MEDICAL TESTING LABORATORY APPLICATION

PLEASE CONTACT YOUR AGENT WITH ANY QUESTIONS AND TO RETURN COMPLETED APPLICATION

1. Full Named Insured (include all legal names and DBAs you are requesting coverage for):

_____

_____

Mailing Address: _____

Physical Location #1: _____

Physical Location #2: _____

Attach separate sheet if more than 2 locations

Contact Name: _____ Telephone Number: _____

Name(s) of all current owner(s) and percentage owned by each: _____

_____

****NOTE: Your insurance company must be notified of any changes in ownership at the time the ownership changes are made. Insurance coverage is not transferable.**

How many years experience in the medical field? _____ How many years under the same ownership? _____

(NEW VENTURES: Please provide owner's resume/experience related to the medical industry)

2. Tax Identification Number: _____ 3. Are you currently enrolled in a PCF? ☐ Yes ☐ No

4. Provide names of all legal entities, including subsidiaries, desiring coverage. Please provide a description of the entity, percentage owned, and date acquired. And, if applicable, the requested Prior Acts date.

Name	Description	% Owned	Date Acquired	Prior Acts Date

5. Within the past 5 years, has applicant acquired, sold, or discontinued any operations? ☐ Yes ☐ No

6. Applicant is: ☐ Individual ☐ Partnership ☐ Corporation Other: _____

7. Fully describe your operations:_____

8. Does the applicant provide any overnight bed facilities? ☐ Yes ☐ No
   a) If yes, do any patients ever stay more than one night? ☐ Yes ☐ No

   What is the maximum number of nights any patient ever stays at the facility? _____

9. Does the applicant perform any treatment or services on the applicant's premises? ☐ Yes ☐ No

a) If yes, explain in detail (attach separate sheet if necessary): _____

_____

_____

COVERAGE REQUESTED

10. Requested Effective Date: _____

11. ____ **Professional Liability** ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date:_____
(Attach a copy of prior claims made policy Declarations if requesting prior acts.)

☐ $100,000 per incident / $300,000 aggregate
☐ $500,000 per incident / $500,000 aggregate
☐ $1,000,000 per incident / $2,000,000 aggregate
☐ $2,000,000 per incident / $2,000,000 aggregate
☐ $2,000,000 per incident / $4,000,000 aggregate
☐ $250,000 per incident / $750,000 aggregate
☐ $1,000,000 per incident / $1,000,000 aggregate
☐ $1,000,000 per incident / $3,000,000 aggregate
☐ $2,000,000 per incident / $3,000,000 aggregate
☐ $3,000,000 per incident / $3,000,000 aggregate

12. ____ **General Liability** ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date: _____
(Attach a copy of prior claims made policy Declarations if requesting prior acts.)

13. **Employee Benefits Liability** (General Liability must be selected)
(Attach a copy of current EBL Dec page if requesting Retro Date)

☐ $25,000 per incident / $50,000 aggregate
☐ $500,000 per incident / $500,000 aggregate
☐ $1,000,000 per incident / $1,000,000 aggregate
☐ $100,000 per incident / $300,000 aggregate
☐ $500,000 per incident / $1,000,000 aggregate
☐ $1,000,000 per incident / $2,000,000 aggregate

Average professional turnover: _____ % Average non-professional turnover: _____%

Employee benefits provided: ☐ Health ☐ Life ☐ 401K ☐ Section 125

14. **Stop Gap Liability** (General Liability Coverage must be selected)

Bodily Injury By Accident	$		Each Accident
Bodily Injury By Disease	$		Aggregate Limit
Bodily Injury By Disease	$		Each Employee

Payroll by State: _____

15. Per Claim Deductible (same deductible must be selected for both Professional and General Liability.)

☐ $0 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000 ☐ Other: _____

16. List Professional Liability policies covering the firm indicated in Question #1 over the past 5 years.
If **No** insurance was in effect for a given year, state **"None"** where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

17. List General Liability policies covering the firm indicated in Question #1 over the past 5 years.
If **No** insurance was in effect for a given year, state **"None"** where applicable below.

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

CLAIM HISTORY

18. Has any Professional or General Liability claim or suit been brought in the past five years against the applicant or any predecessor in interest concerning the entity to be insured, or are you aware of any claims or suits, or any incident that could become a claim or suit that has not been reported to your current insurance carrier?

☐ Yes ☐ No

If **YES**, please attach information for each claim, suit, or incident that includes the following:

- Date of accident and date of notice
- Claimant Name
- Amount paid or reserved
- Status – Open or Closed
- Insurance carrier
- Allegations
- Description of treatment rendered

19. Has any company cancelled, declined, or refused to issue similar insurance? ☐ Yes ☐ No
If **Yes**, please explain:

_____

_____

GROSS RECEIPTS AND NUMBER OF TREATMENTS (Please attach financial statement prepared by a CPA.)

20. Total Annual Gross Receipts last 12 months: $ _____
Total Annual Gross Receipts next 12 months: $ _____

21. Gross Receipts by Category:

Sleep Testing _____ Cytology _____ Imaging _____ Drug Testing _____
All Other _____

22. **Number of Treatments/Procedures**

	Last Year	Prior Year
Sleep Testing		
Cytology		
Imaging		
Drug Testing		
All other, explain		

23. If a reference lab is used, the expected annual receipts for the reference lab: $_____

24. Reference lab name: _____

25. Does the reference lab hold you harmless? ☐ Yes ☐ No

26. Do you have proof of insurance with $1,000,000 limit for the reference lab? ☐ Yes ☐ No

27. Please provide information requested for each medical director and/or physician providing services at the applicant's facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Eff. Date	Policy Limits	State / License #	Specialty / Board Certified	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Physician						

HIRING / SCREENING AND EMPLOYMENT PROCEDURES

28. Are employees' / contractors' references contacted before hiring or placement? ☐ Yes ☐ No
Check all that apply: _____ Written _____ Verbal

29. Check all the following that apply if obtained, verified, and filed as part of each employee screening and hiring process:

☐ Applications
☐ Drug / HIV / Hep. Testing
☐ Education/Competency
☐ Multi-state Registry
☐ Criminal Background Checks
☐ Licenses/Annual Confirmation

30. Does applicant question prospects about previous claims or suits? ☐ Yes ☐ No

31. Are employees required to actively participate in continuing education? ☐ Yes ☐ No

32. Does applicant verify any pending license suspensions, revocations, or pending disciplinary actions? ☐ Yes ☐ No

33. Are professional employees required to carry their own insurance? ☐ Yes ☐ No
If Yes, what minimum is required? $_____
Are certificates of insurance kept on file? ☐ Yes ☐ No

ACCREDITATION AND LICENSING

34. Is your facility accredited? ☐ Yes ☐ No
If so, by whom? _____
(Please attach verification of accreditation.)

35. Is applicant licensed to do business in the states listed above where required? ☐ Yes ☐ No

Has applicant's license ever been suspended, revoked, or restricted? ☐ Yes ☐ No
(If yes, please provide details)._____

_____

36. Is applicant certified for Medicare reimbursement? ☐ Yes ☐ No

RISK MANAGEMENT

37. What management body oversees the quality of patient care? (e.g., medical director, advisory board, etc.)
_____

38. Do you have a formal written quality assurance and risk management program? ☐ Yes ☐ No
Person responsible: _____+ Title: _____

39. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers.

If yes to any of the following, please attach explanation including number of tests/procedures and gross receipts:

a.	Test result interpretation in lab's name:	☐ Yes ☐ No
b.	Consultation in lab's name:	☐ Yes ☐ No
c.	Therapy or any treatment procedures:	☐ Yes ☐ No
d.	Blood banking or blood storage:	☐ Yes ☐ No
e.	Intravenous transfusions:	☐ Yes ☐ No
f.	Procurement of blood or its components:	☐ Yes ☐ No
g.	Plasmapheresis procedures:	☐ Yes ☐ No
h.	Medical, genetic, or drug research:	☐ Yes ☐ No
i.	Any type of environmental analysis:	☐ Yes ☐ No
j.	Manufacturing, dispensing, or testing of pharmaceuticals:	☐ Yes ☐ No
k.	Manufacture or sell laboratory equipment or supplies:	☐ Yes ☐ No
l	Experimental or research in nature:	☐ Yes ☐ No
m.	Solely mobile in nature:	☐ Yes ☐ No
n.	Any services to the public (health fairs, shopping mail exhibits, etc.):	☐ Yes ☐ No
o.	AIDS or HIV testing:	☐ Yes ☐ No

