SHAND MORAHAN & COMPANY, INC.
MARKEL®

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
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APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.) 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 date 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: _____

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

_____
(City) (State) (Zip)

c. [ ] Professional Corporation (for profit) [ ] Partnership
[ ] Professional Corporation (non-profit) [ ] Professional Association
[ ] Other (describe) _____

d. Date established: _____

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

f. Business, corporate or partnership name: _____

g. Name of all partners or members of the firm who provide professional services: _____
_____

h. Professional societies or associations in which you are a member: _____
_____

i. Please attach a copy of letterhead or other business stationery.

2. OPERATIONS

a. States Clinics are registered and licensed to practice: _____
_____
If none, please explain.

b. Clinics professional specialty: _____
_____

c. Do you maintain any beds for overnight occupancy? [ ] Yes [ ] No. If yes, also complete application form SM 271 or SM 686.

d. Total sq. ft. that you occupy (all locations): _____

e. Division of patients or clients:

(i)	Hemodialysis	_____%	(vii)	Psychiatric	_____%	(xiii)	Bariatrics	_____%
(ii)	Holistic Medicine	_____%	(viii)	Drug Addicts	_____%	(xiv)	Physical Rehabilitation	_____%
(iii)	Surgical	_____%	(ix)	Alcoholics	_____%	(xv)	Disability Evaluation	_____%
(iv)	Stress Testing	_____%	(x)	Obstetrical	_____%	(xvi)	Research or Experimental	_____%
(v)	Communicable	_____%	(xi)	Dental	_____%	(xvii)	Other _____	_____%
(vi)	Family Planning	_____%	(xii)	Pediatric	_____%		_____	100%

f. Does Clinic use a collection agency? .....[ ] Yes [ ] No
If yes, name of agency: _____
Does the agency have authority to file a collection suit on Clinics behalf?.....[ ] Yes [ ] No

g. Do owners, partners or directors, (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?.....[ ] Yes [ ] No
If yes, give details including name, location, size and number of beds. _____
_____

h. Do you own or operate any business other than that shown in question 1a? .....[ ] Yes [ ] No
If yes, please attach detailed explanations of this activity.

i. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory? .....[ ] Yes [ ] No
If yes, please attach a copy of ALL of the advertisements.

j. Names and locations of any hospitals or institutions Clinic use is in practice: _____
_____
_____

k. 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. PROFESSIONAL SERVICES

a. Do you perform:
(i) Acupuncture or acupuncture anesthesia? Explain: _____ ....[ ] Yes [ ] No
(ii) Angiography/arteriography/venography? Describe: _____ ....[ ] Yes [ ] No
(iii) Catheterization (other than urinary or umbilical)? Describe: _____ ....[ ] Yes [ ] No
(iv) Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion?.....[ ] Yes [ ] No
(v) Injection of radioisotopes and/or use of irradiated substances? Describe:.....[ ] Yes [ ] No
_____
(vi) Radiation therapy and/or chemotherapy? Describe: _____ ....[ ] Yes [ ] No
(vii) Psychiatric shock therapy?.....[ ] Yes [ ] No
(viii) Silicone injections? Describe: _____ ....[ ] Yes [ ] No
(ix) Spinal anesthesia (other than saddle blocks or caudals)? .....[ ] Yes [ ] No
(x) Laser treatment? Describe: _____ ....[ ] Yes [ ] No
(xi) Experimental procedures or research testing? Describe in detail on separate sheet. .....[ ] Yes [ ] No
(xii) Hypnosis? Describe: _____ ....[ ] Yes [ ] No

b. Do you perform:
(i) Norplant insertion/removals advise # yearly.....[ ] Yes [ ] No
(ii) Surgery other than incision of superficial boils or suturing superficial fascia? .....[ ] Yes [ ] No
(iii) Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker? .....[ ] Yes [ ] No
(iv) Tonsillectomies and/or adenoidectomies and/or caesarean sections? [ ] Yes [ ] No
(v) Cosmetic plastic surgery? Describe: _____ ....[ ] Yes [ ] No
(vi) Excision of large cysts and/or I&D of deep-seated boils or carbuncles? .....[ ] Yes [ ] No
(vii) Hysterectomies?.....[ ] Yes [ ] No
(viii) Open reduction of fractures? Describe: _____ ....[ ] Yes [ ] No
(ix) Surgery for weight reduction of patients? .....[ ] Yes [ ] No
(x) Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): _____ ....[ ] Yes [ ] No
(xi) Cryosurgery (other than use on benign or pre-malignant dermatological lesions)? Describe: _____ ....[ ] Yes [ ] No
(xii) Silicone implants? Describe: _____ [ ] Yes [ ] No

