POLICY NUMBER _____

COMPANY USE ONLY

MEDPRO RRG Risk Retention Group

IMAGING CENTER LIABILITY APPLICATION

I. ORGANIZATION INFORMATION

PLEASE PRINT LEGIBLY. IF THE APPLICATION IS APPROVED, THE POLICY WILL BE BASED ON THE INFORMATION PROVIDED. PLEASE ANSWER ALL QUESTIONS. IF A QUESTION IS NOT APPLICABLE, STATE "N/A". IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SUPPLEMENTAL FORM.

A.

_____

BROKERAGE FIRM/AGENCY NAME

_____

CITY, STATE, AND ZIP CODE

_____

BROKER/AGENT NAME

_____ - _____ - _____ _____ - _____ - _____ _____

PHONE **FAX** **E-MAIL**

B. CONTACT INFORMATION

_____

APPLICANT NAME (LEGAL CORPORATION NAME)

_____ _____

MAILING ADDRESS **COUNTY**

_____

STREET ADDRESS (IF DIFFERENT)

_____ _____

CONTACT PERSON NAME **TITLE**

_____ - _____ - _____ _____ - _____ - _____ _____ - _____ - _____

BUSINESS PHONE **BUSINESS FAX** **RESIDENCE PHONE**

_____

WEBSITE ADDRESS

C. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM): _____

This date cannot be earlier than the expiration date of your current policy.

D. REQUESTED COVERAGE EXPIRATION DATE (12:01 AM): _____

Annual policy terms will begin and end on the same month and day.

II. COVERAGES, LIMITS AND DEDUCTIBLES

COVERAGE (*)	REQUESTED LIMITS	POLICY TYPE	DEDUCTIBLE (PRIMARY COVERAGE)
☐ PROFESSIONAL LIABILITY FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ GENERAL LIABILITY FACILITY	$_____ PER EVENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ EXCESS - PROFESSIONAL LIABILITY - FACILITY	$_____ PER MEDICAL INCIDENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	
☐ EXCESS - GENERAL LIABILITY FACILITY	$_____ PER EVENT $_____ ANNUAL AGGREGATE	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____	

If requesting shared limit or separate limit coverage for employed or contracted Physicians, Surgeons, Residents, Interns, Fellows, Dentists, Oral Surgeons, CRNAs, Nurse Midwives, CRNPs, Podiatrists, Physician Assistants or Surgical Assistants, please complete Section III (Coverages, Limits And Deductibles Schedule) of the Imaging Center Supplemental Application.

(*) IF THERE ARE ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.), PLEASE COMPLETE SECTION II (SCHEDULE OF RELATED ENTITIES) OF THE IMAGING CENTER SUPPLEMENTAL APPLICATION OR ATTACH A COPY OF AN ORGANIZATIONAL CHART WHICH INCLUDES THE INFORMATION REQUESTED.

III. GENERAL INFORMATION

A. TYPE OF LEGAL ENTITY (Please put an "X" in the applicable spaces):

- ☐ Professional Corporation
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Corporation (LLC)
- ☐ Other (Please Explain): _____

B. ENTITY OWNERSHIP (Please put an "X" in the applicable spaces):

- ☐ Physician Owned
- ☐ Hospital Owned
- ☐ Independently Owned
- ☐ Other (Please Explain): _____

C. TAX STATUS (Please put an "X" in the applicable spaces):

- ☐ For Profit
- ☐ Not For Profit
- ☐ Other (Please Explain): _____

D. LICENSES HELD BY YOUR FACILITY: _____

E. CERTIFICATIONS/ACCREDITATIONS HELD BY YOUR FACILITY:

☐ CMS ☐ JCAHO ☐ AAAHC ☐ IAC ☐ ACR ☐ IMQ ☐ OTHER: _____

PLEASE PROVIDE A COPY OF CERTIFICATE/ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

F. HOW MANY IMAGING CENTER LOCATIONS DO YOU HAVE? _____

IF MULTIPLE LOCATIONS EXIST, ARE ALL LOCATIONS ACCREDITED/CERTIFIED? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE DETAILS: _____

_____

G. MEDICAL DIRECTOR:

_____
NAME OF MEDICAL DIRECTOR

_____ - _____ - _____ _____
PHONE NUMBER **EMAIL**

H. ANNUAL PAYROLL

TOTAL ANNUAL PAYROLL: _____ TOTAL PROJECTED ANNUAL RECEIPTS: _____

I. ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

IV. IMAGING CENTER OPERATIONS

A. INDICATE THE TOTAL NUMBER OF READS/SERVICES:

PERFORMED AT APPLICANT'S FACILITY DURING THE LAST 12 MONTHS: _____

EXPECTED TO BE PERFORMED AT APPLICANT'S FACILITY DURING THE NEXT 12 MONTHS: _____

B. INDICATE THE TYPES OF READS OR SERVICES PROVIDED:

UTILIZATION	CURRENT (LAST 12 MONTHS)		PROJECTED (NEXT 12 MONTHS)	
	READS/SERVICES	TOTAL REVENUE	READS/SERVICES	TOTAL REVENUE
GENERAL RADIOGRAPHY (X-RAY)				
COMPUTERIZED TOMOGRAPHY (CT)				
MAGNETIC RESONANCE IMAGING (MRI)				
POSITRON EMISSION TOMOGRAPHY (PET)				
MAMMOGRAPHY				
ULTRASOUND				
RADIATION ONCOLOGY / THERAPY				

C. ARE ANY CHANGES IN SERVICES PLANNED IN THE NEXT 12 MONTHS? ☐ YES ☐ NO
(i.e. ARE ANY SERVICES BEING DISCONTINUED OR ADDED?)
IF YES, PLEASE DESCRIBE: _____

D. HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS? ☐ YES ☐ NO
IF YES, PLEASE DESCRIBE: _____

E. DOES THE FACILITY PROVIDE? ☐ INITIAL READS ☐ OVER-READS / SECOND READS ☐ EXTERNAL PEER REVIEW SERVICES

F. WHAT TYPE OF CONTRAST MEDIA IS BEING ADMINISTERED?

☐ IONIC _____ % ☐ NON-IONIC _____ % ☐ LOW-OSMOLAR _____ % ☐ OTHER _____ / _____ %

G. ARE THERE PROTOCOLS FOR USE OF CONTRAST MEDIA? ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN: _____

H. IS A PHYSICIAN PRESENT DURING THE INJECTION OF CONTRAST MEDIA? ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN: _____

I. DOES THE FACILITY HAVE WRITTEN PROTOCOLS FOR HANDLING ALLERGIC REACTIONS INCLUDING CARDIAC OR RESPIRATORY ARREST? ☐ YES ☐ NO
IF NO, PLEASE EXPLAIN: _____

J. ARE MOBILE RADIOLOGY SERVICES PROVIDED? ☐ YES ☐ NO
IF YES, WHAT PERCENTAGE OF OVERALL SERVICES DOES THIS REPRESENT? _____ %

K. DOES THE FACILITY USE TELERADIOLOGY SERVICES FOR INTERPRETATION OF READS? ☐ YES ☐ NO

L. DOES THE FACILITY PROVIDE ANY TELERADIOLOGY SERVICES TO OTHER ORGANIZATIONS? ☐ YES ☐ NO

M. IF YES TO EITHER QUESTION K. OR L. ABOVE, PLEASE COMPLETE THE FOLLOWING:

1. IS THE APPLICANT COMPLIANT WITH THE AMERICAN COLLEGE OF RADIOLOGY (ACR) TECHNICAL STANDARDS FOR ELECTRONIC PRACTICE OF MEDICAL IMAGING? ☐ YES ☐ NO

   If no, describe the areas of non-compliance: _____

2. IS THE FACILITY EQUIPPED WITH A DIGITAL PAC RADIOLOGY SYSTEM? ☐ YES ☐ NO
3. ARE FILMS TRANSMITTED INTERSTATE? ☐ YES ☐ NO
4. DO ANY "READING" PHYSICIANS RESIDE OUTSIDE OF THE U.S. AND ITS TERRITORIES? ☐ YES ☐ NO
5. PLEASE PROVIDE ADDITIONAL COMMENTS IF THE APPLICANT WOULD LIKE TO EXPLAIN ITS USE OF TELERADIOLOGY SERVICES:

_____

_____

_____

IN SOME SITUATIONS, THE APPLICANT MAY BE ASKED TO COMPLETE A TELERADIOLOGY SUPPLEMENTAL QUESTIONNAIRE.

IV. IMAGING CENTER OPERATIONS (CONTINUED)

N. DOES THE APPLICANT PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY, PHARMACY ETC.)? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: _____

_____

O. DOES OR WILL THE APPLICANT PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? ☐ YES ☐ NO

IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE.

P. DOES THE FACILITY HAVE THE FOLLOWING EQUIPMENT:

1. CRASH CART WITH FULL CARDIAC LIFE SUPPORT CAPABILITIES AND NECESSARY IV FLUIDS? ☐ YES ☐ NO
2. DEFIBRILLATOR? ☐ YES ☐ NO
3. EKG? ☐ YES ☐ NO
4. OXYGEN? ☐ YES ☐ NO

Q. WHAT PROVISIONS HAVE BEEN MADE FOR EMERGENCY CARE/TRANSFER PROTOCOL? PLEASE DESCRIBE: _____

_____

R. HOSPITAL PROVIDING EMERGENCY CARE:

_____
NAME

_____
ADDRESS

S. DOES THE APPLICANT HAVE WRITTEN POLICIES AND PROCEDURES THAT ADDRESS:

1. FORMALIZED WRITTEN PEER REVIEW PROCESS THAT INCLUDES RANDOM OVER-READS? ☐ YES ☐ NO
2. PROTOCOLS ON MATCHING THE CORRECT PATIENT WITH THE CORRECT DIAGNOSTIC EXAMS? ☐ YES ☐ NO
3. FORMALIZED GUIDELINES RELATING TO THE COMMUNICATION OF DIAGNOSTIC SERVICES INCLUDING THE FOLLOWING:
   - A. COMMUNICATING RESULTS TO PATIENTS AND THEIR PHYSICIAN VIA LETTER OR PHONE CALLS? ☐ YES ☐ NO
   - B. COMMUNICATING ABNORMAL FINDINGS TO REFERRING PHYSICIANS NOT ON APPLICANT'S MEDICAL STAFF? ☐ YES ☐ NO
   - C. COMMUNICATING MAMMOGRAM RESULTS TO PATIENTS AND THEIR REFERRING PHYSICIAN WITHIN 30 DAYS? ☐ YES ☐ NO
   - D. COMMUNICATING RESULTS OF SELF-REFERRED PATIENTS TO A PHYSICIAN WHEN CLINICALLY INDICATED? ☐ YES ☐ NO
   - E. ACTIVE RECALL OR REMINDER SYSTEM FOR REPEAT EXAMS? ☐ YES ☐ NO
4. PROCEDURES FOR THE ARCHIVING OF FILMS FOR A SPECIFIC PERIOD OF TIME? ☐ YES ☐ NO
5. EMERGENCY TRANSFER PROTOCOLS? ☐ YES ☐ NO
6. WRITTEN AGREEMENT WITH A HOSPITAL TO PROVIDE EMERGENT HIGHER LEVEL OF CARE? ☐ YES ☐ NO
7. EQUIPMENT SAFETY PROTOCOLS SUCH AS CALIBRATION, IDENTIFYING OPERATING IRREGULARITIES, ETC.? ☐ YES ☐ NO
8. PERIODIC TRAINING AND IN-SERVICE EDUCATION? ☐ YES ☐ NO

