

**ADMIRAL INSURANCE COMPANY**

1255 Caldwell Road  
Cherry Hill, NJ 08034  
Phone: 856-429-9200- Fax: 856-429-8611  
Internet: <http://www.admiralins.com>

**Medical Testing Laboratory  
PROFESSIONAL LIABILITY APPLICATION**

**NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTATION ONLY. NO COVERAGE WILL BE EFFECTED UNTIL RECEIPT OF WRITTEN INSTRUCTION AND PREMIUM PAYMENT. ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION (AND ATTACHMENTS HERETO) AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.**

**IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS-MADE BASIS. THE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR DEFENSE EXPENSES. AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE APPLICABLE DEDUCTIBLE AMOUNT.**

*All Questions must be fully completed. If there is insufficient space to complete an answer, continue on a separate sheet of the Applicant's letterhead. If a Question is not applicable, state "N.A."*

**SECTION I – GENERAL INFORMATION:**

1. **Full Name of Applicant (include ALL Firm names, trade names or dba's under which the Applicant operates, including subsidiaries):**

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

2. **Internet Address:** \_\_\_\_\_

3. **Address of Principal Office ( street, city, state, zip)**

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

4. **List all states in which Applicant operates:**

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

5. A) **Does the Applicant have any other office locations?**  YES  NO

If YES, list complete addresses on a separate sheet.

B) **Does Applicant have a location at a hospital or other medical premises?**  YES  NO

**If YES, does Applicant lease a distinct area?**  YES  NO

6 **Applicant is a:**  Individual  LLC  Corporation:  For profit  Non-profit  
 Partnership  Joint Venture **Other (specify):** \_\_\_\_\_

**Date Established:** \_\_\_\_\_ (mm/dd/yy)

7 **Has the name of the Applicant ever changed or has there been any acquisition, consolidation, dissolution, merger or any other change in business organization during the past five (5) years?**  YES  NO

**If YES, provide full particulars on a separate sheet, including all Firm names, in chronological order. Additionally, provide claims information (as per SECTION III) for all prior Firms.**

8. **During the coming twelve (12) months, does the Applicant contemplate offering any services not currently offered, or any mergers or acquisitions?**  YES  NO

**If YES, please explain:** \_\_\_\_\_

9. Professional Activities and Specialties (describe): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

10. State approximate % of gross income derived from the following (total should be 100%) :

- |                                       |                      |
|---------------------------------------|----------------------|
| _____ % Alcohol/Drug Testing          | _____ % HIV (AIDS)   |
| _____ % CT/CAT                        | _____ % Immunology   |
| _____ % Cytology                      | _____ % MRI/fMRI     |
| _____ % DNA                           | _____ % Occupational |
| _____ % Fertility/Pregnancy/Paternity | _____ % PET/SPECT    |
| _____ % Hematology                    | _____ % STDs         |
| _____ % Hepatitis                     | _____ % Sonography   |
| _____ % Histology                     | _____ % ultrasound   |
| _____ % other (describe) _____        | _____ % X-ray        |
| _____ % other (describe) _____        |                      |
| _____ % other (describe)- _____       |                      |

11. Does Applicant own (wholly or in part), operate, or administer any hospital, nursing home, assisted living facility or other institution where medical services are customarily rendered?  Yes  No  
 If Yes, please provide details by separate attachment.

12. State sources and amounts of TOTAL GROSS REVENUE/RECEIPTS:

SOURCE	This Year: _____	Last Year: _____
Charitable Contributions:	\$ _____	\$ _____
Government Funding:	\$ _____	\$ _____
Fee for Service:	\$ _____	\$ _____
_____	\$ _____	\$ _____
<b>TOTAL GROSS REVENUE:</b>	<b>\$ _____</b>	<b>\$ _____</b>

Estimate of Total Gross Revenue for Next Year: \$ \_\_\_\_\_

13. Staff:

	<i>Independent</i>	
	<i>Employees</i>	<i>Contractors</i>
A. Principals, Partners, Officers, Directors:	_____	_____
B. Registered Nurse:	_____	_____
C. LPN/LVN:	_____	_____
D. Nurse Anesth.:	_____	_____
E. Nurses Aides:	_____	_____
F. Certified Lab Tech./Technologist.:	_____	_____
G. Certified Medical Assistant :	_____	_____
H. EEG/EKG Tech./Technologist:	_____	_____
I. X-Ray Tech./Technologist:	_____	_____
J. Phlebotomist:	_____	_____
K. Medical Tech./Technologist:	_____	_____
L. Radiation Therapist:	_____	_____
M. Inhalation Therapist:	_____	_____
N. Physicians Assistant :	_____	_____
O. Social Worker	_____	_____
P. Clerical/Administrative	_____	_____
Q. : Other (specify): _____	_____	_____
<b>TOTAL STAFF:</b>	_____	_____

14. a) Are all above individuals licensed in accordance with all applicable state and federal regulations?  
 Yes  No If No, please attach explanation.
- b) Have any of the above individuals had their licenses/certifications revoked/suspended, voluntarily surrendered or cancelled?  Yes  No If YES, please attach explanation
- c) Do you require any above personnel to maintain their own professional liability coverage?  
 Yes  No If Yes please list individuals and required limits:

