



- o DEERFIELD INSURANCE COMPANY
- o ESSEX INSURANCE COMPANY
- o EVANSTON INSURANCE COMPANY
- o MARKEL AMERICAN INSURANCE COMPANY
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### SUPPLEMENT FOR POST MORTEM SERVICES

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. (a) Services provided by the Applicant and percentage of gross revenues derived:

		<b>Percentage</b>
(i) Embalming	[ ] Yes [ ] No	_____ %
(ii) Cremation	[ ] Yes [ ] No	_____ %
(iii) Funeral Director	[ ] Yes [ ] No	_____ %
(iv) Funeral Home	[ ] Yes [ ] No	_____ %
(v) Cemetery	[ ] Yes [ ] No	_____ %
(vi) Pre-Need Sales	[ ] Yes [ ] No	_____ %
(vi) Casket and Other Product Sales	[ ] Yes [ ] No	_____ %
(vii) Other (specify) _____		_____ %
TOTAL		100%

(b) If only embalming and cremation services are provided answer the following.

(i) Is the Applicant an owner of or an employee of a funeral home?..... [ ] Yes [ ] No  
 If Yes, provide the name of the funeral home and advise of the general and professional liability insurance and limits of liability they maintain.

\_\_\_\_\_  
 \_\_\_\_\_

(ii) Does the embalmer have a contract with any funeral home? ..... [ ] Yes [ ] No  
 If Yes, provide the name of the funeral home and advise of the general and professional liability insurance and limits of liability they maintain.

\_\_\_\_\_  
 \_\_\_\_\_

(c) If any pre-need sales are provided answer the following:

(i) Are pre-need sales insured? ..... [ ] Yes [ ] No

(ii) If No, provide complete details of how such sales are financed. \_\_\_\_\_

(iii) If Yes, provide the names of all insurance companies that insurance is placed with. \_\_\_\_\_

(iv) Attach a copy of the Applicant's insurance license(s).

3. Does the Applicant contract with any out of state funeral homes? ..... [ ] Yes [ ] No

If Yes, list the states. \_\_\_\_\_

4. Is the Applicant responsible for:

(a) picking up remains from hospitals, hospices or nursing homes?..... [ ] Yes [ ] No

(b) shipping remains out of state? ..... [ ] Yes [ ] No

(c) picking up remains from any means of transportation? ..... [ ] Yes [ ] No

5. Is the Applicant licensed in all states where services are performed?..... [ ] Yes [ ] No

6. Where are embalming services done:

(i) At the embalmer's own facility?

[ ] Yes [ ] No

**Percentage**

\_\_\_\_\_ %

(ii) At another location? (specify) \_\_\_\_\_

[ ] Yes [ ] No

\_\_\_\_\_ %

7. How many bodies are handled per year? \_\_\_\_\_

8. Describe the procedures that are used to ensure that bodies are given the arranged-for post mortem treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Attach a copy of the consent form used by the embalmer to obtain the family's permission to cremate remains (if applicable).

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

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date



**2. EDUCATION/EXPERIENCE (Individual Applicant Only)**

<u>Institution Name and Address</u>	<u>Years of Training</u>	<u>Degree or Certification Attained</u>
_____	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):

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

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

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

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

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

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.

<u>Type of Profession</u>	<u>No.</u>	<u>Type of Profession</u>	<u>No.</u>
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.

<u>Description of Professional Services</u>	<u>Percent of Time Supervised</u>	<u>Qualifications of Supervisor</u>
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____

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. 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.

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

<u>Policy 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>	
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____
_____	_____	_____	_____	_____	_____	_____	[ ]	[ ]	_____

- 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.