

WKF&C Professional
 One Huntington
 Quadrangle, Suite 4N-20
 Melville, NY 11747
 telephone: (631) 756-3000
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APPLICATION FOR ALLIED HEALTH PROFESSIONAL AND GENERAL LIABILITY INSURANCE

1. NAME OF APPLICANT: _____

2. MAILING ADDRESS: _____
 (If multiple name and locations, please attach list)

_____ PHONE NO. _____

3. a) DATE ESTABLISHED Corp. _____ Partnership Prof. Assoc. _____ Individual _____

b) In what states is the applicant registered and licensed to practice? _____

4. Is the firm engaged in, owned by, associated with or controlled by any other business? _____ if yes, give detail

5. State approximate division of applicant's patient among:

- | | | | |
|--------------------------------|------|-----------------------|------|
| a) Alcoholics | | k) Obstetrical | (%) |
| b) Counseling/ Family Planning | (%) | l) Pediatric | (%) |
| c) Communicable | (%) | m) Psychiatric | (%) |
| d) Dental | (%) | n) Research | (%) |
| e) Drug Addicts | (%) | o) Senile or Aged | (%) |
| f) General | (%) | p) Stress Testing | (%) |
| g) Hemodialysis | (%) | q) Surgical | (%) |
| h) Holistic medicine | (%) | r) Tubercular | (%) |
| i) Medical | (%) | s) Other _____ | (%) |
| j) Mentally Retarded | (%) | | |

6. a. List the number and type of applicant's employees and volunteers: If None, State None.

Number	Type of Profession		
a) _____	EMT's	j) _____	Paramedics
b) _____	Inhalation Therapists	k) _____	Perfusionists
c) _____	Laboratory Technicians	l) _____	Pharmacists
d) _____	Nurse Anesthetists	m) _____	Physicians - Minor Surgery
e) _____	Nurses, Licensed Practical	n) _____	Physicians - No Surgery
f) _____	Nurse Practitioner	o) _____	Physiotherapists
g) _____	Nurses Registered	p) _____	Social Workers
h) _____	Opticians	q) _____	Speech Therapists
i) _____	Optometrists	r) _____	Other

Handwritten signature and date:
 P.S.
 08.

b. List the number and type of independent contractors who provide professional services on behalf of the applicant. IF NONE, STATE NONE. _____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations _____ Yes _____ No If no, attach explanation.

7. PROFESSIONAL ACTIVITIES AND SPECIALTY

Please check all that apply:

GENERAL

- | | |
|--|--|
| _____ Acupuncture Clinic | _____ Mental Health Clinics |
| _____ Acupuncturist | _____ Mental Health Tech |
| _____ Adult Day Care | _____ Nurse |
| _____ Alcohol / Drug Rehab (Adults Only) | _____ Nurse Practitioner |
| _____ Ambulance Services (NON EMERG ONLY) | _____ Nurse Aide |
| _____ Artificial Limb Clinic | _____ Occupational Therapist |
| _____ Audiologist | _____ Occupational Therapist Assistant |
| _____ Case Management | _____ Ocularist |
| _____ Community Health Clinic (non-surgical) | _____ Oncology Treatment |
| _____ Consultant | _____ Optical - related establishments |
| _____ Counselor | _____ Optical Goods Stores |
| _____ Diagnostic Imaging / X-ray | _____ Optometrist |
| _____ Diagnostician | _____ Pastoral Counselor |
| _____ Dialysis Center - Hemo | _____ Pharmacy - non prescription |
| _____ Dialysis Center - In Home Peritoneal | _____ Pharmacy - prescription |
| _____ Dialysis Center - Peritoneal | _____ Phlebotomist |
| _____ Durable medical equipment - Sales | _____ Physical Therapy Assistant |
| _____ EMT | _____ Physical Therapy Clinic |
| _____ Halfway House | _____ Physician Assistant (no surgery exposures) |
| _____ Health and Fitness Center | _____ Physician Assistant (surgery exposures) |
| _____ Hearing Aid Fitter | _____ Pregnancy Center |
| _____ Home Health Agencies | _____ Psychiatric Social Worker |
| _____ Home Health Aide | _____ Psychologist |
| _____ Imaging Tech | _____ Radiation Therapy Technician |
| _____ LVN / LPN | _____ Respiratory Therapist |
| _____ Massage Therapist | _____ School for Handicapped |
| _____ Medical Clinic | _____ Sheltered Workshops |
| _____ Medical Clinic -LVN | _____ Speech Therapist |
| _____ Medical Clinic - Counseling | _____ Speech / Language Pathologist |
| _____ Medical Clinic - Nurse Practitioner | _____ Surgical Technician |
| _____ Medical Clinic - Physician | _____ Surgicenter |
| _____ Medical Clinic RN / PT | _____ Surgicenter - w/ Anesthe |
| _____ Medical Director | _____ Surgicenter - w/out Anesthe |
| _____ Medical Lab Tech | _____ Testing Services |
| _____ Medical Lab All Other | _____ Testing Services (specimen collection only) |
| _____ Medical Lab - DNA Testing | _____ Ultrasound Technician |
| _____ Medical Lab - Drug Testing | _____ Veterinarian |
| _____ Medical Lab - Fertility Testing | _____ X Ray Technician |
| _____ Medical Personnel Services - Home Health | |
| _____ Medical Personnel Services - Staff Relief | |

