**AMERICAN INTERNATIONAL COMPANIES[a]**
**ABORTION CLINIC – APPLICATION**

The Applicant represents and declares that all statements and facts set forth herein are true and no material facts have been suppressed or misstated. Any material misstatements and/or omissions may result in coverage being rescinded. The Applicant agrees that if the information supplied on this Application changes between the date of this Application and the effective date, then the Applicant will immediately notify the company of such changes. The Applicant acknowledges that the company is relying on the information contained in the Application, and it is agreed that this Application shall be the basis of the contract and shall be incorporated by reference into the policy should a policy be issued. Therefore, it is mandatory that all questions be answered completely. Completion of this Application does not bind coverage.

Instructions:
1) Please type or print clearly.
2) Answer ALL questions completely, leaving no blanks (use "N/A" if Not Appropriate).
3) If you need more space for your responses, continue on a separate sheet with letterhead and indicate question number.

**INCLUDE THE FOLLOWING AND CHECK THE BOX IF SUBMITTED:**

? LOSS HISTORY – Submit company produced 5 year loss history for Professional Liability and General Liability with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and a detailed explanation for each loss.

? Copies of all marketing materials.

? Most current year-end financial statements.

? Copies of most recent inspection reports within the past three years.

**GENERAL/OVERVIEW INFORMATION – APPLICANT**

Corporate Entity Name: ____________________

Corporate Entity Address: ____________________

Mailing Address: ____________________
Street City State Zip

DBA Name: ____________________

DBA Address (if same write "same"): ____________________
Street City State Zip

Requested Effective Date: ____________ Retroactive Date: ____________

Current Form of Insurance: Professional Liability: ? Claims-made ? Occurrence
Commercial General Liability: ? Claims-made ? Occurrence

Applicant is a:
? Corporation ? Partnership
? Partnership Association ? Sole Proprietorship
? Joint Venture ? Other (*Please Explain*) ____________

Applicant operates: ? For Profit ? Not for Profit

Date Business Established: ____________

**Limits of Liability – Primary***
? $500,000/$1,500,000 ? $1,000,000/$3,000,000 ? Other ____________
**Professional Liability and General Liability Limits must be the same, but apply separately.*

**Deductible / SIR**
(applies separately to Professional Liability and General Liability)
? $10,000 ? $25,000 ? $50,000 ? $100,000 ? Other ____________

**Limits of Liability – Excess Coverage Requested** ? Yes ? No
? $1,000,000/$1,000,000 ? $3,000,000/$3,000,000
? $5,000,000/$5,000,000 ? Other ____________

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1) Revenue Data – Provide historical, current and projected revenues:

| Year | $ Revenues |
|---|---|
| 1999 | |
| 2000 | |
| 2001 | |
| 2002 | |
| 2003 | |
| 2004 | |
| 2005 | |
| Projected 2006 | |

2) Location and Operational Information – List each location of operations:

| Name of Location | Address | Description of Operations | % Ownership |
|---|---|---|---|
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3) Professional Employees/Independent Contractors – List each physician providing services at your facility.

3a) What is the total number of doctors working at your facility? _______________________

3b) What are the Professional Liability insurance requirements for physicians: ____________________________

3c) Are you requesting doctor coverage? ? Yes ? No If yes, then complete separate Physicians Professional Liability Application for each physician.

3d) Give names of each person working at your facility:

| Medical Director - Name | Specialty | Insurance Carrier | Employee/ Contractor | Hours/Month |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| Physician Names | Specialty | Insurance Carrier | Employee/ Contractor | Hours/Month |
| | | | | |
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4) Do you require that the physicians working at your facility be Board Certified by the American Board of Obstetrics and Gynecology? ? Yes ? No

5) Are you requesting coverage for any Contracted Healthcare professional? ? Yes ? No

If yes, list number, type and how many hours does each work? __________________________________________

________________________________________________________________________________

________________________________________________________________________________

6) Specify each type and number of allied health professionals working at the clinic:

| Type of Professionals | Employees | | Contractors/Volunteers | |
|---|---|---|---|---|
| | Number | Hours Per Month | Number | Hours Per Month |
| Nurse Midwives ? Yes ? No | | | | |
| CRNA ? Yes ? No | | | | |
| Physician Assistants ? Yes ? No | | | | |
| Nurse Practitioners ? Yes ? No | | | | |
| List other types: | | | | |
| | | | | |
| | | | | |
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## PROFESSIONAL LIABILITY EXPOSURE INFORMATION

