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 Underwriting Manager

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
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**SUPPLEMENT FOR MEDICAL SPA/ANTI-AGING CLINICS
 (USE WITH APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.)
 PROFESSIONAL LIABILITY INSURANCE (SM-30006))**

All questions MUST be completed in full.

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

I. GENERAL INFORMATION

1. Full name of Applicant: _____

II. OPERATIONS

1. What is the professional specialty of the clinic? _____

2. (a) Provide a list of the Applicant's Medical Director(s): _____

(b) Attach a CV for each of the Applicant's Medical Directors and a description of their duties.

3. Provide the percentage of the Applicant's patients/clients in the following categories:

(a) Acupuncture	_____%	Plastic Surgery	_____%
Beauty Shop (nails, hair, facials)	_____%	Research or Experimental	_____%
Chelation Therapy	_____%	Sclerotherapy	_____%
Dental	_____%	Surgical	_____%
Dermatology	_____%	Weight Control	_____%
Hormone Therapy	_____%	Other (specify)	_____%
Massage	_____%		
Medical Spa	_____%	TOTAL	100%

4. Applicant's practice is run by:

- | | | |
|-------------------|---------------------|----------------------|
| ___ Doctor | ___ Plastic Surgeon | ___ Other – describe |
| ___ Dentist | ___ Nurse | _____ |
| ___ Dermatologist | ___ Administrator | |

III. PROFESSIONAL SERVICES

1. List all manufactured equipment and drugs used in the Applicant's practice and the purpose for which each is used. Attach separate sheet if necessary:

Equipment/Drug	Purpose	Used only as approved by the FDA? (Yes or No)	If No, describe off-label usage.

2. Does the Applicant take before and after pictures of every patient?[] Yes [] No
 If No, explain. _____

3. Must all clients sign a patient consent form specific to the procedures to be performed prior to treatment?[] Yes [] No
 If No, explain. _____

IV. PROCEDURES

1. Botox Injections

Does the Applicant perform Botox Injections?[] Yes [] No

If Yes, complete the following:

(a) Total number of Botox Injections: (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Botox Injections?.....

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(c) Have all staff performing Botox Injections:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?.....[] Yes [] No

(ii) Performed a minimum of ten procedures on live patients?.....[] Yes [] No

(d) Does the Applicant have a physician available for consultation and complications?[] Yes [] No

If Yes,

(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?.....[] Yes [] No

(ii) Does the physician have Medical Malpractice Liability Insurance for this activity?[] Yes [] No

If No, submit a separate application for each physician to be included.

2. Chemical Peels

Does the Applicant perform Chemical Peels?[] Yes [] No

If Yes, complete the following:

(a) Total number of Chemical Peels with solution strength <30%: . (i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength <30%:

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(ii) Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours training specifically for this procedure including anatomy, physiology, skin typing, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?[] Yes [] No

(b) Total number of Chemical Peels with solution strength >30%: . (i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength >30%:

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(ii) Are all staff performing Chemical Peels with solution strength >30% licensed physicians with a specialty of Dermatology or Plastic Surgery?[] Yes [] No

3. Dermal Fillers

Does the Applicant perform Dermal Fillers (Artefill, Collagen, Hylaform, Restylane)?[] Yes [] No

If Yes, complete the following:

(a) Total number of Dermal Fillers: (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Dermal Fillers?

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(c) Have all staff performing Dermal Fillers:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?[] Yes [] No

(ii) Performed a minimum of five procedures on live patients?[] Yes [] No

Dermal Fillers continued

- (d) Does the Applicant have a physician available for consultation and complications?[Yes [No
If Yes,
(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?[Yes [No
(ii) Does this physician have Medical Malpractice Liability Insurance for this activity?[Yes [No
If No, submit a separate application for each physician to be included.
- (e) Does the Applicant
(i) Use only dermal fillers approved by the FDA?[Yes [No
If No, explain: _____
(ii) Disclose off-label use to all patients receiving such treatment on the patient consent form?[Yes [No

4. Laser Skin Treatments

Does the Applicant perform Laser Skin Treatments including Laser Hair Removal, IPL (Intense Pulse Light Treatments), Acne Blue Light Treatments, and Laser Vein Treatments?[Yes [No
If Yes, complete the following:

- (a) Total number of Laser Skin Treatments: (i) Past 12 months: _____ (ii) Next 12 months: _____
- (b) Who performs Laser Skin Treatments Injections?
_____ Physician _____ Physician's Assistant _____ Nurse
_____ Dentist _____ Nurse Practitioner _____ Other-describe: _____
- (c) Does the Applicant comply with the following standards of practice:
(i) Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient.....[Yes [No
(ii) Prior to the initiation of any patient care activity the individual has read and sign the clinic's policies and procedures regarding the safe use of lasers.[Yes [No
(iii) Continuing education of all licensed medical professionals is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.)[Yes [No
(iv) A minimum of ten procedures of precepted training is required for each laser procedure and laser type to assess competency. Participation in all training programs, acquisition of new skills and number of hours spent in maintaining proficiency is well documented.[Yes [No
(v) After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician.[Yes [No
- (d) Does the Applicant comply with the following standards of practice for non-physicians use of laser related technology:
(i) Any physician who delegates a procedure to a non-physician must be qualified to do these laser procedures themselves by virtue of having received appropriate training in physics, safety, surgical techniques, pre and post operative care, and be able to handle the resultant emergencies or sequela.[Yes [No
(ii) Any licensed medical professional employed by a physician to perform a procedure has received appropriate documented training and education in the safe and effective use of each system and are a licensed medical professional in the state of practice.....[Yes [No
(iii) A properly trained and licensed medical professional carries out these specifically designed procedures only under the direct, on-site physician supervision and following written procedures.[Yes [No
(iv) The supervising physician is available on-site to respond to any untoward event that may occur. Ultimate responsibility lies with the supervising physician.[Yes [No

