Admiral INSURANCE GROUP
a Berkley Company

PUBLIC HEALTH PROFESSIONAL LIABILITY APPLICATION

(CLAIMS MADE COVERAGE)

1. Name of Applicant:

2. Address:
Street City State Zip Code

3. Other locations:

4. Population served: Name of Health Officer:

5. Applicant is: State County Municipality District other (describe)

6. Staff:

	#Employed	#Contracted
Officers and Directors:		
Physicians		
Dentists		
Psychiatrists		
Nurse Practitioners		
Registered Nurses		
Licensed Practical Nurse		
Physicians Assistant		
Sanitarians		
X-Ray Technicians		
Lab Technicians		
Dental Hygenist		
PhysicalTherapists		
Speech Therapists		
Psychologists		
Social Workers		
Dental Technician		
Clerical		
Other (describe)		
TOTAL		

7. If applicant contracts for services to any outside health care staff, do you require evidence of proper license and insurance?

Yes No If Yes, explain procedure and limits requirements of contractors:

8. Are there any professionals who volunteer their services? Yes No If Yes, please explain:

9. SERVICES (total should equal 100%)

Laboratory	%	Substance Abuse	%	Children	%
Dental	%	Psychiatric Rehabilitation	%	Abortion	%
Home Health	%	Pre-Natal	%	Jail/Prison Healthcare	%
Geriatric	%		%	Family Planning	%
Environmental Health	%	Communicable Disease	%		

Other (describe) % %

10. Medical Services:

a. Do you provide surgical procedures? Yes No If Yes please explain on separate attachment.
b. Do you provide Radiation Therapy/Chemotherapy treatment? Yes No If Yes please explain on separate attachment.
c. Do you administer or provide electric shock therapy? Yes No If Yes please explain on separate attachment.
d. Do you Dispense Methadone? Yes No
If Yes, how many patient contacts for 2000 estimate for 2001
e. Do you provide Angiography/Artiography/Venography? Yes No If Yes please explain on separate attachment.
f. Do you administer anesthesia other than local? Yes No If Yes please explain on separate attachment.
g. Do you provide oral/dental surgery? Yes No If Yes please explain on separate attachment.
h. Do you operate any other Healthcare Facility such as:
Hospital Nursing Home Shelter Care other

Patient Contacts:

	Last 12 months	Estimate next 12 months
# Visits - Clinic		
# Immunizations		
# Visits- Mental health		
# FCM Program		
# WIC Program		
# Other		

11. Environmental Services:

	Last 12 months	Estimate next 12 months
# Inspections		
# Investigations		
# Water Tests		
# Permit/License		
#Other:		

12. Annual Budget:

	Next 12 months (From / To)	Previous 12 Months (From / To)
a. Medical Services	$	$
b. Environmental Services	$	$
c. Total	$	$

13. Current General Liability Coverage:

Carrier: Limits:

Policy Term:

Do you carry Excess Liability? Yes No If Yes, Carrier: Limits:

14. Professional Liability (3 years):

Carrier:	Limits:	Deductible:	Exp. Date	Premium

What is the current Retroactive Date on your Professional Liability Policy:

15. What Limit and Deductible options are you requesting?

☐ $1,000,000/1,000,000 ☐ $1,000,000/3,000,000 ☐ $0 ☐ $5,000 ☐ $10,000 ☐ other

If deductible of $25,000 or higher is requested please include latest financials with this application.

16. Has any application for Professional Liability Insurance made on behalf of the applicant ever been declined or has the insurance ever been canceled or renewal refused? ◯ Yes ◯ No If Yes, please give details:

17. Has any claim ever been made against the applicant ? ◯ Yes ◯ No
If Yes, please attach details stating:
(1) date when claim was made
(2) date the act giving rise to the claim was committed;
(3) name of the claimant
(4) nature of the claim
(5) amount of alleged damages
(6) amount of reserves if claim is open
(7) final disposition (include paid indemnity amounts and expense amounts)

18. After inquiry, is the Applicant, aware of any act, error, omission or circumstance which may possibly result in a claim being made against them? ◯ Yes ◯ No
If Yes, attach a statement giving full details.

19. Has the Applicant, ever reported a potential claim circumstance to a professional liability carrier? ◯ Yes ◯ No
If Yes, attach a statement giving full details.

20. As of what date have your internal computer systems been Y2K compliant?
Have your internal computer systems experienced any date-related errors? ◯ Yes ◯ No
If Yes, please explain in detail by separate attachment.

I/We warrant that the information contained herein is true and understand that the Application for Public Health Professional Liability Insurance shall be the basis for the contract of insurance should a policy be issued.

NOTE: The insurance for which you are applying is written on a CLAIMS MADE POLICY. Only claims which are first made against you and reported to the company during the policy period are covered subject to policy provisions. "Claim" means any demand for money or services, including but not limited to the service of suit or the institution of arbitration proceedings against you.

The LIMITS OF LIABILITY stated in the Policy are reduced by CLAIM EXPENSES. CLAIM EXPENSES are also applied against your deductible or self insured retention, if applicable to the claim. If you have any questions about coverage, please discuss them with your insurance broker.

Date: Signature:

Title:
(Officer/Director)