MARKEL

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

BSR
PO Box 768 · Hendersonville, TN 37075
(T) 800-768-7475 · (F) 615-264-3980
www.bsrins.com

SUPPLEMENT FOR HOME HEALTH CARE, NURSE REGISTRY, INFUSION THERAPY OR OTHER MEDICAL STAFFING FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS

All questions MUST be completed in full.

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

1. Full name of Applicant: _____

2. Type of Firm (check all that apply): _____ Home Health Care _____ Infusion Therapy _____ Visiting Nurse Agency _____ Nurse Registry _____ Other Medical Staffing (specify) _____

3. Date Established: _____

4. Location(s) where services are provided (total must equal 100%):
_____%Home _____%Hospice _____%Nursing Home _____%Assisted Living Facility _____%Hospital
_____%Clinic/Doctor's Office _____%Adult Day Care _____% Other Facility (specify)_____

5. Employees/Independent Contractors – Annual Staffing:

Type of Employee/Independent Contractor	No. Full-Time	No. Part-Time	Billable Hours Per Year
Employed Registered Nurse			
Contracted Registered Nurse			
Employed Licensed Practical Nurse			
Contracted Licensed Practical Nurse			
Employed Certified Nurse Assistant			
Contracted Certified Nurse Assistant			
Employed Nurse Practitioner/Physician Assistant			
Contracted Nurse Practitioner/Physician Assistant			
Employed Companion/Home Health Aide			
Contracted Companion/Home Health Aide			
Employed Social Worker			
Contracted Social Worker			
Employed Physical Therapist			
Contracted Physical Therapist			
Employed Other Medical (specify) _____			
Contracted Other Medical (specify) _____			

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 the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

_____ _____
Name of Applicant Title

_____ _____
Signature of Applicant Date

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APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS FOR 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 (include professional degree if applicant is an individual): _____

_____

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

_____
(City) (State) (Zip)

Please attach a list of additional office addresses.

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

d. Business Phone: (____) _____ Home Phone: (____) _____

e. Date of Birth:_____ Place of Birth: _____

Are you a U.S. citizen? [ ] Yes [ ] No. If No, your status, date of entry into USA: _____

f. Square feet of total office space (all locations): _____

g. Your practice:

[ ] Solo practitioner (unincorporated) [ ] Professional corporation (for profit)
[ ] Solo practitioner (incorporated) [ ] Professional corporation (non-profit)
[ ] Partnership [ ] Employee of _____
[ ] Professional Association (Give name of employer)
[ ] Other (please describe)_____

h. Formal business, corporate or partnership name:

i. Please list the names of all partners or members of your professional association/corporation who provide professional services: _____

_____

j. Please attach a copy of your letterhead.

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.markelcorp.com. This is the only Business Associate Agreement we will recognize.

2. EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

(i) Where have you practiced your profession during the last ten years?

In _____ From _____ To_____

In _____ From _____ To_____

In _____ From _____ To_____

(ii) Have you ever failed any professional licensing or specialty organization examination? .....[ ] Yes [ ] No
If yes, please attach a detailed explanation including the dates and location.

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

_____

b. Please indicate your professional specialty (CHECK ONE):

[ ] Chiropractor	[ ] Naprapath	[ ] Pharmacist
[ ] Counselor (Describe)	[ ] Nurse, Licensed Practical	[ ] Physical Therapist
_____	[ ] Nurse, Registered	[ ] Psychologist
[ ] Dental Hygienist	[ ] Nurses Registry	[ ] Social Worker
[ ] Hearing Aid Fitter	[ ] Occupational Therapist	[ ] Speech Therapist
[ ] Home Health Care Agcy.	[ ] Optician	[ ] Veterinarian
[ ] Inhalation Therapist	[ ] Optometrist	[ ] Visiting Nurse Assoc.
[ ] Laboratory Technician	[ ] Orthotist	[ ] X-ray Technician
[ ] Medical Personnel Pool	[ ] Perfusionist	[ ] Other (Specify) _____

c. Please indicate the sources and amounts of actual and projected revenue:

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

d. Please provide the number of patient or client visits:

Type of Visit	Number of Visits Last 12 Months	Number of Visits Next 12 Months
Clinic	_____	_____
Laboratory	_____	_____
Other (specify)_____	_____	_____
TOTAL NUMBER OF VISITS	_____	_____

e. Please specify any professional societies or associations in which you are a member: _____

_____

f. Are you associated with or do you work for a physician or surgeon?.....[ ] Yes [ ] No
If yes, please give the name and the specialty of the physician: _____

g. Please give the approximate percentage of time spent in the following work locations:

_____% Administrative Office	_____% Laboratory	_____% Hospital Ward (specify)
_____% Classroom	_____% Operating Room	_____
_____% Emergency Dept of Hospital	_____% Outpatient Clinic	_____% Professional Office (specify profession)
_____% Nursing Home	_____% Patient's Home	_____
_____% Other (specify) _____		

h. 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	_____% _____

i. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

Type of Profession	No.	Type of Profession	No.
Inhalation Therapists	_____	Opticians	_____
Laboratory Technicians	_____	Optometrists	_____
Nurse Anesthetists	_____	Perfusionists	_____
Nurses, Licensed Practical	_____	Pharmacists	_____
Nurse Practitioner	_____	Physiotherapists	_____
Nurses, Registered	_____	Social Workers	_____
Speech Therapists	_____	Other (please specify)	_____

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

4. APPLICANT PROCEDURES

a. Do you render professional services directly to patients? [ ] Yes [ ] No. If yes, please describe in detail and indicate the extent of supervision by others.

Description of Professional Services	**Percent of Time Supervised**	**Qualifications 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. (i) Do you perform or assist in any surgical procedures? [ ] Yes [ ] No

(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.

d. Do you perform radiation therapy?..... [ ] Yes [ ] No

e. Do you perform psychiatric shock therapy? ..... [ ] Yes [ ] No

f. Do you compound in bulk, manufacture or wholesale medicine?..... [ ] Yes [ ] No
If yes, please provide a detailed explanation. _____

g. (i) Do you perform veterinary services? ..... [ ] Yes [ ] No

If yes, please indicate the approximate division of your work among the following categories.

_____ % Greyhounds _____ % Thoroughbreds

_____ % Animals valued over $5,000.

Please attach an explanation including the frequency and the type(s) of animals treated.

h. Do you administer artificial insemination? ..... [ ] Yes [ ] No

If yes, please answer the following questions:

(i) What type(s) of animals are involved? _____

(ii) Are you responsible for the storage of the semen? ..... [ ] Yes [ ] No

If yes, please explain. _____

_____

(iii) What percent of your practice is involved with artificial insemination? _____ %

i. Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action? ..... [ ] Yes [ ] No

If yes, please attach a detailed explanation.

5. PERSONNEL

a. Please list the number and type of independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.

No.	Type of Profession	No.	Type of Profession	No.	Type of Profession
_____	Inhalation Therapists	_____	Laboratory Technicians	_____	Nurse Anesthetists
_____	Nurses, Licensed Practical	_____	Nurse Practitioner	_____	Nurse, Registered
_____	Opticians	_____	Optometrists	_____	Perfusionists
_____	Pharmacists	_____	Physiotherapists	_____	Social Workers
_____	Speech Therapists	_____	Other (specify)_____		

b. Do you supervise any individuals who are not your own employees? [ ] Yes [ ] No. If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

c. Please indicate by profession the number of individuals you supervise.

No.	Type of Profession	No.	Type of Profession
____	Physicians	____	Laboratory technicians
____	X-ray technicians	____	Other (please specify):_____

6. APPLICANT AFFILIATIONS

a. Do you own or operate any business other than that shown in Question 1(a) above? ..... [ ] Yes [ ] No

If yes, please give details on a separate sheet.

b. Are you employed by any individual or entity other than that shown in Question 1(a) above? ..... [ ] Yes [ ] No

If yes, please attach an explanation describing details of your responsibilities.

c. 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 describing details of your responsibilities. If your contract contains a hold-harmless agreement, a copy of the contract must be attached.

d. Are you employed by or under contract to any government entity? ..... [ ] Yes [ ] No

If yes, please attach an explanation including the details of your responsibilities.

e. 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 your advertisements.

f. 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 a detailed explanation and a copy of ALL of your advertisements.

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

h. If you have a training school, please complete the following. Attach a separate sheet 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 (e.g. MD, RN, PhD, etc.)

i. (i) Do you use a collection agency? [ ] Yes [ ] No
If yes, please state the name of the agency

(ii) Does the agency have the authority to file a collection suit at its discretion? [ ] Yes [ ] No

7. APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

a. Have you or any of your employees:

(i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or 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 refuses 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 Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	Was this a Claims Made Policy Form? No	Retro Date
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	

c. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? [ ] Yes [ ] No

d. 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.

e. 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 a separate sheet.

* 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 the underwriting manager, Company and/or affiliates thereof.**

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.