HUNTERSURE LLC

ALLIED HEALTH CRYOTHERAPY APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

1. Name of Applicant: _____

2. Location Address: _____
(If this is not your mailing address or if multiple name and locations, attach list)

3. Telephone Number: _____ Fax Number: _____ Date Established: _____

5. Desired Effective Date: _____ Desired Limits of Liability: $_____ / $_____ Desired Deductible: _____

6. Gross Receipts for the Past 12 Months: $_____ Gross Receipts for the Next 12 Months: $_____

7. Full description of services provided:_____

8. Do you have any ancillary operations not stated above? Yes _____ No _____ If yes, provide details on last page

9. What was your total number of patient/client visits last year? _____ Estimated next year? _____

10. Do you work with professional athletes and/or celebrities? Yes ____ No ____ If yes, provide % exposure: _____

11. Do you treat minors? Yes _____ No _____ If yes, provide % exposure: _____

12. Are patients/clients screened prior to use to ensure that they do not have any of the following conditions?

High Blood Pressure Yes ____ No ____ Diabetes Yes ____ No ____ Pregnancy Yes ____ No ____

Bleeding Disorders Yes ____ No ____ Uncontrolled Seizures Yes _____ No _____

Cardiovascular Disease, Pacemakers or any other related cardiac issues Yes _____ No _____

Severe Anemia Yes ____ No ___ Claustrophobia Yes ____ No _____

Acute Kidney &/or Urinary Tract Diseases Yes _____ No _____

13. Are informed consent forms used in all cases prior to treatment (including minors)? Yes ___ No ___ If yes, please provide copies.

14. a) List the number and type of applicant's employees estimated over the next 12 months. If none, state none.

Profession (i.e. NP, PA, OT, PT)	Number	Profession	Number

b) Do you use Independent Contractors: ____ Yes ____ No If yes, and you would like coverage for them, please attach a list including their profession.

c) Are all the above individuals licensed in accordance with applicable state and federal regulations?

Yes _____ No _____ If no, attach explanation.

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15. 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? $_____

16. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage?

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

17. Are all operators of the cryotherapy units required to go through training prior to operation of the unit?
Yes _____ No _____ If yes, please provide details of required training: _____
_____

18. Do you sell, rent or otherwise provide any equipment to products or others? If yes, give details including types of products & gross receipts from each: _____

19.
a) Do you conduct pre-employment screening and investigation? Yes _____ No _____
b) Do you question prospects about previous claims or suits? Yes _____ No _____
c) Are employees required to actively participate in continuing education? Yes _____ No _____
d) Do you prepare job descriptions and instructional manuals for your staff? Yes _____ No _____
e) Do you have a written incident/occurrence reporting policy and procedures? Yes _____ No _____

20. Check all the following that apply if obtained, verified & kept on file as part of the employee hiring & screening process:

Applications	_____	Criminal Background Checks	_____
Drug / HIV/ Hepatitis Testing	_____	Licenses Held	_____
Education/Training/Competence	_____	Multi-State Registry	_____

21. 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 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 been treated for alcoholism or drug addiction?	_____	_____
d) 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?	_____	_____

22. Give details of Professional Liability coverage for the firm:

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

If expiring insurance is a claims made policy, what is the retroactive date? _____

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23. Give details of General Liability coverage for firm:

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

If expiring insurance is a claims made policy, what is the retroactive date? _____

24. 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 _____

25. Has any insurer cancelled or refused to renew any similar insurance during the past five years?
Yes_____ No_____ If yes, please give full details.

26. Has any claim ever been made against the firm or any of its employees? Yes_____ No_____ If yes, please complete & attach claims supplement with details.

27. 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.

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)

ADDITIONAL INFORMATION SECTION:
_____
_____
_____
_____
_____
_____