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 Underwriting Manager

- o DEERFIELD INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
- o MARKEL INSURANCE COMPANY



P.O. Box 768 Hendersonville, TN 37077  
 800-768-7475 Fax (615) 264-3980  
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**APPLICATION FOR CLINICS (MEDICAL, DENTAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER)  
 PROFESSIONAL LIABILITY INSURANCE**

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

**I. GENERAL INFORMATION**

1. (a) Full name of Applicant: \_\_\_\_\_
- (b) Principal practice address: \_\_\_\_\_  
 \_\_\_\_\_ (Street) \_\_\_\_\_ (County)  
 \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)
- (c) Location: Stand alone \_\_\_\_\_ Hospital \_\_\_\_\_ School \_\_\_\_\_ Correctional Facility \_\_\_\_\_ Other \_\_\_\_\_
- (d) (i) Phone: \_\_\_\_\_  
 (ii) E-Mail Address: \_\_\_\_\_ (iii) Website Address: \_\_\_\_\_
- (e) Date Established: \_\_\_\_\_  
 Attached a proforma business plan if the Applicant is newly established.

2. Applicant is a:
 

|  |   |
|--|---|
| <input type="checkbox"/> professional corporation  | <input type="checkbox"/> joint venture            |
| <input type="checkbox"/> limited liability company | <input type="checkbox"/> professional association |
| <input type="checkbox"/> other _____               | <input type="checkbox"/> partnership              |

3. Name(s) of all partners or members of the clinic who provide professional services: \_\_\_\_\_

4. Does any owner, partner or director operate or administer, wholly or in part, any hospital, nursing home or other institution where medical services are rendered? ..... [ ] Yes [ ] No  
 If Yes, provide details, including name, location, size and number of beds. \_\_\_\_\_

5. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No

- If Yes,
- (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... [ ] Yes [ ] No
  - (b) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_

Our Business Associate Agreement is available at [www.markelshand.com](http://www.markelshand.com). This is the only Business Associate Agreement we will recognize.

**II. OPERATIONS**

1. Days/hours of operation: \_\_\_\_\_
2. (a) Provide the name and specialty of the Applicant's Medical Director: \_\_\_\_\_  
 (b) Does the Applicant's Medical Director have direct patient contact? ..... [ ] Yes [ ] No  
 (c) Is the Applicant's Medical Director full-time or part-time? \_\_\_\_\_

3. Applicant's professional specialty: \_\_\_\_\_

4. Provide the percentage of patients/clients:

|                              |                                 |                        |
|------------------------------|---------------------------------|------------------------|
| Bariatrics _____%            | Holistic medicine _____%        | Sleep Disorders _____% |
| Communicable Disease _____%  | Obstetrical _____%              | Stress Testing _____%  |
| Correctional Medicine _____% | Oncology _____%                 | Students _____%        |
| Dental _____%                | Pain Management _____%          | Substance Abuse _____% |
| Disability Evaluation _____% | Pediatric _____%                | Surgical _____%        |
| Family Planning _____%       | Physical Rehabilitation _____%  | Urgent Care _____%     |
| Free Clinic _____%           | Psychiatric _____%              |                        |
| Hemodialysis _____%          | Research or Experimental _____% |                        |

5. List all Locations where Applicant is registered and licensed to operate:

Location 1: \_\_\_\_\_

Location 2: \_\_\_\_\_

Location 3: \_\_\_\_\_

Location 4: \_\_\_\_\_

6. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: \_\_\_\_\_

7. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered?..... [ ] Yes [ ] No  
If Yes, provide details. \_\_\_\_\_

8. List all accreditations and association memberships held by Applicant's facility and include a copy of the most recent report: \_\_\_\_\_

9. Does the Applicant participate in any state patient compensation fund? ..... [ ] Yes [ ] No

10. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")? ..... [ ] Yes [ ] No  
If Yes, what percentage of services are provided under the FTCA? \_\_\_\_\_

11. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.? ..... [ ] Yes [ ] No

12. Applicant's Gross Revenues:

|                             | <u>Last Twelve Months</u> | <u>Next Twelve Months</u> |
|-----------------------------|---------------------------|---------------------------|
| Fee for Service             | \$ _____                  | \$ _____                  |
| Medicare/Medicaid Funds     | \$ _____                  | \$ _____                  |
| Research                    | \$ _____                  | \$ _____                  |
| Other (describe)            | \$ _____                  | \$ _____                  |
| <b>TOTAL GROSS REVENUES</b> | <b>\$ _____</b>           | <b>\$ _____</b>           |

13. Number of outpatient/client visits:

|                      | <u>Last Twelve Months</u> | <u>Next Twelve Months</u> |
|----------------------|---------------------------|---------------------------|
| Clinics              | _____                     | _____                     |
| Laboratory           | _____                     | _____                     |
| X-ray/Imaging        | _____                     | _____                     |
| Pharmacy             | _____                     | _____                     |
| <b>TOTAL VISITS:</b> | <b>_____</b>              | <b>_____</b>              |

NOTE: If Applicant provided services for correctional facilities, provide number of inmates: \_\_\_\_\_

14. Does the Applicant maintain any beds for overnight occupancy:

(a) On the Applicant's premises? ..... [ ] Yes [ ] No

If Yes,

(i) No. of beds: \_\_\_\_\_

(ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

- (b) Off the Applicant's premises? ..... [ ] Yes [ ] No  
 If Yes,  
 (i) No. of beds: \_\_\_\_\_  
 (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

**III. STAFF**

1. Indicate the number of professional employees, independent contractors and volunteers. If None, state None.

|   | Employees |           | Independent Contractors |           | Volunteers |           |
|---|-----------|-----------|-------------------------|-----------|------------|-----------|
|   | Full-Time | Part-Time | Full-Time               | Part-Time | Full-Time  | Part-Time |
| Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures |           |           |                         |           |            |           |
| Physicians: Minor surgery or obstetrical procedures not constituting major surgery                |           |           |                         |           |            |           |
| Anesthesiologists   |           |           |                         |           |            |           |
| Obstetrics-Gynecologists  |           |           |                         |           |            |           |
| Oncologists   |           |           |                         |           |            |           |
| Ophthalmologists  |           |           |                         |           |            |           |
| Urologists  |           |           |                         |           |            |           |
| Dentists  |           |           |                         |           |            |           |
| Chiropractors   |           |           |                         |           |            |           |
| Nurse Anesthetists  |           |           |                         |           |            |           |
| Nurse Practitioners   |           |           |                         |           |            |           |
| Optometrists  |           |           |                         |           |            |           |
| Pharmacists   |           |           |                         |           |            |           |
| Physician Assistants  |           |           |                         |           |            |           |
| Podiatrists   |           |           |                         |           |            |           |
| Psychologists   |           |           |                         |           |            |           |
| RNs/LPNs/LVNs   |           |           |                         |           |            |           |
| Social Workers  |           |           |                         |           |            |           |
| Other(describe):  |           |           |                         |           |            |           |

NOTE: If the Applicant requires any of the above to be Insureds, submit a separate application for each such individual.

2. Are all of the above persons licensed in accordance with applicable state and federal regulation?..... [ ] Yes [ ] No  
 If No, attach explanation.
3. Do all professional staff maintain a Professional Liability Insurance Policy? ..... [ ] Yes [ ] No  
 If Yes, what are the minimum limits of liability that the Applicant requires?  
 \$ \_\_\_\_\_ each claim / \$ \_\_\_\_\_ aggregate

**IV. PROFESSIONAL SERVICES**

1. Does the Applicant's employees or independent contractors:
- (a) Perform any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? ..... [ ] Yes [ ] No  
 If Yes, list all minor/invasive procedures \_\_\_\_\_
- (b) Perform any anti-aging procedures, including Botox or other injectables? ..... [ ] Yes [ ] No  
 If Yes, complete a Supplement for Medical Spa/Anti-Aging Clinics (SM31001).

