APPLICATION FOR PARAMEDICS, EMT'S, 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 .... [ ] Yes [ ] No
detailed explanation of responsibilities and relationships to the entity which employs these individuals.

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.

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: