HUNTERSURE LLC

ALLIED HEALTH GENERAL APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

1. Name of Applicant: _____

2. Mailing Address: _____

3. Location Address: _____
(If multiple name and locations, please attach list)

4. Telephone Number: _____ Fax Number: _____

5. a) Date Established: _____

b) Entity Type: Corp. _____ Partnership_____ Prof. Assoc. _____ Individual_____

c) For Profit _____ Non-Profit _____

6. Funding is: Medicare _____% Medicaid _____% Private Pay _____%

7. a) Desired Effective Date: _____

b) Desired Limits of Liability: $_____ / $_____

c) Desired Deductible: $_____

8. a) Gross Receipts for the Past 12 Months: $_____

b) Estimated Gross Receipts for the Next 12 Months: $_____

c) Payroll for the Past 12 Months: $_____

d) Estimated Payroll for the Next 12 Months: $_____

9. Applicant's Service is licensed as a:___

10. Full description of services provided:_____

11. Does the applicant have any ancillary operations not stated above? Yes _____ No _____

If yes, please provide details: _____

12. Is the firm engaged in, owned by, associated with or controlled by any other business? If yes, please provide details:
_____
_____

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13. a) What was your total number of patient/client visits last year? _____

b) Estimated next year? _____

14. Breakdown of patient services:

AIDS _____ %	Alcoholic _____ %	Bariatric _____ %
Communicable _____ %	Dental _____ %	Disability _____ %
Drug Addiction _____ %	Emergency Medical _____ %	Family Planning _____ %
General Exams _____ %	Gynecological _____ %	Hemodialysis _____ %
Holistic Medicine _____ %	Major Surgery _____ %	Minor Surgery _____ %
Nutritional (Diet) _____ %	Obstetric _____ %	Occupational Medical _____ %
Optometry/Ophthalmology _____ %	Orthopedic _____ %	Pediatric _____ %
Psychiatric _____ %	Rehab Therapy _____ %	Research/Experimental _____ %
Stress Testing _____ %	Substance Abuse _____ %	Other; Describe: _____

15. Does the applicant provide weight loss services? Yes _____ No _____
If yes, please provide details of methods used & what % this is of their total operation: _____
_____
_____

16. Is the applicant involved in the use of HCG and/or Hormone Therapy? Yes _____ No _____
If yes, please provide details & what % this is of their total operation: _____
_____
_____

17. Are any of the following performed:

Administer anesthesia (general or local)? Yes _____ No _____

Surgery (major or minor including Face Peel, Dermabrasion, Silicone Injection, and Needle Biopsies)? Yes _____ No _____

Cardiac Catheterization? Yes _____ No _____

Diagnostic tests? Yes _____ No _____

Chemotherapy? Yes _____ No _____

X-Rays? Yes _____ No _____

Radiation Therapy? Yes _____ No _____

Reduction of Fracture? Yes _____ No _____

Shock Therapy? Yes _____ No _____

Prescribe medication? Yes _____ No _____

Obstetric procedures? Yes _____ No _____

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If yes to any of the above, please provide a detailed description below: _____

_____

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

Profession	Number	Profession	Number
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Physical Therapist	_____	Aide/Homemaker	_____
Occupational Therapist	_____	Social Worker	_____
Respiratory Therapist	_____	Pharmacists	_____
Speech Therapist	_____	Clerical/Admin	_____
Nurse Practitioner	_____	CRNA/Surgical Technician	_____
Physician Assistant	_____	Optician/Optometrist	_____
Medical Technician	_____	Chiropractor	_____
Paramedic/EMT	_____	Psychiatrist	_____
Psychologist	_____	Other (please describe)	_____

b) List the number and type of independent contractors estimated over the next 12 months. If none, state none.

Profession	Number	Profession	Number
Registered Nurse	_____	Physician (patient contact)	_____
Licensed Practical Nurse	_____	Physician (medical director only)	_____
Physical Therapist	_____	Aide/Homemaker	_____
Occupational Therapist	_____	Social Worker	_____
Respiratory Therapist	_____	Pharmacists	_____
Speech Therapist	_____	Clerical/Admin	_____
Nurse Practitioner	_____	CRNA/Surgical Technician	_____
Physician Assistant	_____	Optician/Optometrist	_____
Medical Technician	_____	Chiropractor	_____
Paramedic/EMT	_____	Psychiatrist	_____
Psychologist	_____	Other (please describe)	_____

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

Yes _____ No _____ If no, attach explanation.

19. 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 _____

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20. 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? $_____ / $_____

21. Are all services provided at the applicant's location address(s)? Yes _____ No _____
If no, please provide details of any off-site exposure: _____
_____
_____

22. Does the applicant provide any beds for overnight stays? Yes _____ No _____
If yes, give details: _____
_____

23. 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: _____
_____
_____

24. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician?

Yes _____ No _____ If no, give details: _____

25. 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 _____

26. 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	_____

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

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28. 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?	_____	_____

29. 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:

_____

_____

30. Do you provide any legal and/or financial services or handle client's money, bills or finances of any type?

Yes _____ No _____

If yes, please provide details: _____

31. Do you act as legal guardian or power of attorney for anyone?

Yes _____ No _____

If yes, please provide details: _____

32. Give Professional Liability coverage for last five years 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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33. Give General Liability coverage for last five years for the firm:

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

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

34. 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 _____

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

Yes_____ No_____ If yes, please give full details.

36. 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.

37. 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.

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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.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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