



MEDICAL TESTING LABORATORY PROFESSIONAL LIABILITY APPLICATION and GENERAL LIABILITY APPLICATION (CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

1) Full Name of Applicant:

(Include all DBA's and subsidiaries seeking coverage under the policy for which you are applying)

2) Principal Office Mailing Address:

(Attach a schedule of all locations if more than one)

3) Website:

4) List all states in which applicant operates and percentage of work in each state:

5) Does applicant have a location at a hospital or within another medical facility? Yes No
If Yes, provide details:

6) Applicant is a:

Individual	LLC	Corporation
Partnership	Joint Venture	Other:

7) Date Established (mm/dd/yy):

8) FEIN:

9) Has the name of the applicant ever changed or has there been any acquisition, consolidation, dissolution, merger or any other change in business organization during the past five (5) years? Yes No
If Yes, provide full details:

10) During the next twelve (12) months, does the applicant contemplate offering any services not currently offered, or any mergers or acquisitions? Yes No
If Yes, provide details:

SECTION II – FACILITY OPERATIONS

11) Professional Activities and Specialties (describe):

12) State approximate percentage of gross income derived from the following types of tests (total overall percentage should be 100%):

Medical Testing Lab Services		Imaging Testing Lab Services	
Clinical / Chemistry	%	Bone Density	%
DNA / Paternity	%	Compound Tomograph (CT)	%
Genetics	%	Digital Mammograms	%
Hematology	%	Electrocardiogram (EKG)	%
Immunology	%	Fluoroscopy	%
Molecular	%	Mammograms	%
Pathology / Cytology / Histology	%	Magnetic Resonance Imagin (MRI)	%
Pregnancy	%	Positron Emission Tomography (PET)	%
Sample Collections Only	%	Ultrasounds	%
STD's / HIV / AIDS	%	X-rays	%
Toxicology (Drug / Alcohol)	%		
Other:			%
Other:			%
Total			100%

13) What is the total number of tests estimated for the next 12 months?

Last 12 months?

14) Specimen collection:

a. Samples collected by you or your employees at your lab site: %

b. Samples collected by others and sent into or delivered to your lab site: %

15) Do you provide any services to long term care facilities including but not limited to hospitals, nursing homes, assisted living facilities, and/or senior homes? Yes No

What percentage of overall services are performed at these facilities? %

Provide a brief explanation of these services:

16) Do you provide any correctional care services? Yes No

What percentage of overall services are correctional care? %

Provide a brief explanation of your correctional care services:

17) State sources and amounts of **TOTAL GROSS REVENUE / RECEIPTS**

Source of Revenue	Estimated for Next 12 Months	Last 12 Months
Charitable Contributions	\$	\$
Government Funding	\$	\$
Fee for Service	\$	\$
Other:	\$	\$
TOTAL GROSS REVENUE	\$	\$

SECTION III – STAFF

18) Staff:

	Employees	Independent Contractors	Own Med Mal? Y or N	
Principals, Partners, Officers, Directors			Y	N
Physicians			Y	N
LPN/LVN/RN			Y	N
Nurse Anesthetist			Y	N
Nurses Aides			Y	N
Certified Lab Technician/Technologist			Y	N
Certified Medical Assistant			Y	N
EEG/EKG Technician/Technologist			Y	N
X-Ray Technician/Technologist			Y	N
Phlebotomist			Y	N
Medical Technician/Technologist			Y	N
Radiation Therapist			Y	N
Inhalation Therapist			Y	N
Physician’s Assistant			Y	N
Social Worker			Y	N
Clerical/Administrative			Y	N
Other:			Y	N
TOTAL STAFF:			Y	N

*Attach copies of declarations pages for all of the above that carry their own insurance.

- 19) Are all of the above individuals licensed in accordance with all applicable state and federal regulations? Yes No
 If No, provide details:
- a. Have any of the above individuals had their license/certification revoked/suspended, voluntarily surrendered or cancelled? Yes No
 If Yes, provide details:
- b. Have any of the above individuals been the subject of disciplinary or investigative proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? Yes No
 If Yes, provide details:
- c. Have any of the above individuals been convicted of an act in violation of any law or ordinance other than a traffic accident? Yes No
 If Yes, provide details:

20) Do you offer any of the following services? If yes, attach a detailed explanation.

- | | | |
|--|-----|----|
| a. Therapy or any treatment procedures? | Yes | No |
| b. Blood banking or blood storage? | Yes | No |
| c. Procurement of blood or its components? | Yes | No |
| d. Plasmapheresis procedures? | Yes | No |
| e. Medical, genetic or drug research? | Yes | No |
| f. Manufacture, testing or dispensing of pharmaceuticals? | Yes | No |
| g. Experimental testing or procedures? | Yes | No |
| h. Mobile services? | Yes | No |
| If Yes, what percentage? | | % |
| i. Any services at malls/shopping centers, health fairs, etc.? | Yes | No |
| j. Intravenous transfusions? | Yes | No |

21) What hours/days a week do you operate?