IF "NO" TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE FURTHER EXPLANATION: _____

_____

_____

_____

_____

_____

_____

V. MEDICAL STAFF

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN THAT PRACTICES AT THE FACILITY.
(If more room is needed, please attach a separate roster of Medical Staff)

IMPORTANT NOTE: IF COVERAGE IS DESIRED FOR PHYSICIANS, PLEASE INDICATE THAT ON SECTION III (COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE) AND SECTION IV (THE SCHEDULE OF MEDICAL PROFESSIONALS) OF THE IMAGING CENTER SUPPLEMENTAL APPLICATION. ALSO COMPLETE A SEPARATE PHYSICIAN INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR EACH PHYSICIAN.

PHYSICIAN'S NAME	INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)	PRIMARY LICENSE NUMBER	INDICATE PRIMARY SPECIALTY	INDICATE THE NUMBER OF HOURS PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT THE FACILITY

B. ARE ALL OF THE PHYSICIANS PRACTICING AT THE FACILITY BOARD CERTIFIED? ☐ YES ☐ NO

IF NO, HOW MANY ARE NOT BOARD CERTIFIED? _____

C. DO YOU HAVE ANY PHYSICIANS ON STAFF THAT DO NOT MAINTAIN STAFF PRIVILEGES AT A HOSPITAL? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

D. PLEASE INDICATE THE NUMBER OF HEALTH CARE PROFESSIONALS, OTHER THAN PHYSICIANS, WHO WORK AT THE FACILITY: _____

IMPORTANT NOTE: IF COVERAGE IS DESIRED FOR HEALTH CARE PROFESSIONALS, OTHER THAN PHYSICIANS, PLEASE SO INDICATE ON SECTION III (COVERAGES, LIMITS AND DEDUCTIBLE SCHEDULE) AND SECTION V (THE SCHEDULE OF MEDICAL PROFESSIONALS) OF THE IMAGING CENTER SUPPLEMENTAL APPLICATION. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL FOR WHOM COVERAGE IS REQUESTED.

ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED
NURSE PRACTITIONERS			
PHYSICIAN ASSISTANTS			
LPNs / RNs			
MEDICAL TECHNICIANS			
RADIOLOGICAL TECHNICIANS (DIAGNOSTIC)			
RADIOLOGICAL TECHNICIANS (THERAPY)			
OTHERS (DESCRIBE)			

E. DOES THE FACILITY SUPERVISE ANYONE OTHER THAN ITS OWN EMPLOYEES? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE RESPONSIBILITY OF THE INDIVIDUALS AND WHAT YOUR RELATIONSHIPS ARE TO THESE INDIVIDUALS:

_____

ALSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL, THE NUMBER OF INDIVIDUALS THE FACILITY SUPERVISES: _____

VI. RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT PROGRAM? ☐ YES ☐ NO

B. IS THERE A FULL-TIME RISK MANAGER? ☐ YES ☐ NO

IF NO, WHAT ARE THE RISK MANAGER'S RESPONSIBILITIES OTHER THAN RISK MANAGEMENT, AND HOW MUCH TIME IS DEVOTED TO RISK MANAGEMENT? _____

C. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR RISK MANAGEMENT:

_____ _____

NAME TITLE

VI. RISK MANAGEMENT (CONTINUED)

D. IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS? ☐ YES ☐ NO

E. IS THERE A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ YES ☐ NO

1. IF YES, DOES THIS PROCEDURE REQUIRE REVIEW AND APPROPRIATE CORRECTIVE ACTION BE TAKEN? ☐ YES ☐ NO
2. IS FOLLOW-UP MADE TO ASSURE COMPLIANCE? ☐ YES ☐ NO

F. IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE? ☐ YES ☐ NO

1. IF YES, IS THE PERSON RESPONSIBLE FOR RISK MANAGEMENT A MEMBER OF THIS COMMITTEE? ☐ YES ☐ NO
2. TO WHOM IS THE QUALITY ASSURANCE COMMITTEE ACCOUNTABLE?

