



PROFESSIONAL and GENERAL LIABILITY APPLICATION MEDICAL LAB / DIAGNOSTIC IMAGING (Edition 06.2026)

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple names and locations, please attach list)
4. Telephone Number: _____ Website Address: _____ Date Established: _____

Section 2: Business Details

5. Entity Type: ☐ Corporation ☐ Individual ☐ LLC ☐ Partnership ☐ Other: _____
6. Status: ☐ For Profit ☐ Non-Profit
7. Funding is: Medicare _____% Medicaid _____% Private Pay _____% Other: _____

Section 3: Coverage Requested

8. Effective Date: _____
9. Liability Limits: \$ _____ / \$ _____
10. Deductible: \$ _____

Section 4: Financials

11. Gross Receipts (Past 12 Months): \$ _____
12. Estimated Gross Receipts (Next 12 Months): \$ _____

Section 5: Services Provided

13. Applicant's Service is licensed as: _____
14. Full description of services provided: _____
15. Does the applicant have any ancillary operations not stated above? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application? ☐ Yes ☐ No
16. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses? ☐ Yes ☐ No
If Yes, please provide details: _____
If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application? ☐ Yes ☐ No

17. Are all services provided at the applicant's location address(es)? ☐ Yes ☐ No
 If No, please provide details of any off-site exposure including a breakdown as to where services are provided by percentage at each type of location: _____
18. Indicate the percentage of total services provided to each of the following client types. (Total must equal 100%)
- | | |
|---|---------|
| ☐ Assisted Living Facilities / Nursing Homes | _____ % |
| ☐ Industrial Facilities | _____ % |
| ☐ Corporate Clients | _____ % |
| ☐ Veterinary Clinics | _____ % |
| ☐ Physician Offices | _____ % |
| ☐ Other (Describe): _____ | _____ % |
19. Please provide the total number of tests:
- a) Conducted during the past 12 months: _____
- b) Expected during the next 12 months: _____
20. Indicate all services provided and the percentage of total operations attributable to each. For new ventures, please provide estimated percentages. (Total must equal 100%)
- | | |
|---|---------|
| a) ☐ AIDS Testing | _____ % |
| b) ☐ Blood Collection / Phlebotomy | _____ % |
| c) ☐ Bone Density Scans | _____ % |
| d) ☐ Clinical Laboratory Testing | _____ % |
| e) ☐ Diagnostic Imaging (X-ray, MRI, CT/CAT, Ultrasound) | _____ % |
| f) ☐ DNA Testing (including paternity testing) | _____ % |
| g) ☐ Drug and/or Alcohol Testing | _____ % |
| h) ☐ Marijuana/Cannabis Testing | _____ % |
| i) ☐ Immunology Testing | _____ % |
| j) ☐ Mammography Services | _____ % |
| k) ☐ Mobile Imaging Services | _____ % |
| l) ☐ Pathology Services | _____ % |
| m) ☐ Specimen Transport | _____ % |
| n) ☐ Other (describe): _____ | _____ % |

Section 6: Testing Responsibilities

21. Provide the percentage breakdown of testing by service provider. (Total must equal 100%)
- | | |
|--|---------|
| a) ☐ Applicant's laboratory and/or staff | _____ % |
| b) ☐ Contracted laboratory retained by the applicant | _____ % |
| c) ☐ Independent laboratories selected by third parties | _____ % |
| d) ☐ Other (describe): _____ | _____ % |

22. Does the applicant confirm any contracted and/or independent laboratories carry their own separate professional and general liability coverage for these operations with minimum limits of \$1M/\$3M? ☐ Yes ☐ No
23. Is the applicant responsible for interpreting or communicating results from tests conducted by third-party providers? ☐ Yes ☐ No
If Yes, please identify the entity whose letterhead is used when issuing the results: _____
24. Does the applicant interpret test results or render diagnoses? ☐ Yes ☐ No
If Yes, provide details of the interpreting/diagnosing personnel and their qualifications.
If No, identify the party responsible for interpretation and diagnosis: _____
25. Does the applicant confirm any person diagnosing/interpreting the results of the tests carry their own separate professional liability coverage for these operations with minimum limits of \$1M/\$3M? ☐ Yes ☐ No

Section 7: Special Activities

26. Indicate any involvement in the following activities, and attach a separate sheet detailing the specific tests performed, annual test volume, and percentage of annual gross receipts:
- ☐ 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, products or supplies (If Yes, complete DME Supplement)
 - ☐ Performing any type of environmental analyses
 - ☐ Therapy or treatment procedures
 - ☐ Services open to the public (Health fairs, shopping malls, exhibits, etc.)
 - ☐ Manufacturing or distributing any "test kits" used by others including and "home test kits"
 - ☐ None
27. 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: _____
28. Please provide name, qualifications and number of years of experience of Medical Director, manager and/or supervisor(s):

29. Are random tests performed to audit false positive and/or negative results? ☐ Yes ☐ No
If No, please explain the reason: _____
30. 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:

31. How long does your lab retain specimens collected for future reference? _____
32. Describe the referral source(s) by which patients are directed to the entity: _____

Section 8: Staffing

33. Employee and Independent Contractor Details:

a) List the **NUMBER** and type of **PERSONNEL**:

PROFESSION	EMPLOYEE		INDEPENDENT CONTRACTOR	
	Full-Time	Part-Time	Full-Time	Part-Time
Lab Technician				
RN / LPN				
Pathologist				
Phlebotomist				
Physician				
Radiologist				
X-Ray Technician				
All others (Describe):				

34. Are all the above individuals listed on Q33 licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
(If No, attach details)

35. Are you seeking coverage under this proposed insurance for the independent contractors? ☐ Yes ☐ No
If No, is coverage at equal or greater limits maintained by each independent contractor? ☐ Yes ☐ No

36. Do you require pathologists, physicians, and radiologists listed in Q33 to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No ☐ N/A
If Yes, at what limits? \$_____ / \$_____

37. Are employees up to date on any training required by the state or other governing body, and is proof of this required training kept on file at the facility? ☐ Yes ☐ No

38. Is the applicant accredited, certified, licensed, or a member of any professional association or governing body? ☐ Yes ☐ No
If Yes, describe: _____

39. Screening and Policies:

a) Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No
b) Do you have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No

40. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:

☐ Applications/Resumes ☐ Criminal Background Checks ☐ Licensure Verification
☐ Drug Testing ☐ Education/Training/Competence



41. Disclosure of Disciplinary or Legal History:

Attach a detailed explanation for any **YES** answers below:

Has the applicant or have any of the employees:

- a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
- b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)? ☐ Yes ☐ No
- c) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
- d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered? ☐ Yes ☐ No

Section 9: Insurance History

Currently valued loss runs for all prior coverage are required.

42. Professional Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

43. General Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

Section 10: Claims and Incidents

44. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details) ☐ Yes ☐ No
45. Has any claim been made against the insured or its employees that would be covered by this policy in the past 5 years? ☐ Yes ☐ No
If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported)
46. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees that would be covered under this policy? (If Yes, attach details) ☐ Yes ☐ No

Signature and Attestation

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.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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