ADMIRAL INSURANCE COMPANY 6455 East Johns Crossing, Suite 240 Duluth, GA 30097 Phone: 770-476-1561 — Fax: 770-418-9597 Internet: http://www.admiralins.com	MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY APPLICATION (CLAIMS-MADE FORM)

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. NAME OF APPLICANT: ____
   (If other than parent firm, supply full details of ownership entity)

2. a) MAILING ADDRESS: ____
   b) Square feet of total office space (all locations) ______________________________

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 details: ____
   ____
   ____

5. PROFESSIONAL ACTIVITIES AND SPECIALITY (Attach narrative description if necessary) Check One:

   _____ Health Maintenance Organization
   _____ Home Healthcare Agency
   _____ Medical/Testing Laboratory
   _____ Nurse's Registry
   _____ Out-Patient Clinic
   _____ Residential Healthcare Facility
   _____ Other (Specify) ______________________
   ____
   ____

6. State approximate division of applicant's patients among:

(a) Alcoholics	(%)	(k) Obstetrical	(%)
(b) Counseling/Family Planning	(%)	(l) Pediatric	(%)
(c) Communicable	(%)	(m) Psychiatric	(%)
(d) Dental	(%)	(n) Research or Experimental	(%)
(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	(%)		

7. a. List the number and type of applicant's employees and volunteers: If none state none.

NUMBER	Type of Profession	NUMBER	Type of Profession
(a) ______	Inhalation Therapists	(e) ______	Nurse Practitioner
(b) ______	Laboratory Technicians	(f) ______	Nurses Registered
(c) ______	Nurse Anesthetists	(g) ______	Opticians
(d) ______	Nurse, Licensed Practical	(h) ______	Optometrists

NUMBER	Type of Profession	NUMBER	Type of Profession
(i) ______	Perfusionists	(m) ______	Physiotherapists
(j) ______	Pharmacists	(n) ______	Social Workers
(k) ______	Physicians — minor surgery	(o) ______	Speech Therapists
(l) ______	Physicians — no surgery	(p) ______	Other ____________________________

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 applicant state and federal regulations?____Yes____No. If no, attach explanation.

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 reprimanded 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 of license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	(d)	_____	_____

8. Does the applicant perform:		**YES**	**NO**
A. Acupuncture or acupuncture anesthesia? Explain: ______________________________	A.	_____	_____
B. Angiography/Arteriography/Venography? Describe: ____________________________	B.	_____	_____
C. Catheterization (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?	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.	_____	_____

9. Does the applicant perform any: **YES** **NO**

		YES	NO
A.	Surgery other than incision of superficial or suturing superficial fascia?	A. _____	_____
B.	Circumcisions and/or dilation and currettage 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.	Cryosurgery (other than use on benign or per-malignant dermatological lesions)? Describe: ____	J. _____	_____
K.	Silicone implants? Describe: ____	K. _____	_____
L.	Sterilization procedures? Describes: ____	L. _____	_____
M.	Biopsies and/or endoscopies? List types performed: ____	M. _____	_____
N.	Sex change operations? Describe and advise the number performed per year: ____	N. _____	_____
O.	Other Surgery? Describe: ____	O. _____	_____

10. Does the applicant perform hospital emergency room care?
    (a) for its own regular patients? _____Yes _____No (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.

11. Does the applicant use drugs for weight reduction of patients? _____ Yes _____No. If yes, on last page list drugs used and advise: percentage of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant.

12. Does the applicant administer any methadone treatment? _____ Yes _____No. If yes, describe treatment and controls used and indicate number of treatments during last 12 months __________________ next 12 months _____________________.

13. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? _____ Yes _____ No.

14. Does the applicant maintain any beds overnight occupancy? _____ Yes _____No. If yes, total number: ___________

15. State 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: ____
    ____

16. 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. ____
____

17. State sources and amount of total revenue:

Source	Amount Last Policy Year	Est. Amount This Policy Year
A. Charitable Contributions	$ ____________	$ ____________
B. Government Funding	$ ____________	$ ____________
C. Fee For Service	$ ____________	$ ____________
D. ____________	$ ____________	$ ____________
E. ____________	$ ____________	$ ____________
TOTAL GROSS REVENUE:	$ ____________	$ ____________

18. 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).

19. 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).

20. If applicant has a training school, complete the following.

Specify profession for which students are being trained	Max. No. of students per session	No. of sessions per year	% of Time involved in clinical setting	Number of students	Qualification of faculty (e.g. MD, RN, PHD)

21. Give Professional Liability Coverage for last five years for the firm:

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

22. Is the applicant currently insured under a Commercial General Liability Policy? _____ Yes _____No. If yes, please give details:

Insurance Company	Type of Coverage	Limits		Effective	
		BI	PD	From	To

23. 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: ____
____

24. 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.

25. 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 23.

26. Has any insurer cancelled or refused to renew any similar insurance during the past five years? __________________
____

27. Limits of Liability requested: _______________________________ Deductible: _____________________________

28. Desired term of policy: From: _____________________________ To: _____________________________________

29. 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 contracts issued will be in full reliance upon the statements and representations made in this application and the application will be a part of the policy.

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

____ ____

Date Signature of Applicant Title

____

Producer