GREENHILL
INSURANCE SERVICES

WWW.GRNHLL.COM

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056

Professional Liability Application for Medical Laboratories

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED. If the answer is NONE, state NONE; If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A). If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's):

_____

Tax ID:

_____

1.2 Mailing Address:

_____

_____

1.3 Location Address(es):

_____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office (_____)_____Fax (_____)_____

Email: _____

Website: _____

1.6 Person to contact for Survey: Name: _____Title: _____

Email: _____Telephone Number:

1.7 Year entity established: _____

1.8 The Applicant is (Please check and complete A) or B) below:

☐ A. The **APPLICANT** is an: ☐ INDIVIDUAL ☐ Employee ☐ Student ☐ Sole Practitioner

☐ B. The **APPLICANT** is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ LLC

☐ Other –Please Describe:_____

1.9 Entity is: ☐ For Profit ☐ Non-Profit

Please describe source of funds: _____

1.10 **Proposed Effective Date:** _____

1.11 Requested Limits of Liability (if available): $_____/$ _____

1.12 Annual Gross Receipts: Estimated next twelve months - $_____

Last twelve months - $_____

1.13 Annual Remuneration: Estimated next twelve months - $_____

Last twelve months - $_____

1.14 Total Premises Square Footage Occupied By Applicant:_____

PART II. EXPOSURES

2.1 Describe fully the operations, activities, services and professional procedures administered:

_____

_____

Attach a list by major category of all tests performed in the last annual period. Please indicate percentage breakdown of all tests by type.

2.2 Employees

_____ Total Number of Full Time (including all employees)

_____ Total Number of Part Time (including all employees)

_____ Number/FTE Professional Type

_____/_____ Physicians-employed (other than Medical Director)*

_____/_____ Physician-Contract (attach copy of contract)*

_____/_____ Bioanalysts

_____/_____ Cytotechnicians

_____/_____ Technologist

_____/_____ Technologist-Trainee

_____/_____ Other (Please describe) _____

* If any, please complete Physician's Exposure Supplement

2.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ☐ Yes ☐ No

2.4 Does the laboratory own or operate any mobile laboratories? ☐ Yes ☐ No

If **YES**, indicate manufacturer and the gross receipts from each unit: _____

_____

2.5 Is your facility owned by an M.D.? ☐ Yes ☐ No

If **YES**, please indicate owner name(s): _____

If **YES**, indicate annual number and % of facility total that represents the owner's patient's tests:

_____# _____%

2.6 If the answer to any part of this question is yes, please attach a separate sheet and provide details (i.e. specific tests performed, number of tests performed per year, percentage of gross annual receipts).

a) Are you involved in any blood banking or cross matching? ☐ Yes ☐ No

b) Are you involved in any intravenous transfusion or in the procurement of blood and/or its components? ☐ Yes ☐ No

c) Are you involved in any medical, genetic or drug research? ☐ Yes ☐ No

d) Are you involved in the manufacturing, dispensing or testing of pharmaceuticals? ☐ Yes ☐ No

e) Do you manufacture and/or sell laboratory equipment or supplies? ☐ Yes ☐ No

f) Do you perform any type of environmental analyses? ☐ Yes ☐ No

g) Are you involved in any services open to the public (health fairs, shopping mall exhibits)? ☐ Yes ☐ No

h) Do you send tests to reference labs? ☐ Yes ☐ No

If **YES**, please state % of receipts: _____

Reference Lab Name: _____

Location: _____

2.7 Does your staff perform arterial sticks? ☐ Yes ☐ No

If **YES**, who performs? _____

_____

If **YES**, what restrictions and precautions are utilized? _____

_____

2.8 Does your staff perform PAP Smears? ☐ Yes ☐ No

If **YES**, who performs the test? _____

If **YES**, who reads and interprets the results? _____

2.9 Does the applicant provide drug screening for any entity? ☐ Yes ☐ No

If **YES**, please attach copies of all applicable contract types and a copy of the applicant's policy on confidentiality.

2.10 Does the applicant perform HIV testing? ☐ Yes ☐ No

If **YES**, please attach consent/disclosure form, copies of any contracts, and the applicant's policy confidentiality.

2.11 Are biopsies performed by the applicant? ☐ Yes ☐ No

If **YES**, specify type and number: _____

2.12 Does applicant prepare any immunological, pharmaceutical or similar agents? ☐ Yes ☐ No

If **YES**, please describe: _____

_____

_____

2.13 Does your facility manufacture or distribute any "test kits" used by others, including any "home test kits"? ☐ Yes ☐ No

If yes, please describe in detail each type of kit, indicate gross receipts for each type of kit, and specify which kits your facility manufactures. _____

_____

_____

_____

2.14 Are test results interpreted or diagnosed by applicant? ☐ Yes ☐ No

If yes, who diagnoses/interprets? _____

2.15 Are diagnoses made by any non-physician members of your staff? ☐ Yes ☐ No

If yes, please provide on a separate sheet their qualifications, and who else reviews the diagnoses.