(xiii) Sterilization procedures? Describe: _____ ....[ ] Yes [ ] No
(xiv) Biopsies and/or endoscopies? List types performed: _____ ....[ ] Yes [ ] No
(xv) Sex change operations? Describe and advise number yearly: _____ ....[ ] Yes [ ] No
(xvi) Experimental surgery or surgical research? Describe in detail on separate sheet. ....[ ] Yes [ ] No
(xvii) Other surgery? Describe: _____ ....[ ] Yes [ ] No
_____

c. (i) Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? .....[ ] Yes [ ] No
If yes, answer (ii) and (iii) below.

(ii) List ALL surgical procedures performed (including minor surgery): _____
_____
_____

(iii) Do you administer anesthesia (other than topical or local infiltration)? .....[ ] Yes [ ] No
If yes, please attach detailed explanation.

d. Do you perform hospital emergency room care for patients not your own? .....[ ] Yes [ ] No
If yes, please attach explanation and also advise the number "patient contact" hours MONTHLY by you:

(i) Emergency Room Physicians _____ hrs. (iii) Nurses _____hrs.
(ii) Paramedics _____ hrs. (iv) Other_____ _____hrs.

e. Do you use drugs for weight reduction or patients? .....[ ] Yes [ ] No
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.

f. Do you administer any methadone treatment?.....[ ] Yes [ ] No
If yes, please attach description of treatment and controls used and indicate number of treatments during: Last 12 months _____; Next 12 months _____.

g. Number of annual x-ray exposures: for diagnosis _____; for treatment _____.

h. If x-ray treatment is given, what qualifications are required of the staff? _____
_____

i. Do you participate in any activity, e.g., newspaper columns, broadcasts, etc., in which professional advice is offered to the public? If Yes, please attach detailed explanation of this activity. .....[ ] Yes [ ] No

j. Attach detailed description of any additional activities and/or procedures which you performed.

4. STAFF

a. Please indicate the number of professional employees, volunteers and independent contractors. IF NONE, STATE NONE.

		Employees and Volunteers	Independent Contractors			Employees and Volunteers	Independent Contractors
(i)	Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	_____	_____	(xi)	Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	_____	_____
(ii)	Physicians: Minor surgery or obstetrical procedures not constituting major surgery	_____	_____	(xii)	Physicians & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet	_____	_____
(iii)	Proctologists, Ophthal-mologists and Urologists	_____	_____	(xiii)	Unlicensed Interns	_____	_____
(iv)	General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____	(xiv)	Dentists (no oral surgery)	_____	_____
(v)	Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing	_____	_____	(xv)	Orthodontists	_____	_____

plastic surgery

		Employees and Volunteers	Independent Contractors			Employees and Volunteers	Independent Contractors
(vi)	Oral Surgeons	_____	_____	(xvi)	Podiatrists	_____	_____
(vii)	Nurse Anesthetists	_____	_____	(xvii)	Chiropractors	_____	_____
(viii)	Optometrists, Opticians	_____	_____	(xviii)	RN, LPNs	_____	_____
(ix)	Pharmacists	_____	_____	(xix)	Other _____	_____	_____
(x)	Perfusionists	_____	_____	(xx)	_____	_____	_____

NOTE: If you require any of the above to be Named Insureds, please submit separate application for each such individual.

b. Are all of the above individuals licensed in accordance with applicable state and federal regulation? ..[ ] Yes [ ] No
If no, please attach explanation.

c. PLEASE ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

(i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative 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

d. Do you supervise any individual other than your own employees? .....[ ] Yes [ ] No
If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals. _____

_____

Also, indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technician	_____	_____

5. REVENUES

a. Please state sources and amounts of total revenue:

Source	This Fiscal Year	Next Fiscal Year
(i) Charitable Contributions	$_____	$_____
(ii) Government Funding	$_____	$_____
(iii) Fee for Service	$_____	$_____
(iv) Other _____	$_____	$_____
TOTAL GROSS REVENUE	$_____	$_____

b. Please provide number of outpatient visits:

Type of Visit	Last 12 Months	Next 12 Months
Clinics	_____	_____
Laboratory	_____	_____
Emergency Room	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL NO. OF VISITS	_____	_____

c. If you have a training school, please complete the following. Attach separate schedule if needed.

