



ADMIRAL VIRTUAL CARE PROFESSIONAL LIABILITY RENEWAL APPLICATION

SECTION I – GENERAL INFORMATION

1. Full Name of Applicant:
(Include all prior names, DBAs and subsidiaries seeking coverage under the policy for which you are applying)

2. Applicant's Address (include mailing address if different than physical address):

3. Website Address(es):

4. FEIN:

5. In the last 12 months have you experienced any mergers, acquisitions, or divestitures? Yes No

Do you plan on any within the next 12 months? Yes No

If Yes to either of the above, provide complete details:

SECTION II – GETTING TO KNOW YOU- WHAT'S CHANGED?

6. Complete all sections that apply:

	Total Revenue	# of Outpatient Visits	# of Inpatient Beds	# of Non-Emergency Transports	# of Emergency Transports	# of Students	# of Surgeries
Next 12 Months	\$						
Last 12 Months	\$						
Two Years Ago	\$						

7. Provide the percentage (%) of Total Revenue attributed to foreign locations/operations: %

If greater than 0%, provide details including list of countries, number of employees in each and percentage of revenue associated with each country:

8. Within the last 12 months, have you added any new technology services, new products or made any changes to your current offerings?
If Yes, provide complete details: Yes No

9. Have any of your products or third-party products you provide to clients been subject to a product recall?
If Yes, provide details including product recall costs to you, the remedy and if any third-party claims or litigation related to the product recall: Yes No

10. Have you discontinued any software, product, or service in the last year?
If Yes, provide details including whether you continued to provide maintenance and software patching services: Yes No

11. Within the last 12 months, have you made any significant changes or improvements to your data privacy and risk management practices?
If Yes, provide complete details: Yes No

12. Provide the estimated record count of sensitive information you maintain on your servers, store with a cloud provider and host for others:

	Number of Records
Medical Records	
Medical Records Attributed to Minors	
Financial Records (credit/debit cards, bank account #'s, etc.)	
Other Protected Personally Identifiable Information	
TOTAL RECORD COUNT	

13. For your **Medical Personnel**, complete the following employee breakdown as applicable:

	Number of Employees	Number of Independent Contractors*	Insured on Own Med Mal Policy	Current Carrier & Limits of Liability
Physicians (no surgery)			Yes No	
Physicians (surgical)			Yes No	
Physician Assistants			Yes No	
Nurse Practitioners / APRNs			Yes No	
CRNAs			Yes No	
Surgical Technicians			Yes No	
Nurses (RN/LPN/LVN)			Yes No	
Aestheticians			Yes No	
Laser Techs			Yes No	
Medical Assistants			Yes No	
Massage Therapists			Yes No	
Pharmacists			Yes No	
Paramedics/EMT's			Yes No	
Social Workers/LMT/Counselors			Yes No	
Physical/Speech/Occupational Therapists			Yes No	
Other:			Yes No	

* Attach copies of declaration pages on all individuals that carry their own malpractice.

Would you like to include coverage for any physician's, dentist's, surgeon's, podiatrist's or chiropractor's direct patient care?

Yes No

If Yes, have each Physician complete the [Admiral Physicians and Surgeons Short Form Application](#).

14. Does your practice include prescribing of opioids?

Yes No

If Yes, provide the following details:

a. Specify the percentage of your practice derived from opioid prescriptions:

%

b. Do you fully comply with the [CDC Guideline for Prescribing Opioids](#)?

Yes No

c. Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business?

Yes No

d. Do you also dispense the opioids?

Yes No

15. In the past twelve (12) months or next twelve (12) months projected, has the applicant or is the applicant planning on administering any Non-Invasive Weight Loss treatment (i.e. Semaglutide)?

Yes No

If Yes, complete the [Non-Invasive Weight Loss Supplemental Application](#) and provide the informed consent specific to non-invasive weight loss used.

16. Provide percentage breakdown for the location(s) your services are provided (total must equal 100%):

%	Patient's Home
%	Clinic, Hospital or Physician's Office
%	Virtually (online platform, telephone, etc.)
%	Nursing Home
%	Assisted Living Facility
%	Jails or Correctional Facilities
%	Other (explain):

17. Provide percentage breakdown of patient population (total must equal 100%):

Check if not applicable.

%	Ages 0 – 17
%	Ages 18 – 59
%	Ages 60+

18. Indicate the percentage or number of patient encounters for each state (if using percentage, total must equal 100%):

Check if not applicable.

State	Percent	Number	State	Percent	Number	State	Percent	Number	State	Percent	Number
AL	%		IA	%		MT	%		RI	%	
AK	%		IL	%		NE	%		SC	%	
AZ	%		IN	%		NV	%		SD	%	
AR	%		KS	%		NH	%		TN	%	
CA	%		KY	%		NJ	%		TX	%	
CO	%		LA	%		NM	%		UT	%	
CT	%		ME	%		NY	%		VT	%	
DC	%		MD	%		NC	%		VA	%	
DE	%		MA	%		ND	%		WA	%	
FL	%		MI	%		OH	%		WV	%	
GA	%		MN	%		OK	%		WI	%	
HI	%		MS	%		OR	%		WY	%	
ID	%		MO	%		PA	%				

SECTION III – CLAIMS HISTORY

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS

19. Have any of the Applicant’s employee(s) or independent contractors been the subject(s) of alleged or actual incidents regarding sexual abuse or molestation or child abuse/neglect? Yes No
 If Yes, provide details on a separate attachment.