NAME _____ TITLE _____

3. WHAT QUALITY INDICATORS ARE MONITORED (PLEASE LIST)? _____

4. DOES THE FACILITY MONITOR INFECTION RATES? ☐ YES ☐ NO

G. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS THAT IS PART OF THE QUALITY MANAGEMENT PROGRAM? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

H. IS THERE AN ON-GOING CONTINUING EDUCATION PROGRAM F NURSING STAFF? ☐ YES ☐ NO

OTHER ALLIED HEALTH CARE PROFESSIONALS? ☐ YES ☐ NO

I. NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:

NAME _____ TITLE _____

VII. CREDENTIALING

A. WHEN HIRING PROFESSIONALS AND SUPPORT STAFF, DOES APPLICANT:

1. VERIFY EDUCATIONAL BACKGROUND? ☐ YES ☐ NO
2. CHECK ALL REFERENCES INCLUDING PAST EMPLOYERS? ☐ YES ☐ NO
3. CHECK FOR PENDING LICENSE SUSPENSIONS, REVOCATIONS, OR DISCIPLINARY ACTIONS BY OTHER FACILITIES? ☐ YES ☐ NO
4. CHECK CRIMINAL HISTORY? ☐ YES ☐ NO
5. REQUIRE PRIOR MEDICAL PROFESSIONAL CLAIM HISTORY? ☐ YES ☐ NO

B. ARE THE CREDENTIALS OF EACH PHYSICIAN AND HEALTH CARE PROFESSIONAL REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES? ☐ YES ☐ NO

C. IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK? ☐ YES ☐ NO

D. DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN WORKING AT THE FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE? ☐ YES ☐ NO

1. IF YES, WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED? $ _____ / $ _____
2. ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

E. WHAT ARE THE MINIMUM LIMITS OF LIABILITY REQUIRED FOR NON-PHYSICIAN HEALTH CARE PROFESSIONALS WORKING AT THE FACILITY? $ _____ / $ _____

ARE CERTIFICATES OF INSURANCE OBTAINED AT LEAST ANNUALLY FROM EACH INDIVIDUAL TO VERIFY COVERAGE IS IN PLACE? ☐ YES ☐ NO

F. HAS THE LICENSE OF ANY PHYSICIAN OR HEALTH CARE PROFESSIONAL BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

G. DURING THE LAST FIVE YEARS, HAVE REPORTS BEEN MADE TO THE NATIONAL PRACTITIONER DATA BANK REGARDING ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: _____

VIII. PHYSICAL PLANT

A. PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY APPLICANT. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE, PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.

ADDRESS OF PROPERTY TO BE INSURED	USE/OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	FIRE PROTECTION*
PATIENT CARE BUILDINGS:						
OTHER BUILDINGS:						

*FOR EACH BUILDING INDICATE IF THERE IS A: SPRINKLER SYSTEM - FULL, PARTIAL OR NO SPRINKLER SYSTEM
SMOKE DETECTOR, HEAT DETECTOR
FIRE ALARM - CENTRAL STATION OR LOCAL ALARM

B. DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN: _____

IX. GENERAL LIABILITY

DOES APPLICANT DESIRE GENERAL LIABILITY COVERAGE? ☐ YES ☐ NO
If yes, complete this section. If no, skip to Section X.

A. IS THERE A PREVENTIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR THE BIO-MEDICAL EQUIPMENT AND SURGICAL MACHINES OR DEVICES AT THE FACILITY? ☐ YES ☐ NO

1. HOW OFTEN ARE NON-EXPENDABLE MEDICAL OR SURGICAL MACHINES OR DEVICES INSPECTED AND MAINTAINED? _____
2. WHO PERFORMS THE MAINTENANCE ON THE ABOVE EQUIPMENT? ☐ EMPLOYEES ☐ INDEPENDENT CONTRACTORS
3. IF MAINTENANCE IS PERFORMED BY AN INDEPENDENT CONTRACTOR, WHAT MINIMUM GENERAL LIABILITY LIMIT IS REQUIRED?
   $ _____ / $ _____
4. IS A CERTIFICATE OF INSURANCE OBTAINED ANNUALLY TO VERIFY THAT THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO

B. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT THE FACILITY OWNED BY PHYSICIANS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE PREVENTIVE MAINTENANCE, INSPECTION AND REPAIR OF THE EQUIPMENT?

C. DOES THE APPLICANT LEND OR DONATE BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE? ☐ YES ☐ NO

IF YES, DESCRIBE: _____

D. DOES THE APPLICANT RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS? ☐ YES ☐ NO

IF YES, WHO IS RESPONSIBLE FOR THE MAINTENANCE OF THE EQUIPMENT? _____

E. DOES THE APPLICANT USE AN ADVERTISING AGENCY? ☐ YES ☐ NO

1. IF YES, WHAT IS THE MINIMUM PROFESSIONAL LIABILITY LIMIT REQUIRED?
   $ _____ / $ _____
2. IS THE APPLICANT INCLUDED AS AN ADDITIONAL INSURED ON THE ADVERTISING AGENCY'S POLICY? ☐ YES ☐ NO
3. IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF THE FACILITY? ☐ YES ☐ NO

F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE THE CHANGES PLANNED, INCLUDING THE TIME FRAME AND THE ESTIMATED COST: _____

G. PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJECTED NUMBER OR AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS:

HABITATIONAL RISK: INDICATE IF AN: ☐ APARTMENT ☐ DWELLING ☐ HOTEL

1. NUMBER OF UNITS: _____ YEAR BUILT: _____
   a. ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER? ☐ YES ☐ NO
   b. FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? ☐ YES ☐ NO

☐ PAY PARKING RECEIPTS PER YEAR: _____

☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS RECEIPTS PER YEAR: _____

2. DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED: _____

IX. GENERAL LIABILITY (CONTINUED)

H. DOES THE APPLICANT LEASE OR RENT SPACE TO OTHERS? ☐ YES ☐ NO

IF YES, INDICATE THE FOLLOWING:

_____

CITY, STATE, AND ZIP CODE

_____ _____

SQUARE FOOTAGE OCCUPANCY/USE OF SPACE

1. DOES THE LEASE REQUIRE THE TENANT TO CARRY GENERAL LIABILITY INSURANCE WITH AT LEAST A $1,000,000 LIMIT? ☐ YES ☐ NO
2. DOES THE APPLICANT OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE? ☐ YES ☐ NO
3. IS THE TENANT REQUIRED TO LIST APPLICANT AS AN ADDITIONAL INSURED ON ITS GENERAL LIABILITY POLICY? ☐ YES ☐ NO

X. EXCESS LIABILITY

DOES THE APPLICANT DESIRE EXCESS LIABILITY COVERAGE? ☐ YES ☐ NO
If yes, complete this section. If no, skip to Section XI.

HAS THE APPLICANT'S EXCESS PROFESSIONAL OR COMMERCIAL GENERAL LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS? ☐ YES ☐ NO

IF YES, WHAT WAS THE PRIOR LIMIT AND WHEN WAS IT INCREASED? _____

XI. COVERAGE HISTORY AND INFORMATION

**** NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATE OF MISSOURI OR CALIFORNIA.**

A. HAS ANY INSURANCE COMPANY EVER CANCELLED OR REFUSED TO OFFER COVERAGE TO THE APPLICANT? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DETAILS: _____

_____

B. PLEASE CHECK WHICH TYPE OF NOTICE YOUR PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES BEFORE THEY WILL FORMALLY RECOGNIZE A CLAIM UNDER THEIR POLICY:

☐ SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.

☐ WRITTEN NOTICE FROM YOU THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.

C. HAS THE APPLICANT CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH MAY GIVE RISE TO FUTURE CLAIMS, AND HAS NOTICE OF SUCH KNOWN CLAIMS OR POTENTIAL FUTURE CLAIMS BEEN FORWARDED TO THE APPLIANT'S CURRENT INSURER? ☐ YES ☐ NO

IF YES, PROVIDE THE DATE OF THE REVIEW AND THE NAME AND TITLE OF THE PERSON CONDUCTING THE REVIEW:

____ ____ _____

MM YYYY NAME AND TITLE

D. PLEASE PROVIDE APPLICANT'S INSURANCE HISTORY FOR THE LAST FIVE YEARS:

POLICY PERIOD	MOST RECENT YEAR	YEAR 1 PRIOR	YEAR 2 PRIOR	YEAR 3 PRIOR	YEAR 4 PRIOR
PROFESSIONAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
GENERAL LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					
EXCESS LIABILITY					
INSURANCE COMPANY					
LIMITS					
CLAIMS-MADE (CM) OR OCCURRENCE (O)					
PREMIUM					

XII. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY)

For <u>EACH</u> claim, potential claim or suit mentioned below, please complete Section I (Loss History) of the Imaging Center Supplemental Application.

A. Has Applicant (independently or through a named insured) been involved now, or in the past, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the applicant corporation, partnership or organization? ☐ YES ☐ NO

If yes, how many? _____

If yes, have these been reported to Applicant's insurer? ☐ YES ☐ NO

B. Does the Applicant or any of its employees/contractors, have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which Applicant may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization which may give rise to a claim? ☐ YES ☐ NO

If yes, how many? _____

If yes, have these been reported to Applicant's insurer? ☐ YES ☐ NO

XIII. ATTACHMENTS

A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION:

A. A COPY OF APPLICANT'S CERTIFICATE / ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE.

B. FINANCIAL INFORMATION. THE MOST RECENT THREE (3) YEARS OF FINANCIAL STATEMENTS INCLUDING THE AUDITOR'S OPINION, IF APPLICABLE.

C. MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS.

D. COPY OF APPLICANT'S LETTERHEAD.

E. LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION.

F. LOSS INFORMATION. RECENTLY VALUED LOSS RUNS FROM INSURANCE CARRIERS COVERING THE LAST TEN (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS.

G. ANNUAL REPORT (IF ONE IS PUBLISHED).

H. ALL CURRENT **ADVERTISING MATERIALS.**

I. ORGANIZATIONAL CHART INCLUDING THE **NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.**

J. COPY OF APPLICANT'S CURRENT INSURANCE POLICY.

XIV. IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES

IMPORTANT NOTICE:
THIS INSURANCE BEING APPLIED FOR MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE.

PLEASE READ AND REVIEW THE POLICY CAREFULLY.

PLEASE READ AND SIGN

ON BEHALF OF THE ENTITY APPLYING FOR COVERAGE HEREIN:

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO MATERIAL FACT HAS BEEN KNOWINGLY SUPPRESSED OR MISSTATED.

I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY.

I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY PHYSICIAN, DENTIST, FIRM, OR PROFESSIONAL ASSOCIATION.

I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND COVERAGE.

BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED OR THAT A POLICY OF INSURANCE WILL BE ISSUED.

I FURTHER UNDERSTAND AND AGREE THAT THERE IS NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED A COMPLETED APPLICATION; (2) OFFERED A PREMIUM QUOTE; AND (3) RECEIVED, AS A PRECONDITION TO COVERAGE, THE TOTAL PREMIUM DUE OR, IF THE COMPANY HAS AGREED TO FINANCE THE PREMIUM, THE FIRST INSTALLMENT DUE. IN ADDITION, I UNDERSTAND THAT IF THE PREMIUM OR FIRST INSTALLMENT IS PAID BY CHECK, ELECTRONIC TRANSFER OR MONEY ORDER, IT SHALL NOT BE CONSIDERED AS "RECEIVED" BY THE COMPANY UNTIL IT HAS BEEN HONORED BY THE BANK.

I AGREE THAT IF THESE TERMS ARE NOT COMPLIED WITH, THERE WILL BE NO COVERAGE FOR ANY CLAIM UNDER ANY POLICY OF INSURANCE FOR WHICH I AM APPLYING.

I ALSO UNDERSTAND THAT THE COMPANY MAY WISH TO CONTACT PERSONS, HOSPITALS, SCHOOLS, EMPLOYERS, INSURANCE AGENTS, PROFESSIONAL LIABILITY INSURERS OR OTHER INDIVIDUALS OR ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING CREDENTIALS AND BACKGROUND BOTH PRIOR TO AND, IF ISSUED, AFTER THE ISSUANCE OF A CONTRACT OF INSURANCE. THEREFORE, I HEREBY INSTRUCT ANY SUCH PERSON, HOSPITAL, SCHOOL, EMPLOYER, INSURANCE AGENT, PROFESSIONAL LIABILITY INSURER OR OTHER ENTITY TO RELEASE TO THE COMPANY ANY INFORMATION REQUESTED, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

SIGNATURE OF AUTHORIZED INDIVIDUAL	TITLE	DATE

XV. FRAUD NOTICE

MANDATORY: ***ALL APPLICANTS MUST READ AND INITIAL THE FOLLOWING:***

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

INITIAL HERE

MEDPRO RRG Risk Retention Group

Subscriber Agreement and Power of Attorney

WHEREAS, the undersigned subscriber ("Subscriber") acknowledges and agrees that this Subscriber Agreement and Power of Attorney ("Subscriber Agreement") (along with other subscriber agreements) constitute the charter of MEDPRO RRG Risk Retention Group ("MEDPRO RRG") and that the subscribers to MEDPRO RRG from time to time shall together comprise the reciprocal insurer, which shall operate through its Attorney-in-Fact as provided in this Subscriber Agreement as a risk retention group in accordance with federal law and as a risk retention group in the form of a reciprocal captive insurer in accordance with District of Columbia law.

NOW THEREFORE, in consideration of similar agreements executed or to be executed by other subscribers and of the benefits of the exchange of such agreements and of the terms of this Subscriber Agreement, the Subscriber agrees to the following terms and conditions.

1. **Appointment and Powers and Duties of Attorney-in-Fact.**

Subscriber agrees to the appointment of MedPro Risk Retention Services, Inc., an Indiana corporation ("Attorney-in-Fact"), as the Attorney-in-Fact for MEDPRO RRG to carry out the purposes and objectives set forth in this Subscriber Agreement and to carry out all business on behalf of MEDPRO RRG and the subscribers thereto. Attorney-in-Fact is vested with all necessary power and authority to act on behalf of MEDPRO RRG and the subscribers thereto, including conducting the affairs of MEDPRO RRG, managing and operating (directly or through contract with third parties (including affiliates of Attorney-in-Fact)) MEDPRO RRG for the benefit of the subscribers, and causing the issuance and exchange of indemnity, insurance or reinsurance contracts with other subscribers.

2. **Limitations of Liability.**

a. The financial liability of Subscriber shall be limited to the amount of annual premiums on any contracts of indemnity, insurance or reinsurance due from Subscriber, provided, however, that all contracts of indemnity, insurance or reinsurance shall contain a "limit of liability" and in the event it is determined that Subscriber's liability on a claim under said contract of indemnity, insurance or reinsurance exceeds the limit of liability, such excess amount shall be the sole and complete responsibility of Subscriber.

b. Should any suit, legal proceeding or other action be brought against Attorney-in-Fact resulting from or arising out of Subscriber's obligation on any contract of indemnity, insurance or reinsurance that Subscriber may enter into, then and in that event, any and all judgments entered against Attorney-in-Fact in that capacity shall be deemed a legal judgment against Subscriber.

3. **Maintenance and Distribution of Surplus.**

Attorney-in-Fact shall cause MEDPRO RRG to maintain surplus in an amount sufficient to provide for the financial integrity of MEDPRO RRG and in an amount satisfactory to the District of Columbia Department of Insurance, Securities and Banking. In no event, however, shall Attorney-in-Fact be required to contribute its own assets or the assets of any affiliate to MEDPRO RRG.

a. Subscriber authorizes Attorney-in-Fact to accrue for the benefit of MEDPRO RRG and the subscribers net income and savings realized from the exchange of contracts of indemnity, insurance or reinsurance hereunder and the management of MEDPRO RRG and its assets.

b. Subject to the laws of the District of Columbia, if MEDPRO RRG is dissolved by Attorney-in-Fact, Attorney-in-Fact shall, after the full satisfaction of all liabilities and surplus notes of MEDPRO RRG from MEDPRO RRG's assets, pay each subscriber then insured an equitable share of all remaining assets, which payment shall be in full satisfaction of all rights and interests of such subscribers. Amounts to be paid to subscribers shall be distributed on an equitable basis as determined by Attorney-in-Fact.