- (c) Perform abortions and/or menstrual extractions? ..... [ ] Yes [ ] No  
If the Applicant provides pregnancy termination complete a Supplement for Abortion Centers (SM31002)
  - (d) Perform any experimental procedures or research testing? ..... [ ] Yes [ ] No  
If Yes, are they FDA approved? ..... [ ] Yes [ ] No  
If No, attach a description.
  - (e) Perform any chelation therapy services? ..... [ ] Yes [ ] No  
If Yes, explain: \_\_\_\_\_
  - (f) Administer anesthesia other than topical or local infiltration? ..... [ ] Yes [ ] No  
If Yes, attach detailed explanation.
  - (g) Use drugs for weight reduction for 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.
  - (h) Administer any methadone treatment? ..... [ ] Yes [ ] No  
If Yes,
    - (i) Provide the number of treatments during the:  
Last 12 months \_\_\_\_\_ Next 12 months \_\_\_\_\_
    - (ii) Attach a description of treatment and controls used.
  - (i) Provide teleradiology services? ..... [ ] Yes [ ] No  
If Yes, provide description of services and for whom services are provided. \_\_\_\_\_
  - (j) Offer professional advice to the public via the internet, newspapers or broadcasts? ..... [ ] Yes [ ] No  
If Yes, provide details. \_\_\_\_\_
  - (k) Advertise professional services in any manner other than a simple listing in a telephone directory?  
..... [ ] Yes [ ] No  
If Yes, attach a copy of all advertisements.
2. Does the Applicant use a collection agency: ..... [ ] Yes [ ] No  
If Yes,
  - (i) Name of agency: \_\_\_\_\_
  - (ii) Does the agency have authority to file a collection suit on behalf of the Applicant? ..... [ ] Yes [ ] No

**V. CLAIMS AND HISTORY**

- 1. Has the Applicant or any of its employees ever:
  - (a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency? ..... [ ] Yes [ ] No
  - (b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses? ..... [ ] Yes [ ] No  
If Yes, provide details. \_\_\_\_\_
  - (c) Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders? ..... [ ] Yes [ ] No  
If Yes, provide details. \_\_\_\_\_
  - (d) Had any professional license or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license? ..... [ ] Yes [ ] No  
If Yes, provide details. \_\_\_\_\_
- 2. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance? ..... [ ] Yes [ ] No  
If Yes, how many? \_\_\_\_\_
- 3. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? ..... [ ] Yes [ ] No  
If Yes, explain. \_\_\_\_\_
- 4. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?.. [ ] Yes [ ] No  
If Yes, how many? \_\_\_\_\_

5. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years?..... Yes [ ] No [ ]  
 If Yes, attach a copy of such insurer's notice.

6. List prior Professional Liability Insurance for each of the last five (5) years, including the current year:  
 If None, check here. [ ]

| Ins Company | Limits of Liability | Premium | Eff./Exp. Dates | Claims Made or Occurrence Form | Retroactive Date |
|-------------|---------------------|---------|-----------------|--------------------------------|------------------|
|             |                     |         |                 |                                |                  |
|             |                     |         |                 |                                |                  |
|             |                     |         |                 |                                |                  |
|             |                     |         |                 |                                |                  |

7. List prior General Liability Insurance for each of the last five (5) years, including the current year:

| Ins Company | Limits of Liability | Premium | Eff./Exp. Dates | Claims Made or Occurrence Form | Retroactive Date |
|-------------|---------------------|---------|-----------------|--------------------------------|------------------|
|             |                     |         |                 |                                |                  |
|             |                     |         |                 |                                |                  |
|             |                     |         |                 |                                |                  |
|             |                     |         |                 |                                |                  |

**VI. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)**

1. Complete the following for each of the Applicant's facilities:

| Location Number | Name of Facility | Address | Description of Facility | Does the Applicant Maintain a Garage? (Yes/No) | Is There an Adjacent Exposure? (Yes/No) |
|-----------------|------------------|---------|-------------------------|--|---|
| 1               |                  |         |                         |  |   |
| 2               |                  |         |                         |  |   |
| 3               |                  |         |                         |  |   |