IF YES, ANNUAL RECEIPTS EXPECTED IN-HOUSE: $_____

ANNUAL RECEIPTS EXPECTED REFERENCE LAB: $_____

CONTRACTUAL AGREEMENTS

40. Does applicant enter into contractual agreements (e.g., hospitals, nursing homes)? ☐ Yes ☐ No

41. Do contractual agreements contain hold harmless or indemnification clauses favorable to the applicant? ☐ Yes ☐ No

42. Is applicant required to name any other entity as an additional insured? ☐ Yes ☐ No
If so, please list name and address of each entity and the business relationship:

_____

_____

_____

43. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? If so, please attach explanation (including name of physician(s), details of financial relationship(s), type of referrals). ☐ Yes ☐ No

"Financial relationship" means all ownership or investment interests, compensation arrangements, and medical directorships with applicant.

GENERAL LIABILITY

44. Does applicant sponsor any sporting, fundraising, or social events? ☐ Yes ☐ No
Please explain: _____

45. Does applicant sell any medical supplies and/or equipment? ☐ Yes ☐ No
If Yes, Annual Receipts $_____

46. Does applicant rent or lease any medical supplies and/or equipment? ☐ Yes ☐ No
If Yes, Annual Receipts $_____

47. Is the applicant named as an additional insured or vendor on the manufacturer's policy for any/all products? ☐ Yes ☐ No

Complete the appropriate Medical testing questionnaire(s) below. If these are not applicable, please so indicate.

DRUG TESTING QUESTIONNAIRE

1. Does applicant perform a second test if the first test is positive? ☐ Yes ☐ No ☐ NA
2. Does applicant or its client obtain the written consent of all people to be tested? ☐ Yes ☐ No ☐ NA
3. Do physicians review test results? ☐ Yes ☐ No ☐ NA
4. Briefly describe the test handling process (specimen collection, transportation, testing, reporting).

_____

_____

_____

CYTOLOGY QUESTIONNAIRE

1. Is all cytology work done per a physician's request? ☐ Yes ☐ No ☐ NA
2. Who reviews the tests? _____
3. Are the tests results sent to the treating physician for review? ☐ Yes ☐ No ☐ NA
4. Are technicians compensated on a per slide basis? ☐ Yes ☐ No ☐ NA

EKG QUESTIONNAIRE

1. Are all EKG tests performed per a physician's request? ☐ Yes ☐ No ☐ NA
2. Who interprets the EKGs?_____
3. Are they sent to the physician for review? ☐ Yes ☐ No ☐ NA
4. Are the tapes condensed by computer before being interpreted? ☐ Yes ☐ No ☐ NA
5. How is the EKG equipment maintained? _____
6. How often is it serviced? _____
7. Are portable holster monitors used? ☐ Yes ☐ No ☐ NA

X-RAY QUESTIONNAIRE

1. What testing substances are ingested or injected into the patient? _____
2. Is there a likelihood of adverse reaction to the substances? ☐ Yes ☐ No ☐ NA
3. What emergency medical procedures have you established in the event of such reactions?
   Explain: _____
4. Please describe the system of delivery and disposal of radionuclides:
   _____
5. Indicate the frequency of testing of air and water discharge from the facility to ascertain local, state, and federal standards of compliance.
   _____
6. What are the qualifications and training of personnel? _____
7. Please describe control and maintenance of equipment: _____
8. How are your x-ray records maintained? _____
9. Are the x-rays done per a physician's request? ☐ Yes ☐ No ☐ NA
10. Who performs the x-rays? _____
11. Who reports the interpretation of the x-ray? _____
12. Are the actual x-rays sent to the requesting physician, or just the report? _____
13. Are the x-rays sent out under the name of the laboratory? ☐ Yes ☐ No ☐ NA
    Or, under the name of the radiologist? ☐ Yes ☐ No ☐ NA
14. How is the x-ray equipment maintained? _____
15. How often is it serviced? _____

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions, and exclusions of the insurance certificate.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Applicant's Warranty Statement: The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the Application does not bind the undersigned to purchase the insurance, nor does the review of the Application bind the Company to issue a policy. It is understood the Company is relying on the Application in the event the Policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued, and may be attached to and become part of the policy. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

_____	_____	_____
Signature of Applicant	**Date**	**Name and Title**

(Must be signed by principal, partner, or officer of group or individual applying for insurance.)