4. **Term of Subscriber Agreement**.

a. This Subscriber Agreement shall have no fixed term and begins with the commencement of the policy period of any contract of indemnity, insurance or reinsurance issued hereunder to Subscriber and ends upon cancellation or other termination of such contract of indemnity, insurance or reinsurance or upon replacement of this Subscriber Agreement by a modified subscriber agreement provided by Attorney-in-Fact. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements.

b. Subscriber agrees that this Subscriber Agreement is expressly limited to the uses and purposes herein expressed and to no other. This Subscriber Agreement may be terminated by Subscriber or by Attorney-in-Fact upon 30 days written notice. The Subscriber's appointment of Attorney-in-Fact and Subscriber's obligations and authorizations under this Subscriber Agreement shall survive the termination of this Subscriber Agreement until any and all claims involving the indemnity, insurance or reinsurance contracts of the Subscriber and any and all other matters existing between the Subscriber and MEDPRO RRG, the Attorney-in-Fact or with third parties have been settled or satisfied. Subscriber agrees that the Attorney-in-Fact shall have the authority and ability to perform all duties and carry out all obligations during any extended reporting or tail coverage endorsements during the term of this Subscriber Agreement or after termination.

c. After termination of this Subscriber Agreement, Subscriber shall have no rights to participate in any distribution of assets upon dissolution of MEDPRO RRG.

5. **Replacement of Attorney-in-Fact**.
Attorney-in-Fact may resign as Attorney-in-Fact upon designation by Attorney-in-Fact of a successor attorney-in-fact and 60 days written notice to existing subscribers. Any such successor attorney-in-fact shall have all the powers, rights and duties provided for in this Subscriber Agreement, and this Subscriber Agreement shall remain in full force and effect with such successor attorney-in-fact.

6. **Principal Office**.
The principal office of MEDPRO RRG shall be maintained in the District of Columbia or at such other place as designated by Attorney-in-Fact.

7. **Limitation of Liability of Attorney-in-Fact**.
Subscriber agrees that no officer, director, or employee of Attorney-in-Fact shall be personally liable to MEDPRO RRG or its subscribers for any breach of duty owed to MEDPRO RRG or its subscribers, provided however that this provision shall not relieve an officer, director or employee from liability for any breach of duty based on an act or omission (a) in breach of such person's duty of loyalty to MEDPRO RRG and its subscribers; (b) not done in good faith or involving a knowing violation of law; or (c) resulting in receipt by such person of an improper personal benefit. Such officers, directors and employees of Attorney-in-Fact shall be entitled to indemnification and advancement of expenses subject to the same exceptions recited above.

8. **Nature of MEDPRO RRG**.
Subscriber acknowledges that MEDPRO RRG is a risk retention group organized in the District of Columbia as a reciprocal captive insurer and as such its contracts of indemnity, insurance or reinsurance are not subject to all state insurance laws and regulations. Further, state insolvency or guarantee funds are not available to risk retention groups, like MEDPRO RRG. Subscriber also acknowledges that MEDPRO RRG is a reciprocal organization under which each subscriber exchanges insurance obligations with the other subscribers through an attorney-in-fact.

9. **Governing Law**.
This Subscriber Agreement shall be governed by and interpreted according to the laws of the District of Columbia without giving effect to the conflict or choice of law provisions of that or any other jurisdiction.

Subscriber Signature

IN WITNESS WHEREOF, the Subscriber has caused this Subscriber Agreement to be executed individually or by its duly authorized officer, as applicable, as of the __ day of _____, 20__.

SUBSCRIBER

By _____

Date: _____ _____

Name and Title

Acceptance

MedPro Risk Retention Services, Inc., an Indiana corporation, Attorney-in-Fact for MEDPRO RRG Risk Retention Group, hereby accepts this Subscriber Agreement from Subscriber.

ATTORNEY-IN-FACT

By _____

Trent Heinemeyer – Vice President and Secretary

MEDPRO RRG Risk Retention Group

IMAGING CENTER SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF THE APPLICANT HAS BEEN INSURED WITH MEDPRO RRG RISK RETENTION GROUP FOR LESS THAN TEN YEARS, OR IF IT PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY MEDPRO RISK RETENTION GROUP BY AND THROUGH ITS CLAIMS ADMINISTRATOR, THE MEDICAL PROTECTIVE COMPANY.

THE LOSS INFORMATION SHOULD REPORT BOTH THE APPLICANT'S PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

IF MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE: _____

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDERWRITING DEPARTMENT'S DISCRETION.

CLAIM NUMBER _____

A. CLAIMANT NAME: _____ AGE: _____

B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST THE APPLICANT. ____ ____ MM YYYY

C. DATE CLAIM/INCIDENT NOTICE RECEIVED. ____ ____ MM YYYY

D. NAME OF DOCTOR(S), HEALTH CARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLVED IN THE CLAIM OR SUIT:

_____

E. INSURANCE CARRIER DEFENDING OR TO WHICH CLAIM / INCIDENT WAS REPORTED:

_____

F. WAS A CLAIM MADE OR A SUIT FILED? ☐ YES ☐ NO

G. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT: ☐ OPEN ☐ CLOSED

IF CLOSED, DATE OF CLOSING /SETTLEMENT OR AWARD: ____ ____ MM YYYY

IF CLOSED, WAS PAYMENT MADE? ☐ YES ☐ NO

IF NO, WAS CLAIM OR SUIT WITHDRAWN? ☐ YES ☐ NO

AMOUNT PAID ON APPLICANT'S BEHALF: $ _____

TOTAL AMOUNT OF SETTLEMENT OR AWARD: $ _____

WAS THIS MATTER CLOSED WITH APPLICANT'S CONSENT? ☐ YES ☐ NO

IF OPEN, HAS SETTLEMENT BEEN OFFERED? ☐ YES ☐ NO

IF OPEN, HAS TRIAL DATE BEEN SET? ☐ YES ☐ NO

TRIAL DATE: ____ ____ MM YYYY

H. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT:

CONDITION TREATED: _____

TREATMENT PROVIDED: _____

ALLEGED NEGLIGENCE: _____

ALLEGED INJURY: _____

I. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BUT NOT LIMITED TO THE TYPE OF TREATMENT AND/OR SURGERY INCLUDING APPLICANT'S LEVEL OF INVOLVEMENT).