22) Does applicant utilize a procedural and quality control manual? Yes No

 If Yes, does applicant make sure that all employees have reviewed these? Yes No

23) Is lab inspected/certified/accredited by any governmental or medical association? Yes No

 If Yes, which association?

24) Does applicant use a reference lab? Yes No

 If Yes, answer the following:

a. What percentage of your tests are sent to reference lab? %

b. Name of reference lab:

c. Does reference lab hold applicant harmless? Yes No

d. Does applicant obtain written proof of insurance with minimum limit of \$1,000,000, for reference lab? Yes No

e. Does the applicant operate as a reference lab? Yes No

25) Does the applicant provide any service under contract? Yes No

 If Yes, provide details and a copy of contract:

SECTION IV – NETWORK SECURITY AND DATA PRIVACY PROCEDURES

1) Do you currently purchase a standalone cyber policy? Yes No

 If Yes, provide the following information:

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

- 2) Do you employ the following tools to protect private sensitive data?
- a. Anti-Virus and Firewalls Yes No
 - b. Encryption Yes No
 - c. Formal Password Management Procedures Yes No
- 3) Are you compliant with the Health Information Portability and Accountability Act (HIPAA) and Health Information Technology for Economic Critical Health Act (HITECH)? Yes No
- 4) Have you ever experienced a security breach, data loss or denial of service attack? Yes No
- If Yes, complete a [Supplemental Claim Information Form](#) for each and every claim.

SECTION V – COVERAGE HISTORY

- 5) List Professional Liability coverage for the last five years beginning with the most recent coverage:

Carrier	Limits	Deductible	Premium	Policy Term	Retroactive Date

- 6) Has any Professional Liability claim or suit been brought against the applicant or any of its employees? Yes No
 If Yes, complete the [Supplemental Claim Information Form](#) for each and every claim. Also, attach five years of currently valued company loss runs.
- 7) Is the applicant aware of any circumstance which may result in any claim against them or their employees? Yes No
 If Yes, provide full details including names of parties involved, dates and allegations:
- 8) Has any applicant for Professional Liability Insurance made on behalf of the applicant ever been declined or has their insurance been cancelled or renewal refused? Yes No
 If Yes, provide details:
- 9) Are you interested in a quote for General Liability? Yes No
 If Yes, complete the General Liability Supplemental Application below.

GENERAL LIABILITY SUPPLEMENTAL 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
1				
2				
3				
4				
5				

	Location 1	Location 2	Location 3	Location 4	Location 5
Own or Lease	Own Lease	Own Lease	Own Lease	Own Lease	Own Lease
% occupied by applicant	%	%	%	%	%
Are there other occupants?	Yes No	Yes No	Yes No	Yes No	Yes No
# of beds / units (if applicable)					

SECTION II – MAINTENANCE

2) Does the Applicant have a full-time maintenance staff? Yes No

Confirm the type of maintenance, service and repair performed by the Applicant (Direct) or subcontracted (Subbed) by completing the table below.

NOTE: Direct is a percentage of total direct payroll and Subbed is a percentage of total subcontractor cost.

Type	Direct	Subbed
Snow & Ice Removal	%	%
Janitorial/Cleaning Services	%	%
General Maintenance & Repairs	%	%
Landscaping	%	%
Other:	%	%

3) Does the Applicant have written procedures for routine inspections of the premises to identify and address potential liability hazards? Yes No

If Yes, are records of the completed inspections and repairs retained for at least five years? Yes No

4) Are there any construction projects planned for the upcoming policy term? Yes No

If Yes, provide full details of project, location, total costs, payroll and sub costs:

a. Will the construction be subbed out? Yes No

b. Are signs clearly posted to warn the third party of construction and/or during routine Maintenance? Yes No

SECTION III – FIRE-LIFE SAFETY INFORMATION

5) 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 |

Attach a separate sheet detailing any No answers.

SECTION IV – OTHER PREMISES EXPOSURES

6) Are any of the following provided:

- | | | |
|--|-----|----|
| a. Sale of any food or drinks? | Yes | No |
| b. Recreational facilities? | Yes | No |
| c. Gym or exercise equipment available to members or the public? | Yes | No |
| d. Swimming pool on any premises? | Yes | No |
| e. Daycare or childcare services? | Yes | No |
| f. Sponsor any sporting or social events? | Yes | No |
| g. Hold any fundraising events? | Yes | No |
| h. Provide alcohol with any of your events or services? | Yes | No |
| i. Participation in trade shows, exhibits or conventions? | Yes | No |
| j. Any plans for new construction or renovations during the next twelve (12) months? | Yes | No |

Attach a separate sheet detailing any Yes answers.