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MEDICAL SPA SPECIALTIES

- | | |
|--|---|
| _____ Laser / LED Treatments - Basic | _____ Laser Hair Stimulation |
| _____ Laser Hair Removal (skin types I -IV only) | _____ Tattoo Removal |
| _____ Professional Package - Veins | _____ Doctor Supervisors (Laser) |
| _____ Professional Package - Age Spots | _____ Doctor (Performing Laser Procedures) |
| _____ Professional Package - Rosaceas | _____ Sclerotherapy |
| _____ Professional Package - Wrinkle Reduction | _____ Medical strength peels (skin types I-IV only) |
| _____ Professional Package - Acne Treatment | _____ Facials / peels and microdermabrasion |
| _____ Mesotherapy | _____ Teeth Whitening |

8. ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the above employees:

- | | YES | NO |
|---|----------|-------|
| a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? | a) _____ | _____ |
| b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? | b) _____ | _____ |
| c) Ever been treated for alcoholism or drug addiction? | c) _____ | _____ |
| d) 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? | d) _____ | _____ |

9. Number of Ground Ambulances _____
 Number of Air Ambulances _____
 Radius of Services _____
 Number of Emergency Calls _____
 Number of Non-Emergency Calls _____

10. Does the applicant perform:

- | | YES | NO |
|---|----------|-------|
| a. Acupuncture or acupuncture anesthesia? Explain: _____ | a) _____ | _____ |
| b. Angiography / Arteriography/ Venography? Describe: _____ | b) _____ | _____ |
| c. Catherterization (other than urinary or umbilical)?
Describe procedure: _____ | c) _____ | _____ |
| d. Closed reduction of compound fractures and / or Normal Deliveries and/or Dermabrasion? | d) _____ | _____ |
| e. Injection of radioisotopes and / or use of irradiated substances?
Describe: _____ | e) _____ | _____ |
| f. Radiation Therapy and/or Chemotherapy? Describe: _____ | f) _____ | _____ |
| g. Psychiatric shock therapy? | g) _____ | _____ |
| h. Silicone injections/ Describe: _____ | h) _____ | _____ |
| i. Spinal Anesthesia (other than saddle blocks or caudals)? | i) _____ | _____ |
| j. Laser treatment? Describe: _____ | j) _____ | _____ |
| k. Botox injections | k) _____ | _____ |
| l. Chelation Therapy / Describe _____ | l) _____ | _____ |

11. Does the applicant perform any:

- | | | |
|--|----------|-------|
| a. Surgery other than incision of superficial boils or suturing superficial fascia? | a) _____ | _____ |
| b. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? | b) _____ | _____ |
| c. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections? | c) _____ | _____ |
| d. Cosmetic Plastic Surgery? Describe _____ | d) _____ | _____ |

- e. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? e) _____
- f. Hysterectomies? f) _____
- g. Open reduction of fractures? Describe: _____ g) _____
- h. Surgery for weight reduction of patients? h) _____
- i. Abortions and / or menstrual extractions? Describe (include trimester, method and number of abortions performed per month): i) _____
- j. Silicone Implants? Describe: _____ j) _____
- k. Sterilization Procedures? Describe: _____ k) _____
- l. Biopsies and/or endoscopies? List types performed: _____ l) _____
- m. Sex change operations? Describe and advise the number performed per year: _____ m) _____
- n. Other Surgery? Describe: _____ n) _____

12. Does the applicant perform hospital emergency room care?
 a) for its own regular patients? _____ \ b) for patients not its own? _____ Yes _____ No
 c) If answer to (b) is yes, please specify: the percentage of its time devoted to this work= _____% the number of hours per month devoted to this work= _____ hrs.

13. Does the applicant use drugs for weight reduction of patients? ___ Yes ___ No If yes, list drugs used and advise: Percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant. _____

14. Does the applicant administer any methadone treatment? _____ Yes _____ No If yes, please complete the methadone supplementary application.

15. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? _____ Yes _____ No If yes, attach detailed explanation

16. Does the applicant maintain any beds for overnight occupancy? _____ Yes _____ No, If yes, number of licensed beds by location: _____

17. State the number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. State by whom treatment is given and number of procedures: _____

18. Does the applicant own (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. _____

19. State sources and amounts of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
A. Charitable contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee for Services	\$ _____	\$ _____
D. _____	\$ _____	\$ _____
E. _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

20. Number of patient encounters last 12 months _____ and / or patient tests carried out _____
 (Note: "patient encounters" refers to number of visits - not number of patients.)

21. Number of estimated patient encounters next 12 months _____ and/or patient tests carried out _____
(Note: "patient encounters" refers to number of visits - not number of patients.)

22. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

23. Is the Applicant currently insured under a Commercial General Liability Policy? Yes _____ No _____ If yes, please give details:

Insurance Company	Type of Coverage	BI	PD	Limits	
				From	To
_____	_____	_____	_____	_____	_____

24. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present Partners ever been declined or has the insurance ever been cancelled or renewal refused? _____ Yes _____ No If yes, please give details : _____

25. Has any claim ever been made against the firm or any of its employees? Yes _____ No _____ If yes, please attach details stating: 1) date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition.

26. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? Yes _____ No _____ If yes, please give full details on the same basis as item 24.

27. Has any insurer cancelled or refused to renew any similar insurance during the past five years? _____

28. Limits of Liability requested _____ Deductible _____

29. Desired term of policy: From _____ To _____

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant:

Please Print Title

Signature:

Name Date

Name of Insurance
Agent or Broker

Please Print Title

Signature:

Name Date

[Handwritten signature]
8/08