_____

_____

_____

_____

II. SCHEDULE OF RELATED ENTITIES

LIST OF ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.)

NAME OF ENTITY	DESCRIPTION OF OPERATIONS	DATE ACQUIRED, CREATED OR MERGED	INDICATE OWNERSHIP PERCENTAGE IN THIS ENTITY	COVERAGE DESIRED? If yes, indicate shared or separate limits.

III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (IF SHARED OR SEPARATE PHYSICIAN OR ALLIED COVERAGE IS BEING REQUESTED)

PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW

COVERAGE	REQUESTED LIMITS	OCCURRENCE / CLAIMS-MADE	DEDUCTIBLE / SIR
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE IMAGING CENTER LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE IMAGING CENTER LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SHARED LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. *IF THIS COVERAGE IS PROVIDED, THE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED.*	THE COVERAGE TYPE (OCCURRENCE/CLAIMS-MADE) MUST BE THE SAME AS INDICATED IN THE IMAGING CENTER LIABILITY APPLICATION.	THE DEDUCTIBLE MUST BE THE SAME AS INDICATED IN THE IMAGING CENTER LIABILITY APPLICATION.
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS - SEPARATE LIMIT COVERAGE**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE IMAGING CENTER.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE
☐ **PROFESSIONAL LIABILITY - EMPLOYED OR CONTRACTED CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS - SEPARATE LIMIT COVERAGE.**	IF THIS COVERAGE IS DESIRED, PLEASE COMPLETE A SCHEDULE OF MEDICAL PROFESSIONALS OR PROVIDE A ROSTER WITH EQUIVALENT INFORMATION. SUBMIT SEPARATE APPLICATIONS FOR EACH INDIVIDUAL COVERAGE DESIRED.	☐ OCCURRENCE ☐ CLAIMS MADE RETRO DATE: _____ **NOTE:** THE UNDERWRITING DEPARTMENT MAY REQUIRE THE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE IMAGING CENTER.	☐ NONE ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ OTHER $ _____ THE DEDUCTIBLE APPLIES TO: ☐ INDEMNITY ONLY ☐ INDEMNITY AND EXPENSE

IMPORTANT NOTE:

UNLESS OTHERWISE REQUESTED BELOW, COVERAGE FOR HEALTH CARE PROFESSIONALS WILL BE LIMITED TO PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED, WHILE EMPLOYED OR UNDER CONTRACT WITH THE APPLICANT OR RELATED ENTITY (SERVICES LIMITED TO DUTY AND SCOPE OF SERVICES). **CHECK ONE**:

☐ COVERAGE LIMITED TO DUTY AND SCOPE OF APPLICANT AS INDICATED ABOVE

☐ REQUESTING 24-HOUR COVERAGE-Coverage not limited to when health care professionals are within duty and scope of Applicant.

IV. SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND / OR ORAL SURGEONS, PLEASE PROVIDE THE INFORMATION BELOW. ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED (SHARED LIMIT OR SEPARATE LIMIT COVERAGE). CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

NAME OF MEDICAL PROFESSIONAL	EMPLOYMENT STATUS: (C)ONTRACT (E)MPLOYED (F)ACULTY (R)ESIDENT	NUMBER OF PROCEDURES PERFORMED AT THE IMAGING CENTER	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOYMENT WITH NAMED INSURED	RESTRICTED (RE) TO NAMED INSURED'S OPERATION OR 24-HOUR (24)	LIMITS: Shared (SH), Separate (SE)

V. SCHEDULE OF HEALTH CARE PROFESSIONALS - CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND / OR SURGICAL ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION BELOW. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED. CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF CLAIMS MADE COVERAGE IS BEING REQUESTED, COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE DATE OF EMPLOYMENT WITH THE NAMED INSURED ENTITY. (*) IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE DATE OF THE EMPLOYMENT WITH THE NAMED INSURED, PRIOR ACTS COVERAGE WILL BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

Instructions For Completing Each Column

#1) Employment Status: (C) Contract, (E) Employed or (F) Faculty
#2) Specialty: CRNA, CRNP, Nurse Midwife, PA, Podiatrist, Surgical Assistant
#3) If CRNP or PA, does individual prescribe medication? Indicate Yes or No.
#4) If Claims Made coverage type, indicate retro date.
#5) Date of employment with First Named Insured (FNI).
#6) Full Time Equivalency (FTE) - Calculate FTE by dividing the total # of hours of professional service per week by 40 hours.
#7) License Number.
#8) Coverage Scope: (RE) Restricted to Named Insured's Operation OR (24) 24-Hour coverage.
#9) Limits: (SH) Shared or (SE) Separate.

Column #:	1	2	3	4	5	6	7	8	9
Name of Medical Professional	**(C), (E) or (F)**	**Specialty**	**Prescr. ? Yes/No**	**If CM, Retro Date**	**Date Of Empl. With FNI**	**FTE**	**License #**	**(RE) OR (24)**	**(SH) or (SE)**