2. Complete the following for each of the Applicant's locations:

|   | Location 1 | Location 2 | Location 3 | Location 4 |
|---|------------|------------|------------|------------|
| Square Footage*                               |            |            |            |            |
| Year Built                                    |            |            |            |            |
| Year Remodeled                                |            |            |            |            |
| Number of Stories                             |            |            |            |            |
| Type of Construction (frame, brick, concrete) |            |            |            |            |
| Percentage of Building Occupied by Applicant  |            |            |            |            |
| Other occupants? (Yes/No)                     |            |            |            |            |

\*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:

- (a) Complete Sprinkler System? ..... [ ] Yes [ ] No
- (b) At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
- (c) Self-closing fire doors on each floor? ..... [ ] Yes [ ] No

- (d) Automatic fire alarm system connected to a local fire department?..... [ ] Yes [ ] No
- (e) Smoke detectors?..... [ ] Yes [ ] No
- (f) Emergency electrical system?..... [ ] Yes [ ] No
- (g) Heat sensors?..... [ ] Yes [ ] No
- (h) Fire escape(s)?..... [ ] Yes [ ] No
- (i) Posted emergency evacuation procedures?..... [ ] Yes [ ] No
- (j) Properly maintained fire extinguishers?..... [ ] Yes [ ] No

If any of the above are answered No, provide details by attachment.

- 4. Does the Applicant have a written safety program in place?..... [ ] Yes [ ] No  
If Yes, attach a copy of the written safety program.
- 5. Does the Applicant have written procedures for incident reporting?..... [ ] Yes [ ] No
- 6. Do any of the Applicant's locations have any:
  - (a) Exposure to flammables, explosive, chemicals?..... [ ] Yes [ ] No
  - (b) Catastrophe exposure?..... [ ] Yes [ ] No
  - (c) Exposure to radioactive materials?..... [ ] Yes [ ] No
- 7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials?..... [ ] Yes [ ] No
- 8. Does the Applicant sell or lease any medical equipment or products to patients/clients or others in connection with Applicant's operation?..... [ ] Yes [ ] No  
If Yes, Total Annual Sales \$ \_\_\_\_\_  
Total Annual/Lease Rental Receipts \$ \_\_\_\_\_
- 9. Does the Applicant:
  - (a) Loan or rent machinery or equipment to others?..... [ ] Yes [ ] No
  - (b) Own any elevators or escalators?..... [ ] Yes [ ] No
  - (c) Own or rent any parking facility?..... [ ] Yes [ ] No
  - (d) Provide any recreational facility?..... [ ] Yes [ ] No
  - (e) Have a swimming pool on the premises?..... [ ] Yes [ ] No
  - (f) Sponsor any sporting or social events?..... [ ] Yes [ ] No
- 10. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance?..... [ ] Yes [ ] No

If Yes, answer the following:

Provide three year loss history for claims under \$100,000 Loss and Expense and ten years for claims \$100,000 and greater. Attach further sheets if needed.

| Date of Occurrence | Date Claim Made | Description of Loss | Amount of Loss Reserved and Paid | Amount of Expenses Reserved and Paid | Open (O) or Closed (C) |
|--------------------|-----------------|---------------------|----------------------------------|--------------------------------------|------------------------|
|                    |                 |                     |                                  |                                      |                        |
|                    |                 |                     |                                  |                                      |                        |
|                    |                 |                     |                                  |                                      |                        |

- 11. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance?..... [ ] Yes [ ] No  
If Yes, provide details for each incident. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VII. ADDITIONAL INFORMATION**

- As part of this Application attach the following:
- 1. A CV of Medical Director including specialty and board certification.
  - 2. Five (5) years of currently valued Professional Liability Insurance and General Liability Insurance claim runs from current and prior insurers or complete a Supplemental Claim Information form (SM6236) for each claim.
  - 3. A list of any activities or procedures performed that are not otherwise described in this Application.





**MARKEL SHAND, 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 Markel 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: