ADMIRAL INSURANCE COMPANY
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MEDICAL / NON-MEDICAL COSMETIC SERVICES & OUT-PATIENT FACILITIES
PROFESSIONAL LIABILITY
CLAIMS MADE

NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTAION 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 THE 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 APPLICALE 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."

1. Applicant Information

a. Full name of applicant: _____

b. Principal business premise address: _____
(Street) (County)
_____
(City) (State) (Zip)

c. _____ Professional Corporation (for profit) _____ Partnership
_____ Professional Corporation (not for profit) _____ Professional Association
_____ Other (describe) _____

d. Date established: _____

e. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____

2. Operations

a. States Clinics are registered and licensed to practice: _____
If none, please explain: _____

b. Clinics professional Specialty: _____

c. Do you maintain any beds for overnight occupancy? _____ Yes _____ No Number of beds: _____

d. Division of patients or clients:

Hemodialysis	_____%	Psychiatric	_____%	Bariatrics	_____%
Holistic Medicine	_____%	Drug Addicts	_____%	Physical Rehabilitation	_____%
Surgical	_____%	Alcoholics	_____%	Disability Evaluation	_____%
Stress Testing	_____%	Obstetrical	_____%	Research or Experimental	_____%
Communicable	_____%	Dental	_____%	Other: _____	_____%
Family Planning	_____%	Pediatric	_____%	_____	100 %

e. Provide a list of the Applicant's Medical Director(s): _____
_____

f. Attach a CV for each of the Applicant's Medical Directors and a description of their duties.

g. Provide the percentage of the Applicant's patients/clients in the following categories:

Beauty Shop (nails, hair, facials)	_____%	Patient/Client Ages	
Dental	_____%	Less than 12 years old	_____%
Massage	_____%	12 to 18 years old	_____%
Medical Spa/Anti-Aging	_____%	Greater than 18 years old	_____%
Research or Experimental	_____%	Total	100 %
Surgical	_____%		
Weight Control	_____%		
Other (specify)_____	_____%		
Total	100 %		

3. Professional Services

a. List all manufactured equipment in the Applicant's practice and the purpose for which each I used:
_____
_____
_____

b. Provide the following information for each type of procedure that is performed and attach a ***TRAINING CERTIFICATE, CV, CLIENT SELECTION PROTOCOL*** and ***INFORMED CONSENT*** for each procedure.

Prodedure	Performed By (Include name of all individuals performing each prodedure)	Is Training Certificate Attached (Yes/No)	Is CV Attached (Yes/No)	Is Client Selection Protocol Attached? (Yes/No)	Is Informed Consent Attached? (Yes/No)	Number of Procedures
Acne Blue Light Treatment						
Botox Injections						
Chemical Peels Specify Solution Strength _____						
Electrolysis						
Hair Transplants						
Laser Hair Removal						
Laser Skin Treatment Specify Type _____						
Massage						
Microdermabrasion						
Other injections Specify type (fat, collagen, silicone) _____						
Permanent Makeup/ Micropigmentation						
Other _____						

c. Are any of the procedures listed in question 4 above performed by a physician or dentist? _____Yes _____ No
If Yes, do all physicians and dentists carry Professional Liability Insurance? _____ Yes _____ No

d. Do you perform:

i Acupuncture or acupuncture anesthesia? Explain _____ ___ Yes ___ No
ii Anglography/arteriography/venography? Describe _____ ___ Yes ___ No
iii Catheterization (other than urinary or umbilical)? Describe_____ ___ Yes ___ No
iv Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? ___ Yes ___ No
v Injection of radioisotopes and/or use of irradiated substances? Describe _____ ___ Yes ___ No
_____
vi Radiation therapy and/or chemotherapy? Describe _____ ___ Yes ___ No
vii Psychiatric shock therapy? ___ Yes ___ No
viii Silicone injections? Describe _____ ___ Yes ___ No
ix Spinal anesthesia (other than saddle blocks or caudals)? ___ Yes ___ No
x Laser treatment? Describe _____ ___ Yes ___ No
xi Experimental procedures or research testing? Describe in detail on a separate sheet ___ Yes ___ No
xii Hypnosis? Describe _____ ___ Yes ___ No

e. Do you perform:

i Norplant insertion/removals? Advise number yearly _____ ___ Yes ___ No
ii Surgery other than incision of superficial boils or suturing superficial fascia? ___ Yes ___ No
iii Circumcisions and/or dilation and curettage and/or insertion of temporary pacemaker? ___ Yes ___ No
iv Tonsillectomies and/or adenoidectomies and/or caesarian sections? ___ Yes ___ No
v Cosmetic plastic surgery? Describe _____ ___ Yes ___ No
vi Excision of large cysts and/or I&D of deep-seated boils or carbuncles? ___ Yes ___ No
vii Hysterectomies? ___ Yes ___ No
viii Open reduction of fractures? Describe _____ ___ Yes ___ No
ix Surgery for weight reduction of patients? ___ Yes ___ No
x Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month) _____ ___ Yes ___ No
xi Cryosurgery (other than use on benign or pre-malignant dermatological lesions? ___ Yes ___ No
xii Silicone implants? Describe _____ ___ Yes ___ No
xiii Sterilization procedures? Describe _____ ___ Yes ___ No
xiv Biopsies and/or endoscopies? List types performed _____ ___ Yes ___ No
xv Sex change operations? Describe and advise number yearly _____ ___ Yes ___ No
xvi Experimental surgery or surgical research? Describe in detail on separate sheet ___ Yes ___ No
xvii Other surgery? Describe: _____ ___ Yes ___ No

f. i Do you perform or engage in any surgical procedure(s) in your professional office or similar non-hospital facility? ___ Yes ___ No

ii List ALL surgical procedures performed (including minor surgery) _____
_____
_____

iii Do you administer anesthesia (other than topical or local infiltration)? ___ Yes ___ No

g. Do you perform hospital emergency room care for patients not your own? ___ Yes ___ No
If yes, please attach detailed explanation.