5. Massage Therapy/Cellulite Treatments

Does the Applicant perform Massage Therapy/Cellulite Treatments?[Yes [No
If Yes, complete the following:

- (a) Total number of Massage Therapy / Cellulite Treatments: (i) Past 12 months: _____ (ii) Next 12 months: _____
- (b) Who performs Massage Therapy / Cellulite Treatments?
_____ Physician _____ Physician's Assistant _____ Nurse
_____ Massage Therapist _____ Nurse Practitioner _____ Other-describe: _____

Massage Therapy/Cellulite Treatments continued

(c) Are all staff performing Massage Therapy / Cellulite Treatments licensed, registered or certified according to state requirements?[] Yes [] No
If No, explain: _____

6. Mesotherapy and/or Lipodissolve

Does the Applicant perform Mesotherapy and/or Lipodissolve at this clinic?[] Yes [] No
If Yes, complete the following:

(a) Total number of Mesotherapy/Lipodissolve Treatments: (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Mesotherapy/Lipodissolve at this clinic?

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(c) Are all staff performing Mesotherapy and/or Lipodissolve licensed physicians with a minimum of eight hours training to perform Mesotherapy and/or Lipodissolve including anatomy, physiology, contraindications, potential complications, and performance of at least one procedure on each part of the anatomy for which coverage is desired?[] Yes [] No

7. Microdermabrasions

Does the Applicant perform Microdermabrasions?[] Yes [] No
If Yes, complete the following:

(a) Total number of Microdermabrasions: (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Microdermabrasion:

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(c) Have all staff performing Microdermabrasion treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient?[] Yes [] No
If No, explain: _____

8. Micropigmentation / Permanent Makeup

Does Applicant perform Micropigmentation / Permanent Makeup?[] Yes [] No
If Yes, complete the following:

(a) Total number of Permanent Makeup / Micropigmentations: ... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Permanent Makeup / Micropigmentations:

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(c) Have all staff performing Permanent Makeup / Micropigmentation treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient?[] Yes [] No
If No, explain: _____

9. Sclerotherapy Injections

Does the Applicant perform Sclerotherapy Injections?[] Yes [] No
If Yes, complete the following:

(a) Total number of Sclerotherapy Injections: (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Sclerotherapy Injections?

____ Physician ____ Physician's Assistant ____ Nurse
____ Dentist ____ Nurse Practitioner ____ Other-describe: _____

(c) Are all staff performing Sclerotherapy Injections physicians who have received a minimum of eight hours training specific for this procedure, including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of a minimum of one procedure on a live patient?[] Yes [] No

10. Tattoo Removals

Does the Applicant perform Tattoo Removals?[] Yes [] No

If Yes, complete the following:

(a) Total number of Tattoo Removals: (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Tattoo Removal:

- Physician Physician's Assistant Nurse
- Dentist Nurse Practitioner Other-describe: _____

(c) Are all staff performing Tattoo Removal licensed physicians who comply with the following standards of practice:

- (i) Physicians are trained appropriately in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient.[] Yes [] No
- (ii) Prior to the initiation of any patient care activity the physician has read and signed the clinic's policies and procedures regarding the safe use of lasers.....[] Yes [] No
- (iii) Continuing education of all physicians is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.)[] Yes [] No

11. Surgical or Minor Surgical / Invasive Procedures

Does the Applicant perform surgical or minor surgical/invasive procedures?[] Yes [] No

If Yes, complete the following:

(a) Total number of surgical procedures: (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs surgical and/or minor surgical/invasive procedures?

(c) Provide a complete list of all surgical and minor surgical/invasive procedures being performed:
Attach a separate sheet if necessary.

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

- 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 <u>Volunteers</u>	Independent <u>Contractors</u>		Employees and <u>Volunteers</u>	Independent <u>Contractors</u>
(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, Ophthalmologists and Urologists	_____	_____	(xiii) Unlicensed Interns	_____	_____
(iv) General Surgeons, Cardia Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____	(xiv) Dentists (no oral surgery)	_____	_____
(v) Obstetrics-Gynecologists,	_____	_____	(xv) Orthodontists	_____	_____

Plastic Surgeons, and
Otolaryngologists doing
plastic surgery

	Employees and <u>Volunteers</u>	Independent <u>Contractors</u>		Employees and <u>Volunteers</u>	Independent <u>Contractors</u>
(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.

<u>Number</u>	<u>Type of Profession</u>	<u>Number</u>	<u>Type of Profession</u>
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technician	_____	_____

5. REVENUES

- a. Please state sources and amounts of total revenue:

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

- b. Please provide number of outpatient visits:

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

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

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

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.

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

* 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.

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: