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BSR
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APPLICATION FOR MICRO PIGMENT IMPLANTATION PROFESSIONAL LIABILITY INSURANCE
(Claims Made)

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)

1. APPLICANT INFORMATION

a. Full Name of Applicant: _____

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

_____
(City) (State) (Zip)

c. Business Phone: ( ) _____

c. Home Address: _____ Home Phone: ( ) _____

d. Number of Employees: Full time _____ Part time_____ Seasonal _____ Total _____

e. Date Established: _____

f. [ ] Sole Proprietor [ ] Corporation [ ] Partnership [ ] Professional Association
[ ] Employee of (specify) _____

2. BUSINESS OPERATIONS

a. The business, corporate or partnership name is: _____

b. Please list names of all partners/members of the firm who provide professional services: _____

_____

c. Annual number of client encounters: _____

d. Total Gross Revenues: This fiscal year: _____ Estimated next fiscal year: _____

If you answer Yes to any of questions (e) through (i) below, please attach a detailed explanation and copies of all pertinent advertisements.

e. Do you own or operate any business other than that shown in Question 2(a) above? [ ] Yes [ ] No

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

g. Are you under contract to any individual or entity? [ ] Yes [ ] No

h. Do you advertise professional services in any manner? [ ] Yes [ ] No

i. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? [ ] Yes [ ] No

j. Do you use a collection agency? [ ] Yes [ ] No
If Yes, please give name of agency: _____

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.

3. YOUR PRACTICE

a. In what states are you registered and licensed to practice? _____

_____

b. Where have you practiced your profession during the last 5 years? _____

_____

c. Detailed description of professional services: _____

d. Indicate professional societies or associations in which you are a member: _____

_____

e. Are you employed by, associated with or do you work for a physician or surgeon? [ ] Yes [ ] No
If Yes, give details including name and specialty of physicians you work for:

f. Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? [ ] Yes [ ] No
If Yes, please describe in detail: _____

_____

g. How are instruments/equipment sterilized? _____

_____

4. CLAIMS/HISTORY

If Yes to below, please attach details.

a. Has any claim or suit been brought against you? [ ] Yes [ ] No

b. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you? [ ] Yes [ ] No

c. Have you:

(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 failed any professional licensing or specialty examination? [ ] Yes [ ] No

d. List prior professional liability insurance carried for each of the past four years. If none, state NONE.

Policy Year	Insurance Company	Liability Limit	Premium	Deductible	Retro Date

e. Please describe your professional liability training and include a copy of your Certificate of Attendance and Diploma.

Institution Name: _____

Years of Training: _____

Certification Attained: _____

5. ADDITIONAL INFORMATION

Please attach copies of the following:

(i) Batch test consent forms.

(ii) Procedural consent forms.

(iii) Certificates of attendance/completion/graduation for all training programs.

(iv) Your business letterhead.

* 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 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.