Mack Specialty Brokerage

Medical Laboratories Professional Liability Application

Mack Specialty Brokerage
7379 Pearl Rd. Suite 6
Cleveland, OH 44130-4808
Phone: (440) 268-0200
Fax: (440) 268-0202
www.mackspecialty.com

INSTRUCTIONS: ANSWER ALL QUESTIONS; IF THE ANSWER IS NONE, STATE NONE; IF THE QUESTION 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 1.
GENERAL INFORMATION

1.1 Applicant Name: _____

1.2 Mailing Address: _____

1.3 Location Address(es): _____

_____

1.4 County (parish) of each location: _____

1.5 Telephone Number: Office _____/_____ Fax _____/_____

1.6 Person to contact for survey: Name _____
Title _____

1.7 Year entity established: _____

1.8 Entity is ___ Individual ___ Corporation ___ Partnership
___ Professional Association/Corporation ___ Other. (Describe) _____

1.9 Entity is ___ For Profit ___ Non-Profit. Describe source of funds: _____

_____

1.10 Proposed effective date _____

1.11 Requested Limits of Liability (if available):
Professional Liability $ _____/$ _____
General Liability $ _____ each occurrence
$ _____ general aggregate

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 11. EXPOSURES

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

_____

_____

NOTICE

THIS POLICY (IF ISSUED) IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

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

2.3 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 (Describe) _____

* If any, please complete Physician's Exposure Supplement

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.9 ____ Yes ____ No.

If yes, 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, 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 crossmatching? ____ 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

0 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/disclo sure form, copies of any contracts, and the applicant's policy on 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, describe: _____

_____

2.13 Does your facility manufacture or distribute any "test kits" used by others, including any "home test kits"
___ Yes ____ No If yes, 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, 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, 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 111. 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, 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? _____
What is the frequency of servicing? _____

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?
____ Yes ____ No
If no, attach explanation of any exception.

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? _____

4.3 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 nay 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, describe the event and indicate the reason for anticipation of a claim.**

_____

_____

_____

Underwritten by The Reciprocal Alliance Risk Retention Group

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 Mid-Continent General Agency, Inc. 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 DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

_____ _____

Date **Applicant/Title**