2.16 Are any patients ever present at the laboratory premises for the purpose of testing, obtaining specimens or any other reason? ☐ Yes ☐ No

If yes, are any of the patients transfers from a healthcare facility? ☐ Yes ☐ No

If yes, who is responsible for these patients while they are on your premises?

☐ Your staff ☐ Accompanying staff

2.17 Describe the occupied building fully, including: Age _____

Construction _____ No. of stories _____

Last remodeled _____ Sprinklered ☐ Fully ☐ Partially ☐ None

Smoke Alarms _____ Fire Alarms _____

2.18 Does applicant provide any services under contract? ☐ Yes ☐ No

If yes, please attach explanation and a copy of the contract.

2.19 Does applicant, or any agency or association on its behalf advertise its professional services in any manner other than a simple listing in the telephone directory? ☐ Yes ☐ No

If yes, please attach a copy of all advertisements.

2.20 Is your facility owned by, or operated in, a hospital? ☐ Yes ☐ No

If yes, which hospital? _____

PART III. RISK MANAGEMENT

3.1 Name, qualifications and number of years of experience of the Medical Director, all Managers and Supervisors:

Name	Title	Experience/Training	Association Membership

3.2 List All Memberships in Professional Organizations. _____

_____

3.3 Are your technologist graduates of medical technology programs? ☐ Yes ☐ No

If not, indicate exceptions and cite qualifications. _____

3.4 Is your facility eligible for certification or accreditation? ☐ Yes ☐ No

If yes, is applicant certified and/or accredited? ☐ Yes ☐ No

If yes, by whom? _____

If **NO**, please explain the reason. _____

3.5 Describe the method and frequency of internal Quality Assurance screens of test results:

3.6 Are random tests performed to audit false positive results? ☐ Yes ☐ No

False negatives? ☐ Yes ☐ No

If **NO**, to either question, please explain the reason. _____

3.7 How long does your lab retain blood, tissue, other specimens for future reference? _____

3.8 What professional organization's standards are followed by your lab? _____

3.9 How frequently are reagents checked? _____

3.10 Who calibrates the precision equipment in your facility? _____

What is the frequency of those calibrations? _____

3.11 Who services and maintains the precision equipment in your facility? _____

3.12 Are logs kept of the calibration and servicing of precision instruments? ☐ Yes ☐ No

3.13 Are your staff CPR trained? ☐ Yes ☐ No

3.14 Describe the referral source(s) by which patients are directed to the entity.

_____

3.15 Is the applicant and all professional employees licensed in accordance with state and federal laws?

If **NO**, attach explanation of any exception ☐ Yes ☐ No

3.16 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital professional association? ☐ Yes ☐ No

b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐ Yes ☐ No

c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

IF THE ANSWER TO ANY OF 3.16 IS YES, PLEASE ATTACH A DETAILED EXPLANATION

PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							

5._____

If claims-made, what is the most recent retroactive date?_____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date?_____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

☐ Yes ☐ No

If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary)._____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?

☐ Yes ☐ No

If yes, please describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Greenhill Insurance Services, LLC any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM <u>DOES NOT BIND</u> THE COMPANY TO COMPLETE THE INSURANCE.

_____ _____

Date Applicant

Title

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Drug and Substance Abuse Testing Supplemental Questionnaire

1. Type specimens taken / tested:

   _____ Urine _____ Blood _____ Other:

   Describe_____

2. Who does testing?

   _____ Insured's own laboratory / staff

   _____ Laboratory insured contracts with for this service (include copy of contract and confirmation that lab carries own insurance and at what limits, provide example of letterhead results are sent out on)

   _____ Independent Laboratories chosen by others (describe who selects lab facility, include copy of any contracts between the parties, confirm lab's own insurance and limits, and confirm letterhead results sent out on)

3. Describe exactly who reads and interprets the test results:

   _____

   _____

4. Describe the "protocols" in place to prevent reporting of "false positive" results:

   _____

   _____

5. Describe the "policy" regarding "confidentially" of reports and records.

   _____

   _____

6. In the past year: (a) How many positive test results? _____

   (b) How many employees:

   (1) Treated? _____ (2) Counseled? _____3) Terminated from employment? _____

7. Is portable equipment used in any on-site testing operations? Describe fully the equipment including its exact use, who manufactures, any lease involving use of same, include brochure if available.

_____

_____

8. Enclose copies of contracts between Insured and Client companies.

_____ _____ _____

Date Applicant Title