i Emergency Room Physicians _____ hrs. iii Nurses _____ hrs.
ii Paramedics _____ hrs. iv Other _____ _____ hrs.

h. Do you use drugs for weight reduction or patients? ___ Yes ___ No
If yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs; and quantity dispensed.

i. Do you administer any methadone treatment? ___ Yes ___ No
If yes, please attach description of treatment and controls used and indicate number of Treatments during: Last 12 months _____ Next 12 months _____

j. Number of annual x-ray exposures: for diagnosis _____ for treatment _____

k. If x-ray treatment is given, what qualifications are required of the staff? _____ ___ Yes ___ No
_____

l. Do you participate in any activity, e.g. newspaper columns, broadcasts, etc., in which professional advise is offered to the public? If yes, please attach detailed explanation of this activity. ___ Yes ___ No

m. Attach detailed description of any additional activities and/or procedures which you performed.

4. Staff

a. Does the Applicant employ anyone? _____ Yes _____ No
If Yes, indicate by profession the number of individuals employed:
_____ Anesthetician _____ Registered Nurse
_____ Electrologist _____ Technician (specify type) _____
_____ Massage Therapist _____ Other (describe) _____

b. Does the Applicant supervise anyone other than its own employees? _____ Yes _____ No
If Yes, Indicate by profession the number of individuals supervised:
_____ Anesthetician _____ Registered Nurse
_____ Electrologist _____ Technician (specify type) _____
_____ Massage Therapist _____ Other (describe) _____

c. Please indicate the number of professional employees volunteers and independent contractors. IF NONE, STATE NONE.

	Employees & Volunteers	Independent Contractors		Employees & Volunteers	Independent Contractors
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures	_____	_____	Anesthesiologists, Thoracic Surgeons, Vascular Surgeons Neurosurgeons, and Orthopedic Surgeons	_____	_____
Physicians: Minor surgery or obstetrical procedures not constituting major surgery	_____	_____	Physicians & Surgeons Assistants, Nurse Practitioners (describe duties on separate sheet	_____	_____
Proctologists, Ophthalmologists and Urologists, General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery)	_____	_____	Unlicensed Interns	_____	_____
Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists	_____	_____	Dentists (no oral surgery)	_____	_____
Oral Surgeons	_____	_____	Orthodontists	_____	_____
Nurse Anesthetists	_____	_____	Podiatrists	_____	_____
Optometrists, Opticians	_____	_____	Chiropractors	_____	_____
Pharmacists	_____	_____	Therapists	_____	_____
Perfusionists	_____	_____	Other _____	_____	_____
			Other _____	_____	_____

Also indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
_____	Physicians	_____	_____
_____	X-ray Technicians	_____	_____
_____	Laboratory Technician	_____	_____

5. Revenues

a. Please state sources and amounts of total revenue:

Source	This Fiscal Year	Next Fiscal Year
Charitable Contributions	$_____	$_____
Government Funding	$_____	$_____
Fee for Service	$_____	$_____
Other _____	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

b. Please provide number of outpatient visits:

Type of Visit	Last 12 Months	Next 12 Months
Clinics	_____	_____
Laboratory	_____	_____
Emergency Room	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL NO. OF VISITS	_____	_____

6. History / Claims

a. 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 with loss runs.

b. 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.

c. Are all professionals licensed in accordance with applicable state and federal regulation? ___ Yes ___ No
If no, please attach explanation.

d. PLEASE ATTACH DETAILED EXPLANATION FOR ANY YES ANSWERS:

i Ever been the subject of disciplinary or investigatory proceedings or reprimanded by a governmental or an 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 refused 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

e. Do you supervise any individual other than your own employees? ___ Yes ___ No
If yes, please provide explanation of responsibilities and relationships to the entity which employs these individuals. _____
_____

7. History / Insurance

a. List the Applicant's prior Professional Liability Insurance for each of the last five (5) years, including the current year; If none, check here _____

Insurance Company	Limits of Liability	Deductible (if any)	Premium	Inception/ Exp Dates (MM/DD/YY)	Claims Made or Occurrence Form	Retroactive Date

b. List the Applicant's prior General Liability Insurance for each of the last five (5) years, including the current year; If none, check here _____

Insurance Company	Limits of Liability	Deductible (if any)	Premium	Inception/ Exp Dates (MM/DD/YY)	Claims Made or Occurrence Form	Retroactive Date

* NOTICE TO APPLICANT: The coverage applies 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 for 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 Admiral Insurance Company, Underwriting Manager for the Company.

_____ _____

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 this insurance, but one copy of this application will be attached to the policy, if issued.