LABORATORY – APPLICATION

The Applicant represents that the statements and facts are true and no material facts have been suppressed or misstated. If a policy is issued, this Application will become part of the policy as if physically attached. 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 the applicant need more space for the applicant 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.

□ Current audited financial statements.

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

GENERAL/OVERVIEW INFORMATION

Applicant's Name:

Business Address:

Mailing Address:

Website:

Reporting/Fiscal Year Start Date:

Requested effective date: Retroactive date:

Current form of Insurance		Retro Date for Claims Made

Requested Form of Insurance:		Retro Date for Claims Made

Applicant is a:

Applicant operates:

Limits of Liability – Primary*

**Professional Liability and General Liability Limits must be the same, but apply separately*.

Deductible (*applies separately to Professional Liability and General Liability*)

Limits of Liability – Excess*

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**Professional Liability and General Liability Limits must be the same, but apply separately*.

List all subsidiaries, date acquired, and description of operations & ownership in percentages:

Subsidiaries	Date Acquired	Description of Operations	% Ownership

1. Professional Employees/Independent Contractors – List each physician providing services at the applicant's facility.

Medical Director - Name	Specialty	Insurance Carrier & Policy Number	Employee/ Contractor	Hours/Month
Other Physicians and PhD scientists - Names	Specialty	Insurance Carrier & Policy Number	Employee/ Contractor	Hours/Month

2. Other Health Care Professionals – Indicate the number in each category, full-time and part-time.

	Employees		Contractors	
	Full Time	Part Time	Full Time	Part Time
Technicians				
Technologists				
Cytotechnologists				
Other (define)				
Other (define))				
Totals				

HISTORICAL CARRIER INFORMATION

1) 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	Deductible/SIR	CM (w/ Retro) Or Occurrence	Retro Date if Claims Made

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PROFESSIONAL LIABILITY EXPOSURE INFORMATION

2) Indicate the total number of tests completed and revenues using the following Categories:

LAB1: Chemistry, Hematology, Endocrinology, Coagulation, Toxicology, Uninalysis, Imnunology, Parisitology
LAB2: Microbiology, Virology, Molecular Diagnostics
LAB3: Pathology, Cytology, Histology, Genetic & reproductive testing, Forensic Testing
Other: (give brief description)

Laboratory Category	Year Tests	Year Revenue	Current Year Tests	Current Year Revenue	Projected 12 Months Tests	Projected 12 Months Revenue
LAB 1						
LAB 2						
LAB 3						
Other						
Total						

Other Description:

3) Does the applicant do any of the following, if so list number of tests for the most recent year:

Total # of Tests	**Number of Tests Annually**
Pap Smear	
Surgical Biopsies	
Forensic Testing	
Reproductive Testing	
Paternity Testing	
Genetic Testing	

4) Does the applicant re-screen 100% of negative PAP smears?

If no, provide the % re-screened:

5) What is the applicant's daily workload limitation for each cytotechnologist interpreting PAP smears?

6) Are there any tests or services that the applicant's facility offered in the past 10 years but are no longer offering?
No If yes, give details.

7) Are there any new tests offered by the applicant's facility that began during the last 3 years?
If yes, give (a) type of test and (b) volume.

8) What percentage of the applicant's facility work is outsourced to other laboratories? %

List the other laboratories utilized:

Name	Location (City/State)	Services Performed	Hold-Harmless Agreement Submitted? Yes/No

9. If the applicant's facility contracts with couriers to pick up specimens, provide details.
10. If the applicant's staff transports specimens in facility owned vehicles provide details:
11. Does the applicant have an electronic tracking system for all specimens that are processed
12. If no, how are the specimens tracked?
13. If there any circumstances when test results are reported directly to the patient, provide details.

ACCREDITATION

14. Is this facility licensed by the state? If yes, list the state(s).
15. CLIA Certified? If yes, give date of last certification: CLIA #

    Has the applicant had any CLIA sanctions during the past year?
16. Accredited by College of American Pathologists?

    If yes, give date of last accreditation:
17. If the applicant is not CAP Accredited, is the applicant performing proficiency testing?

    If yes, provide the names of the agency providing samples for proficiency testing:
18. List other accreditation(s), if any:
19. List all associations that the applicant is a member of:

RISK MANAGEMENT/LOSS CONTROL

20. If the applicant's facility has a formalized Risk Management Program, who coordinates it?

    Name:

    Title: Phone Number:
21. If the applicant's facility owns any biomedical or other equipment used for diagnosis, monitoring or treatment, who is responsible for inspection and maintenance of the equipment?
22. Do qualified personnel inspect and maintain the equipment on a regular basis?
23. Are manufacturers recommendations followed for all maintenance and repair of equipment?
24. Does the applicant have any contractual agreements with independent contractors/providers to provide services at the applicant's facility?□ Yes □ No If yes, please provide a copy of a sample contract.
25. Are certificates of insurance obtained from all contracted providers?
26. If the applicant's facility provides service to others on a contractual agreement, please describe services provided and include a copy of the contract.
27. If the applicant's facility agrees to hold harmless or indemnify others under contract, describe and include a copy of the contract.
28. If the applicant provides preventive maintenance or repairs on medical equipment leased to others, please provide details.

