Hull & Company

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hullandco-texas.com

Medical Testing Laboratories Liability Application

Applicant's Name _____

Mailing Address _____

_____

Location _____

_____

Agent Name _____

Address _____

_____

PROPOSED EFFECTIVE DATE:

From _____ **To** _____

12:01 A.M., Standard Time at the address of the Applicant

LIMITS OF LIABILITY REQUESTED		
COVERAGE	**EACH OCCURRENCE**	**AGGREGATE**
COMBINED SINGLE LIMIT	$	$

PLEASE ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"

1. **Applicant is:** ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture
   ☐ Limited Liability Company ☐ Other (Specify) _____

2. **State annual gross receipts for the last 12 months:** _____ Anticipated next 12 months: _____

3. **State number of patient contacts in the last 12 months:** _____ Anticipated next 12 months: _____

4. **State the number of tests performed in the last 12 months:** _____ Anticipated next 12 months: _____

5. **Briefly describe your location <u>including square feet</u> occupied:** _____
   _____
   _____
   _____

6. **Fully describe your operations, including types of specimens handled.** Attach copy of brochure if available. Attach separate sheets if additional space is needed.

   Description of Operations: _____
   _____
   _____
   _____

7. **Check areas of activity that your facility is involved with:**

Activity	Yes	No	Number of Tests Performed	% of Gross Receipts
Diagnostic services —if yes, describe	☐	☐		
X-Ray services	☐	☐		
Test result consultation for another lab	☐	☐		
AIDS or HIV testing	☐	☐		
Blood banking or blood storage	☐	☐		
Plasmapheresis procedures	☐	☐		
Therapy or treatment procedures —if yes, describe	☐	☐		
Drug testing	☐	☐		
Pap smears	☐	☐		
Cytology	☐	☐		
EKG testing	☐	☐		
MRIs, Cardiac Monitoring, Stress Testing, CAT Scans, Sonograms, Mammography	☐	☐	By type:	By type:

8. **Number of cytologists on staff:** _____

9. **Years in business:** _____

10. **Is applicant owned by or operated at a hospital, whether main location or branch?** ☐ Yes ☐ No

11. **Total number of employees:** _____

12. **Number of employees** (please categorize, i.e., physicians, pathologists, interns, x-ray technicians, lab technicians, radiologist technicians, RN, LPN, LVN, clerical, etc.):

Full-time	Part-time	Functions

13. **Are the applicant, partners and employees all currently licensed?** ☐ Yes ☐ No

Has your license ever been revoked or cancelled? ☐ Yes ☐ No If yes, explain: _____

_____

If any of the following answers are "yes," details must be provided (i.e., specific tests performed, number of tests performed, per year, percentage of gross annual receipts).

14. **Are you involved in cytogenetics or analyzing amniotic fluids?** ☐ Yes ☐ No

15. **Are you involved in PSA analysis?** ☐ Yes ☐ No

16. **Are you involved in alpha fetoprotein analysis?** ☐ Yes ☐ No

17. **Are you involved in any medical, genetic or drug research?** ☐ Yes ☐ No

18. **Are you involved in the manufacturing, dispensing or testing of pharmaceuticals?** ☐ Yes ☐ No

19. **Do you manufacture and/or sell laboratory equipment or supplies?** ☐ Yes ☐ No

20. **Do you perform any types of environmental analysis?** ☐ Yes ☐ No

21. **Are you involved in any services open to the public** (health fairs or shopping mall exhibits)? ☐ Yes ☐ No

    Do you utilize any mobile units or own/operate any portable laboratory equipment? ☐ Yes ☐ No

22. **Do you send tests to reference labs?** ☐ Yes ☐ No If yes, please state percent of receipts: _____

    Reference lab name: _____

    Location: _____

    Are you contractually held harmless? ☐ Yes ☐ No

    Do you have proof of their professional liability insurance with limits at least equal to yours? ☐ Yes ☐ No

    Are you named as an additional insured on their policy? ☐ Yes ☐ No

23. **Attach sample billing document reflecting tests performed.**

24. **Identify exact names, addresses and relationship (ownership holdings) of all entities to be insured:**

Exact Entity	Name	Address	% of Ownership

25. **Identify all physicians involved in laboratory, by name and function served:**

Name	Type of Doctor	% of Ownership	Specific Duties in Lab Operations

If applicant is owned by a practicing physician, does applicant occupy same or contiguous space? ☐ Yes ☐ No

Percentage of gross receipts derived from physician's personal practice: _____%

26. **Identify all independent contractors used by laboratory, by name and function served:**

Name	Type of Operations Conducted	Specific Duties in Lab Operations

26. Independent Contractors (continued)

Are certificates of insurance obtained from all independent contractors? ☐ Yes ☐ No

Are applicants named as an additional insured on the independent's policy? ☐ Yes ☐ No

Are certificates of insurance so designated? ☐ Yes ☐ No

Are there any contractual agreements between the applicant and independent contractors? ☐ Yes ☐ No

Do the contracts contain a hold harmless agreement in the applicant's favor? ☐ Yes ☐ No

27. If any independent contractors are physicians, Certificates of Insurance from the professional liability insurance carrier for doctors will be required. Please list below:

Name of Doctor	Insurance Carrier	Insurance Limit	Expiration Date

28. Has any professional or general liability claim or suit been brought against you in the past five years? ☐ Yes ☐ No

If yes, please provide the following:

Date	Description of Loss	Amount Paid or in Reserves

29. Has any company ever cancelled, declined, or refused to issue similar insurance? (Not applicable in Missouri)

☐ Yes ☐ No If yes, please explain: _____

Previous Insurer: Indicate premium and losses for the past three years. Describe all losses.

Year	Company	Pol. #	Premium	Losses Paid	Losses Reserved	Description

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING:

Any person who knowingly and with intent to defraud any insurance company or other pers on 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.

APPLICANT'S SIGNATURE _____ Date _____

(Must be signed by a principal partner or officer in the firm.)

AGENT NAME _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only.)

Name of contact for inspection or premium audit _____ Phone Number _____

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE NOT APPLICABLE