\_\_\_\_\_

\_\_\_\_\_

If No, is coverage requested for above individuals?  Yes  No

15. Please attach explanation for any of the questions below answered "YES" (include #tests/procedures & gross revenue):

- |   |  |
|---|--|
| a. Test result interpretation in applicant's (lab) name?      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Consultation in Applicant's (lab) name?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Therapy or any treatment procedures?                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Blood Banking or blood/tissue storage                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Procurement of blood or its components?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Plasmapheresis procedures?                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Medical, Genetic or Drug research?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. any type of environmental analysis?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Manufacture, testing or dispensing of pharmaceuticals?     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Manufacture or sell laboratory equipment or supplies?      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. experimental testing/procedures?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. solely mobile services?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. any services at malls/shopping centers, health fairs etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. Intravenous transfusions?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

16. What hours/days a week do you operate: \_\_\_\_\_

17. Does applicant utilize a procedural and quality control manual?  Yes  No  
 If Yes, does applicant make sure that all employees have reviewed these?  Yes  No

18. Is lab inspected/certified/accredited by any governmental or medical association?  Yes  No  
 If Yes, please list on separate attachment along the certifications/inspection dates.

19. Does applicant use a reference lab?  Yes  No  
 If Yes, please answer the following:
- |    |   |
|----|---|
| a. | What are the expected annual receipts for the reference lab? \$ _____   |
| b. | Name of reference lab: _____  |
| c. | Does reference lab hold applicant harmless? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| d. | Does applicant obtain written proof of insurance with minimum limit of \$1,000,000, for reference lab? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. | Does applicant require reference lab to name them as an additional insured and obtain proof of same? <input type="checkbox"/> Yes <input type="checkbox"/> No   |

20. Does applicant provide any service under contract?  Yes  No If Yes, please provide details or sample contract?

21. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant?  Yes  No "Financial relationship means all ownership or investment interests, compensation arrangements, medical directorships with applicant".

If Yes, please provide details, including name of physicians, financial relationship and type of

referral.

22. Attach a list of all physicians providing service at this entity (employed or contracted) and include:

NAME, SPECIALTY, SERVICES, %OF OWNERSHIP, BOARD CERTIFIED, INSURANCE

CARRIER/LIMITS/EXPIRATION DATE, if LAB is Listed AS ADDITIONAL INSURED.

23. Have any employed or contracted personnel been subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association?  Yes  No

24. Have any employed or contracted personnel been convicted of an act in violation of any law or ordinance other than a traffic accident?  Yes  No

25. Please list Professional Liability Policies covering applicant over the past 5 years:

<u>Carrier</u>	<u>Expiration Date</u>	<u>Limits</u>	<u>Deductible</u>	<u>Annual Premium</u>

If above policies were CLAIMS MADE please provide current RETROACTIVE DATE:)

26. Has any Professional or General Liability claim or suit been brought in the past 5 years against the applicant or any predecessor in interest?  Yes  No If Yes, please supply 5 years currently valued Carrier loss runs

27. Is the applicant aware of any circumstance, which may result in any claim against the applicant, or any predecessor in business or present Partner, Officer or Principal?  Yes  No If Yes, please provide details by separate attachment. Has applicant reported this circumstance/incident to their current carrier?  Yes  No

28. Has any application for Professional Liability Insurance made on behalf of the applicant or any predecessor in business or present Partner, Officer of Principal ever been declined or has the insurance been cancelled or renewal refused?  Yes  No If Yes, please provide details by attachment.

Please include along with this application any required attachments/questionnaires, copy of your brochure or advertisements and income statement & balance sheet for most currently completed fiscal year.

Limits of Liability requested: \_\_\_\_\_ Deductible: \_\_\_\_\_

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Signature of Applicant (Principal, Partner or Officer) \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

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**X-RAY/Nuclear Medicine QUESTIONNAIRE**

1. What testing substance are ingested or injected into the patients? \_\_\_\_\_  
\_\_\_\_\_
2. Is there a likelihood of adverse reaction to the substances used? \_\_\_\_\_  
\_\_\_\_\_
3. What emergency medical procedures have you established in the event of such reactions \_\_\_\_\_  
\_\_\_\_\_
4. Describe the system of delivery and disposal of radio-nuclides: \_\_\_\_\_  
\_\_\_\_\_
5. Indicate the frequency of testing of air and water discharge from the facility to ascertain federal standards of compliance: \_\_\_\_\_  
\_\_\_\_\_
6. What training is provided to your personnel? \_\_\_\_\_  
\_\_\_\_\_
7. Maintenance of equipment is provided by: In-house       Manufacturer/Distributor   
Contracted to outside firm   
Other (describe) \_\_\_\_\_
- How often is equipment serviced: monthly  quarterly  BI-annual  annually
8. Do you maintain records of your tests/procedures/scans?  Yes  No If Yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
9. Are all tests/procedures/scans done per a physician request?  Yes  No
10. What personnel perform the test/procedure/scan? \_\_\_\_\_  
Do procedures require two personnel to be with the patient at all times?  Yes  No
11. Who reports the interpretation of the test/procedure/scans etc.? \_\_\_\_\_
12. Are the x-rays/scans sent along with the report?  Yes  No
13. Are the x-rays/scans sent out under the name of the applicant or in the name of the Radiologist? \_\_\_\_\_
14. Number of annual patient contacts for all tests/scans/procedures/x-ray services: \_\_\_\_\_
15. Do employees wear nuclear sensitive badges which warn of potential nuclear problems? \_\_\_\_\_