7) Indicate the services offered.
If locations are in multiple states, then check box here ? and then copy this page and provide complete grid by state.

| **Services Provided – Give Annual # Of Each** Use Different Lines for Each Location (use additional sheet if necessary) | **Year** ________ | **Year** ________ | **Current** ________ | **Projected** ________ |
|---|---|---|---|---|
| Surgical Abortions – 1st Trimester (# of Procedures) | | | | |
| Surgical Abortions – 2nd Trimester (# of Procedures) | | | | |
| Surgical Abortions – 3rd Trimester (# of Procedures) | | | | |
| | | | | |
| Medical Abortions – 1st Trimester (# of Procedures) | | | | |
| Medical Abortions – 2nd Trimester (# of Procedures) | | | | |
| Medical Abortions – 3rd Trimester (# of Procedures) | | | | |
| | | | | |
| GYN/Family Planning (Visits) | | | | |
| | | | | |
| Other Services (List Type and Annual Number) | | | | |
| | | | | |
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| | | | | |
| | | | | |
| Laboratory Testing (in-house) – list main types and give annual number | | | | |
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| **Product Sales (List Type and $ Revenues):** | | | | |
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## GENERAL LIABILITY EXPOSURE INFORMATION

8) Are you requesting GL coverage? ? Yes ? No If yes, complete this section. If no, go to Question 11.

9) Describe any reported incidents of violence (inconclusive or accidental should be included below):

| Violent Incidents | Total # of Incidents |
|---|---|
| Vandalism | |
| Trespassing | |
| Burglary | |
| Assault/Battery (attempted or actual) | |
| Stalking (away from the clinic) | |
| Death Threats | |
| Picketing (# of days of at least 1 picketer) | |
| Harassing Calls/Hate Mail | |
| Other: | |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total Incidents** | |

10) If there are any violent incidents listed above, please specify details (use additional sheets if necessary):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

11) Please list any security measures that your facility undertakes and provide a copy of all security guidelines:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## ACCREDITATION

12) Please check the box if your facility is affiliated with or accredited by:

| | | | Affiliated With or Accredited By? |
|---|---|---|---|
| Planned Parenthood | ? Yes | ? No | ____________________ |
| NAF | ? Yes | ? No | ____________________ |
| NCAP | ? Yes | ? No | ____________________ |
| NFPRHA | ? Yes | ? No | ____________________ |
| JCAHO | ? Yes | ? No | ____________________ |
| Other (please specify): | | | |
| ____________________ | ? Yes | ? No | ____________________ |
| ____________________ | ? Yes | ? No | ____________________ |

13) Is this facility licensed by the state? ? Yes ? No If yes, list the state(s). ____________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

## RISK MANAGEMENT/LOSS CONTROL

14) Does your facility have a formalized Risk Management Program? ? Yes ? No

15) Who coordinates your Risk Management Program?

Name: ______________________________

Title: ______________________________ Phone Number: ______________________________

16) Does your facility employ a Medical Director? ? Yes ? No

Name: ______________________________

Phone Number: ______________________________

17) List the types of healthcare products and approximate annual quantity distributed (including samples) at the clinic:

| Products Distributed – Give Annual # Of Each Including Samples | Year ________ | Year ________ | Year ________ | Current ________ |
|---|---|---|---|---|
| Sponges | | | | |
| IUDs | | | | |
| Birth Control Implantables | | | | |
| Pills | | | | |
| RU-486 (Mifepristone) | | | | |
| Patches | | | | |
| Condoms | | | | |
| Other: (list each) | | | | |
| | | | | |
| | | | | |
| | | | | |
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18) Does your organization document counseling and informed consent regarding the specific risks, benefits, and alternatives of each type of contraception recommended to patients in the medical record? ? Yes ? No

19) Have any of your patients had adverse reactions after taking the following products:
(a) RU-486 (Mifepristone) ? Yes ? No If yes, give # and details below.
(b) Patches ? Yes ? No If yes, give details below.