20. Has the applicant or any of the above employees and/or independent contractors:

- a. Ever been subject to a disciplinary or investigative proceeding or been reprimanded by a government or administrative agency, hospital, or professional association? Yes No
- b. Ever been convicted of a criminal act other than traffic offenses? Yes No
- c. Ever been treated for alcoholism or drug addiction? Yes No
- d. Ever had any professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms, or ever voluntarily surrendered such license? Yes No
 If Yes to any of the above questions, describe:

- | | |
|---|--|
| <p>21. Has any insurer declined, cancelled or non-renewed any similar insurance for which you are applying?
If Yes, provide complete details:</p> | <p>Yes No</p> |
| <p>22. After inquiry, is the applicant, any predecessor, or any other person for whom coverage is requested been subject to any actions or investigations by any regulatory or administrative body for violations arising out of your advertising or electronic communication activities?
If Yes, provide complete details:</p> | <p>Yes No</p> |
| <p>23. Have any claims, suits or regulatory proceedings ever been made against the Applicant or any of its employees?
If Yes, complete a Supplemental Claim Information Form for each and every claim.</p> | <p>Yes No</p> |
| <p>24. Is the applicant aware of any errors, omissions, circumstances, or incidents which may result in a claim being made against them or their employees, or are there any claims that have not yet been reported?
If Yes, provide complete details:</p> | <p>Yes No</p> |
| <p>25. In the past five (5) years:</p> <p>a. Have you experienced any:</p> <ul style="list-style-type: none"> i. Known intrusions (i.e. unauthorized access), security incidents, security breaches or cyber-attacks? ii. Actual or attempted extortion demand with respect to your computer systems? iii. Unexpected outage of a computer network, application, or system lasting greater than four (4) hours? <p>If Yes to any of the above questions, provide complete details:</p> | <p>Yes No</p> <p>Yes No</p> <p>Yes No</p> |
| <p>b. Have you experienced an actual or suspected data breach or cyber-attack?
If Yes, provide a detailed description of the event(s) and remediation action(s) taken:</p> | <p>Yes No</p> |

c. Have you received any complaints concerning the content of your websites or electronic communications? Yes No
If Yes, provide complete details:

d. Have you been accused of, made aware of, or had a claim as a result of actual or alleged infringement upon another's domain name, trademark, copyright, services mark or similar intellectual property? Yes No
If Yes, provide complete details:

*For each and every claim, click the link to complete the [Supplemental Claim Information Form](#)

SECTION IV – COMMENTS

Use this space below to provide us with any other relevant information:

GENERAL LIABILITY SUPPLEMENTAL APPLICATION

If you want GL coverage, complete the following or submit a signed GL Acord Application.

SECTION I – YOUR LOCATIONS

IF YOU HAVE MORE THAN FIVE (5) LOCATIONS, PROVIDE A SPREADSHEET WITH THE INFORMATION BELOW FOR EACH LOCATION.

1.

Loc #	Facility Name	Address	Description / Use	Square Footage	How many other occupants do you share the building with?
1					
2					
3					
4					
5					

SECTION II – FIRE-LIFE SAFETY INFORMATION

2. Are all of your locations equipped with:

- | | | |
|---|-----|----|
| a. Complete sprinkler system? | Yes | No |
| b. At least two clearly marked exits on each floor? | Yes | No |
| c. Smoke detectors? | Yes | No |
| d. Emergency electrical system? | Yes | No |
| e. Heat sensors? | Yes | No |
| f. Fire escape(s)? | Yes | No |
| g. Posted emergency evacuation procedures? | Yes | No |
| h. Properly maintained fire extinguishers? | Yes | No |

SECTION III – CLAIMS

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

- | | | |
|--|----------------|--------|
| 3. Has any general liability claim or suit been brought against you and/or any of your employees?
If Yes, complete a Supplemental Claim Information Form for each and every claim or suit. | Yes | No |
| 4. Are any persons or entities proposed for this insurance aware of any fact, circumstance, or situation which may result in a GL claim, and has not been reported to your current GL insurance carrier?
If Yes, provide details: | None to Report | Yes No |
| 5. Are you aware of any incident, condition, circumstance, defect or suspected defect in any product, which may result in a claim or claims against you that are not listed above?
If Yes, provide details: | None to Report | Yes No |

NOTICE TO APPLICANT: By signing this application, you agree the answers you give us in this application and any other information you give us as part of the application process are:

- 1. Accurate & Complete.**
- 2. Given to us to issue you an insurance policy.**
- 3. Material to our decision-making process in issuing you an insurance policy.**
- 4. A significant part of what we relied upon in making our decision in issuing you an insurance policy. You must agree to notify us, through your insurance brokerage, if during the policy term any material changes to your operations occur.**

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title:

Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.