SECTION V – PRODUCTS AND EQUIPMENT SOLD OR LEASED

7) Do you loan, lease or rent equipment to others?

Yes No

a. Annual gross revenue for equipment rental \$

b. With or without operator (technician)? With Without
Provide details:

c. Who is responsible for equipment maintenance?

- 8) Do you sell durable medical equipment? Yes No
If Yes, complete the following table for Medical Equipment Suppliers Revenue:

	Annual Sales	Annual Lease/Rental
Category I: Expendable Items (i.e. adhesive tape, bandages, hypodermic needles)	\$	\$
Category II: Non-Expendable Items (i.e. hospital beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.)	\$	\$
Category III: Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, transmitting devices)	\$	\$
Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.)	\$	\$

SECTION VI – ADVERTISING

- 9) Do you obtain proper consents and utilize contractual agreements prior to using the image/oral/written publication of any person/celebrity? N/A Yes No
- 10) Are you making any structure/function claims for your products on labels, websites or other marketing materials? Yes No
- Do you maintain documentation that substantiates each claim you make? Yes No
 If Yes, explain the documentation and length of time records are retained:

SECTION VII – ADDITIONAL INSUREDS

- 11) List all parties that should be considered for Additional Insured status under the General Liability. Include a copy of the contract for each entity and a certificate of insurance evidencing GL coverage in place.

Name and Address	Relationship to Applicant

SECTION VIII – PRODUCTS & COMPLETED OPERATIONS

Attach a separate sheet detailing any Yes answers, along with a list of products sold.

If product labels cannot be found on your website, include copies with this application.

- 12) Do you sell any products? Yes No
 If No, skip to question 29.

If Yes, answer the following questions and include product brochures.

Describe the types of products you sell:

- 13) Total gross revenue **from product sales:**

- a. Last twelve (12) months: \$
- b. Next twelve (12) months: \$

- 14) Any herbal supplements, homeopathic remedies, and/or nutraceuticals? Yes No
- 15) Do any of your products include:
- a. Caffeine exceeding 300 mg per servicing (all sources)? Yes No
 - b. Cannabidiol (CBD) hemp products? Yes No
 - c. Class I & Class II Medical Products / Devices? Yes No
- 16) Do you mix or compound any ingredients? Yes No
- 17) Is a prescription required for any of the products you sell? Yes No
- 18) Are products of others sold or re-packaged under your label? Yes No
- 19) Do all of your labels include a disclaimer that the FDA has not evaluated the claims on your labels and that your products are not intended to diagnose, treat, cure or prevent any diseases? Yes No
- 20) Do you obtain Certificates of Insurance from all suppliers evidencing Product Liability Insurance? Yes No
- 21) Are foreign products sold, distributed, or used as components? Yes No
- 22) Have any of your products been recalled, discontinued or changed? Yes No
- 23) Do you offer training or instruction to the user of your products? Yes No
- 24) Do you offer guarantees, warranties or Hold Harmless agreements with your products? Yes No
- 25) Do you install, service or demonstrate products? Yes No
- 26) Is research and development conducted on new products? Yes No
- 27) Are any new products planned in the next year? Yes No
If Yes, provide explanation:

- 28) Are you a manufacturer, wholesaler or importer of products to others? Yes No

If Yes, answer the following questions and attach a separate sheet detailing any No answers, along with copies of product labels (if not available on website).

- a. Are all warning labels and instructions for use reviewed by outside legal counsel? Yes No
- b. Has legal counsel reviewed your labeling and confirmed it is in compliance with regulations established by the FDA and FTC? Yes No
- c. Have you conducted or are you planning to conduct human clinical trials to substantiate your product claims? Yes No

SECTION IX – PRIOR GENERAL LIABILITY COVERAGE HISTORY

29) List prior General Liability insurance carried for each of the past five (5) years. If NONE, check this box

Insurance Company	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form?	Retro Date
					Yes No	
					Yes No	
					Yes No	
					Yes No	
					Yes No	

SECTION X – CLAIMS

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

30) Has any General Liability claim or suit been brought against you and/or any of your employees? Yes No
If Yes, complete a [Supplemental Claim Information Form](#) for each and every claim or suit.

31) 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? None to Report Yes No
If Yes, provide details:

32) 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? None to Report Yes No
If Yes, provide details:

Attach the following information:

- C.V. or Resumes on physicians and principals
- Five years of currently valued company loss runs
- Marketing or advertising brochures

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.