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29. If the applicant sells, rents or leases any medical equipment or products to patients or others in connection with the applicant's operation, complete the following information:

Total Annual Sales: $

Total Annual Lease/Rental Receipts: $

Category I. EXPENDABLE ITEMS – Intended for one time usage and disposed (i.e. adhesive tape, bandages, or hypodermic needles, etc.)
Annual Sales: $

Category II. NON-EXPENDABLE ITEMS – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc. and prosthetic devices and I.V. stands including medical and surgical instruments unless considered diagnostic or treatment, etc.
Annual Sales: $ Annual Lease/Rental Receipts: $

Category III. DIAGNOSTIC OR TREATMENT DEVICES – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical monitoring functions. Also included are blood pressure gauges, I.V. pumps, portable EKG machines, or sending devices.
Annual Sales: $ Annual Lease/Rental Receipts: $

Category IV. LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES – This category includes dialysis or heart/lung machines, apnea monitors, SIDA monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.
Annual Sales: $ Annual Lease/Rental Receipts: $

If any of the products that the applicant distributes have ever been recalled, please provide details.

Please indicate all of the hiring/screening procedures used for professionals and paraprofessionals who provide patient care services at the applicant's facility:

Check of educational background, or residency program, when applicable.
Check of previous employers
Check of personal references
Check on hospital privileges for physicians, oral surgeons and dentists.
How often does the applicant update their list of specific privileges?
Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities.
Require information on any professional liability or work-related claim that has previously been made against any individual.

30. Does the applicant's facility have written job descriptions?

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COMMERCIAL GENERAL LIABILITY INFORMATION

31. Please provide physical plant information as requested (use additional sheet if necessary):

Address/Occupancy	Square Footage	Age	Type of Construction	# Floors	Type of Fire Protection*	Designed for Patient Care?	Designed for Overnight Guests?	Number of Exits per Floor

32. Please indicate any additional insureds to be included under the applicant facility's General Liability Coverage, including an explanation of their interest.

Name	Address	Interest

33. Do have a backup generator to prevent electricity outages while running laboratory tests?
34. Are the electrical, heating and plumbing systems up to code and regularly inspected?
35. Is the building completely sprinklered?
    If partially sprinklered, identify those areas that are sprinklered.
36. Are the fire alarms connected to a local fire station?

LOSS HISTORY

37. LOSS HISTORY – Submit company produced 5 year loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses).
38. If no claims have been reported to the applicant, then initial here:
39. Large Loss Description – On a separate sheet of paper list any liability claims or suits made or brought against the applicant's facility during the past five years for amounts incurred greater than $50,000. If no claims or suits greater than $50,000 then indicate:
40. Is the applicant aware of any circumstances, accidents or losses (occurring after the retroactive date) that have 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 below.

    Enter the most recent valuation date:

41. What company handles the claims?
42. Who values the claims?
43. Who sets the reserves?

UMBRELLA LIABILITY

44. List all Automobile Liability and Workers Compensation\Employer's Liability policies that the applicant is applying for excess/umbrella coverage:

Type of Insurance	Insurer	Policy Number	Effective Date	Expiration Date	Limits	Premium
Auto						
Workers Compensation						
Other						
Other						
Other						

45. Submit company produced 5 year Auto Liability loss history with clearly marked valuation date with breakdowns of incurred losses (including paid and reserves for indemnity and expenses), current status and an explanation for each loss (with detailed explanations for large losses). If no auto claims have been reported, initial here: _____

46. Please indicate the number of vehicles that the applicant owns or leases. If none, indicate "none."
If yes, indicate number of:

(a) Cars	
(b) Light Trucks	
(c) Vans/Buses	
(d) Other (describe):	

47. Does the applicant's auto liability policy include liability coverage for hired and non-owned autos?

If yes, please quantify: _____

_____

If applying for excess auto coverage, does the applicant have any vehicles garaged in any of the following states?

(a) Ohio	
(b) Florida	
(c) Louisiana	
(d) Indiana	
(e) Vermont	
(f) New Hampshire	

48. Did the applicant reject uninsured/underinsured motorist coverage in the above states?

Please include the following information with the completed application:

1. Previous Insurance Company loss runs for the past five years.
2. Current audited financial statement.
3. Brochures, pamphlets or other advertising material utilized by the applicant facility.
4. Copies of any inspection reports/surveys conducted by outside organizations within the past three years.
5. Copies of any contracts for professional services provided to the applicant facility or by the applicant facility.

THE UNDERSISGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. 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 IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

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

NOTICE TO ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES."

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

NOTICE TO FLORIDA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE."

NOTICE TO KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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."

NOTICE TO LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

NOTICE TO MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

NOTICE TO NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

NOTICE TO NEW YORK APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, CONCEALS FOR THE

PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

NOTICE TO OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

NOTICE TO OKLAHOMA APPLICANTS: "WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY" (365:15-1-10, 36 §3613.1).

NOTICE TO PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR 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 AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

NOTICE TO VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

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

APPLICANT

Name of Applicant: _____

Title: _____

Signature: _____

Date: _____

AGENT OR BROKER

Agency: _____
Name

_____
Address

_____

Agent: _____
Print Name

Signature: _____

Date: _____