



**Professional & General Liability Application for
Medical Labs & Medical Testing Services**

1. Name of Applicant: _____
(as it should appear on the policy)

2. Mailing Address: _____

3. Location Address: _____
(If more than one location address, please attach list including gross receipts by location)

4. Telephone Number: _____ Website Address: _____

5. Exposure:

Gross Receipts for the Past 12 Months:	\$
Estimated Gross Receipts for the Next 12 Months:	\$
Payroll for the Past 12 Months:	\$
Estimated Payroll for the Next 12 Months:	\$

6. Description of Services Provided: _____

7. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes _____ No _____

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of \$1M/\$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes _____ No _____

8. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

9. Do you sell, rent or otherwise provide any equipment to products or others? Yes _____ No _____

If yes, please complete the supplement for Durable Medical Equipment Sales/Rentals.

10. Exposure: Please complete the table below listing the types of tests performed along with the % exposure for each.

NOTE: If this is a start-up business not yet in operation, please show estimated exposures along with estimated % for each for the next 12 months.

<u>Type of Test Performed</u>	<u>% Exposure</u>

11. Are any of the exposures listed in the above table expected to change over the next 12 months?

Yes _____ No _____

If yes, please provide details: _____

12. a) Who does the testing?

- (i) Applicant's own laboratory/staff: _____ %
- (ii) Outside laboratory contracted with by the applicant for this service: _____ %
- (iii) Independent laboratories chosen by others: _____ %
- (iv) Other (please describe): _____ %

b) If either (ii), (iii) or (iv) above:

- (i) Does the applicant verify that they carry their own professional & general liability coverage at a minimum of \$1M/\$3M limits?

Yes _____ No _____

- (ii) Is the applicant's letterhead used when sending out results of tests conducted by 3rd parties?

Yes _____ No _____

13. a) Who interprets the results of the tests performed?

- (i) Applicant's own laboratory/staff: _____ %
- (ii) Outside staff contracted with the applicant to provide interpretation services: _____ %
- (iii) Ordering physician or other 3rd party unaffiliated with the applicant: _____ %
- (iv) Other (please describe): _____ %

b) If either (ii), (iii) or (iv) above:

- (i) Does the applicant verify that they carry their own professional & general liability coverage at a minimum of \$1M/\$3M limits?
Yes _____ No _____
- (ii) Is the applicant's letterhead used when sending out interpretation of results of the tests?
Yes _____ No _____

14. Are any tests performed for the purpose of diagnosing cancer? Yes _____ No _____

If yes, please provide the approximate % along with details as to who is responsible for diagnosing cancer and if they carry their own professional liability limits at a minimum of \$1M/\$3M limits:

15. Other Exposures: Please confirm if you involved in any of the following:

	<u>Yes</u>	<u>No</u>
Blood banking or crossmatching		
Intravenous transfusion or the procurement of blood or its components		
Medical, genetic or drug research		
Manufacturing, dispensing or testing of pharmaceuticals		
Manufacturing or selling laboratory equipment or supplies		
Performing any type of environmental analyses		
Services open to the public (health fairs, shopping malls, exhibits, etc)		
Manufacture or distributing any "test kits" used by others including any "home test kits"		

NOTE: If the answer is "yes" to any of the above exposures, please attach a separate sheet with details including types of tests and annual gross receipts.

16. Does the Insured use Artificial Intelligence (AI) in any capacity to provide, or assist in providing, professional services?

Yes _____ No _____

If yes, please provide details including confirmation whether or not it is used to interpret the results of the tests performed by the applicant such as interpreting scans/images:

17. Do you own or operate any mobile lab and/or provide mobile testing services?

Yes _____ No _____ If yes, please provide details: _____

18. Are any patients ever present at the applicant's location for the purpose of testing, obtaining specimens or any other reason?

Yes _____ No _____ If yes, please provide details: _____

19. Are random tests performed to audit false positive and/or negative results?

Yes _____ No _____ If no, please explain the reason: _____

20. How long does your lab retain specimens collected for future reference? _____

21. a) List the number and type of employees/owners including any estimated over the next 12 months:

	<u>Number</u>		<u>Number</u>
Physician (patient contact and/or interpretation of results)		Physician (no patient contact, no interpretation of results)	
Physician Assistant		Nurse Practitioner	
Nurse		Phlebotomist	
Medical Lab Technician		X-Ray Technician	
Admin/Clerical		Other (please describe)	

b) List the number and type of independent contractors including any estimated over the next 12 months:

	<u>Number</u>		<u>Number</u>
Physician (patient contact and/or interpretation of results)		Physician (no patient contact, no interpretation of results)	
Physician Assistant		Nurse Practitioner	
Nurse		Phlebotomist	
Medical Lab Technician		X-Ray Technician	
Admin/Clerical		Other (please describe)	

c) Are all the individuals listed in response to Q20a & b licensed in accordance with applicable state and federal regulations?

Yes _____ No _____

If no, attach explanation.

22. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes _____ No _____ If yes, at what limits? \$ _____ / \$ _____

If no, is coverage desired with shared limits on this policy? Yes _____ No _____

23. Do you require employed, contracted or volunteer physicians, nurse anesthetists, dentists, acupuncturists and/or chiropractors to carry their own Professional Liability Insurance at a minimum of \$1M/\$3M limits and secure Certificates of Insurance as evidence of such coverage?

Yes _____ No _____

Please attach proof of coverage

24. Please confirm which of the following you obtain, review, verify and keep on file as part of the employee/ independent contractor hiring & screening process:

	<u>Yes</u>	<u>No</u>
Employment Application		
Criminal Background Checks		
Drug / HIV/ Hepatitis Testing		
Licenses Held		
Education/Training/Competence		
Multi-State Registry		

25. Additional employment-related questions:

	<u>Yes</u>	<u>No</u>
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

26. Please complete the table below showing the applicant’s Professional Liability coverage for last 5 years:
(if none, state none)

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date (if applicable)</u>

27. Please complete the table below showing the applicant’s General Liability coverage for last 5 years:
(if none, state none)

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	<u>Expiration Date</u>	<u>Retro Date (if applicable)</u>

28. Has the applicant or have any of their employees (please attach a detailed explanation for any “yes” answers):

	<u>Yes</u>	<u>No</u>
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) 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) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

29. Has any claim ever been made against the firm or any of its employees?

Yes _____ No _____ **If yes, please attach completed claims supplement.**

30. 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 attached a separate sheet with date(s) and details.**

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

(NOTE: Application must be signed by the owner or president or principal)