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

20) Have any of the products that you distribute ever been recalled? ? Yes ? No
If yes, give details. ______________________________
______________________________
______________________________
______________________________

21) Is there a credentialing process in place for your physicians? ? Yes ? No

22) What types of anesthesia are provided by your facility?

| | | |
|---|---|---|
| General Anesthesia | ? Yes | ? No |
| Local Anesthesia | ? Yes | ? No |
| Spinal Anesthesia | ? Yes | ? No |
| Conscious Sedation Anesthesia | ? Yes | ? No |

23) Who is providing the anesthesia?

| | | |
|---|---|---|
| Anesthesiologists | ? Yes | ? No |
| CRNAs | ? Yes | ? No |
| Staff Nurses | ? Yes | ? No |
| Physician Performing the Procedure | ? Yes | ? No |

24) What type of patient follow-up is done? ______________________________

______________________________
______________________________
______________________________

25) Who does the patient selection and screening? ______________________________

______________________________
______________________________
______________________________

26) How many patients last year were de-selected: ________________

27) Do you consistently test all pregnant women for RH factor and administer Rhogam as indicated? ? Yes ? No

28) Are there any patients that have more than one abortion? ? Yes ? No

If yes, provide number and details: ______________________________

______________________________
______________________________
______________________________
______________________________

29) How many abortions are performed on minors? ______________________

Was parental consent obtained if required by the state where the abortion was performed? ? Yes ? No

30) How many high risk procedures do you annually perform in an acute care setting? ________________

31) What is the nature of these high risk procedures?______________________________

______________________________
______________________________
______________________________
______________________________

32) How many of these procedures over the past five years have involved any complications and what is the nature of the complications?______________________________

______________________________
______________________________
______________________________
______________________________

33) Do you have a transfer agreement with a hospital in the event there is an emergency? ? Yes ? No

If yes, give name of healthcare facility: ____________________

34) Is there a formalized training program during new hire orientation and annually for all staff to be familiar with policies and procedures pertaining to emergency clinical situations? ? Yes ? No

35) Do you have a formalized maintenance program for all equipment? ? Yes ? No

36) Is there a formalized infection control program? ? Yes ? No If yes, describe. ____________________

____________________

____________________

____________________

____________________

## HISTORICAL CARRIER INFORMATION

37) Please provide past policy information as requested. List all Primary Professional Liability and Commercial General Liability policies and Excess policies for each of the past five years. Begin with the current policies on the top line. If Claims Made, give retroactive date:

| **PRIMARY** | Insurer | Policy Period | Premium | Limits | Ded/SIR | CM (w/ Retro) Or Occurrence |
|---|---|---|---|---|---|---|
| ? Professional Liability<br>? Commercial GL | | | | | | |
| ? Professional Liability<br>? Commercial GL | | | | | | |
| ? Professional Liability<br>? Commercial GL | | | | | | |
| ? Professional Liability<br>? Commercial GL | | | | | | |
| ? Professional Liability<br>? Commercial GL | | | | | | |

## LOSS HISTORY

38) Please provide currently valued carrier produced loss runs for each of the past 5 years.
If provided check the box: ? Yes ? No

39) If no claims have been reported to you, then initial here: ____________

40) Large Loss Description – On a separate sheet of paper list any liability claims or suits made or brought against your facility during the **past ten years** for amounts incurred greater than $50,000. If no claims or suits greater than $50,000 then check the box:

? Submitted on Separate Sheet of Paper
? None Greater than $50,000 and initial here ________

41) Are you aware of any circumstance, accident or loss (occurring after the retroactive date) that has not yet been reported but which may result in a claim? ? Yes ? No

If yes, give dates, allegations and disposition of each claim or suit in the comments section. ________

____________________

____________________

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____________________

____________________

**AMERICAN INTERNATIONAL COMPANIES[a]**
**ABORTION CLINIC – APPLICATION**

THE UNDERSIGNED DECLARES THAT ALL STATEMENTS SET FORTH HEREIN ARE TRUE. ANY MATERIAL MISSTATEMENTS AND/OR OMISSIONS MAY RESULT IN RESCINDED COVERAGE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THE INSURANCE, BUT THE APPLICANT ACKNOWLEDGES THAT THE COMPANY IS RELYING ON THE INFORMATION CONTAINED IN THE APPLICATION, AND IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT AND SHALL BE INCORPORATED BY REFERENCE INTO THE POLICY SHOULD A POLICY BE ISSUED.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO THE COMPANY IN CONJUNCTION WITH THIS APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

**THIS APPLICATION MUST BE SIGNED BY AN OFFICER OR PRINCIPAL OF THE APPLICANT.**

Name of Applicant:_______________________________________________

Title: _______________________________________________

Signature: _______________________________________________

Date: _______________________________________________

Brokerage Firm Name: _______________________________________________

Producer Name: _______________________________________________

Address: _______________________________________________

Telephone: _______________________________________________

Fax: _______________________________________________