Specify Profession for Which Students Are Being Trained	Max. No. of Students Per Session	No. of Sessions Per Year	% of Time Involved in Clinical Setting	Number of Faculty	Qualifications of Faculty (i.e., MD, RN, PhD., etc.)

6. AFFILIATIONS

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

b. Are you employed by any individual or entity other than that shown in Question 1(a) ? .....[ ] Yes [ ] No
If yes, please attach explanation.

c. Are you under contract to any individual or entity other than that shown in Question 1(a)?.....[ ] Yes [ ] No
If this contract contains a hold-harmless agreement, copy of contract must be attached.

d. Are you in the employ of or under contract to any federal governmental entity?.....[ ] Yes [ ] No

7. HISTORY/CLAIMS

a. Has any claim or suit been brought against you and/or any of your employees? .....[ ] Yes [ ] No
If yes, a supplemental claim information form must be completed 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?.....[ ] Yes [ ] No
If yes, please give details on separate sheet.

c. Please list general liability insurance carried for each of the past three years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro 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.

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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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
A Markel Company

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MEDICAL INCIDENT OR THREAT OF CLAIM FORM FOR PHYSICIAN, SURGEON, DENTIST & PODIATRIST APPLICATIONS

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. This is a mandatory form which must accompany a completed application and supplemental claim information form.
3. PLEASE READ THE STATEMENTS AT THE END OF THIS APPLICATION CAREFULLY.

(PLEASE TYPE OR PRINT IN INK)

1. NAME OF APPLICANT

_____

2. APPLICANT HISTORY

a. Are you aware of any act, error, omission or circumstance which could result in a malpractice claim or suit being made against you? ....[ ] Yes [ ] No

If Yes, has this been reported to a prior carrier? ....[ ] Yes [ ] No

SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such medical incident or threat of claim; have you attached the completed form? ....[ ] Yes [ ] No

b. To the best of your knowledge, have any of the following adverse results occurred in your practice in the last (5) years:

(i) Unexpected death (including stillbirths)? ....[ ] Yes [ ] No

(ii) Unexpected organ failure or significant neurological or functional deficit? ....[ ] Yes [ ] No

(iii) Failure to diagnose cancer or infection resulting in death or disability of patient? ....[ ] Yes [ ] No

(iv) Tear or perforation of an organ or body part during an invasive procedure, or unplanned removal of a normal organ or body part during an operative procedure? ....[ ] Yes [ ] No

(v) Suspicious or positive x-ray, Pap smear or mammogram where patient was not contacted? ....[ ] Yes [ ] No

(vi) Follow-up/emergency surgery, myocardial infarction or cerebral vascular accident within **48 hours** of your previous diagnostic treatment or surgery? ....[ ] Yes [ ] No

(vii) Complications from improper medication or improper dosage? ....[ ] Yes [ ] No

(viii) Pathological and/or operative report which do not match? ....[ ] Yes [ ] No

If yes to any of the above, has it been reported to a prior carrier? ....[ ] Yes [ ] No

If you have NOT reported to a prior carrier, please attach an explanation.

SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result; have you attached the completed form? ....[ ] Yes [ ] No

c. Has any attorney contacted you (e.g., request for medical records) in connection with any patient that has NOT been disclosed to us? ....[ ] Yes [ ] No

If yes, **SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result**; have you attached the completed form? ....[ ] Yes [ ] No

d. Does your current professional liability carrier require reporting of an incident or request for records by a patient or attorney? ....[ ] Yes [ ] No

e. Has any prior professional liability carrier refused coverage for, or declined to accept your report of, a medical incident, threat of claim, adverse result or attorney contact? ....[ ] Yes [ ] No

If yes, please attach an explanation.

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

_____ _____

Signature of Applicant Date

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