MORAHAN & COMPANY, INC.
Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

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:

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

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- EVANSTON INSURANCE COMPANY
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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. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is 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 Statute 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.

SHAND MORAHAN & COMPANY, INC.
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Underwriting Manager
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(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is 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 Statute 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.