



Independent Insurance Wholesalers, Inc.
121 SW Morrison St., #325
Portland, OR 97204
Voice (503) 224-1956 Fax (503) 224-3010

APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE
MISCELLANEOUS MEDICAL

1. NAME OF APPLICANT: _____
 (If other than parent firm, supply full details of ownership entity)

2. MAILING ADDRESS: _____
 (If multiple name and locations, please attach list)

PHONE NO. _____

3. a) DATE ESTABLISHED _____ Corp. _____ Partnership _____ Prof. Assoc. _____ Individual _____

b) In what states is the applicant registered and licensed to practice? _____

4. Is the firm engaged in, owned by, associated with or controlled by any other business? _____

If yes, give details _____

5. PROFESSIONAL ACTIVITIES AND SPECIALTY (Attach narrative description if necessary)

Check One:

- _____ Health Maintenance Organization
- _____ Home Healthcare Agency
- _____ Medical/Testing Laboratory
- _____ Nurse's Registry
- _____ Out-Patient Clinic

- _____ Residential Healthcare Facility
- _____ Other (Specify) _____

6. State approximate division of applicant's patients among:

- | | |
|--|--|
| a) Alcoholics (_____) (_____ %) | k) Obstetrical (_____) (_____ %) |
| b) Counseling/Family Planning (_____) (_____ %) | l) Pediatric (_____) (_____ %) |
| c) Communicable (_____) (_____ %) | m) Psychiatric (_____) (_____ %) |
| d) Dental (_____) (_____ %) | n) Research or Experimental (_____) (_____ %) |
| e) Drug Addicts (_____) (_____ %) | o) Senile or Aged (_____) (_____ %) |
| f) General (_____) (_____ %) | p) Stress Testing (_____) (_____ %) |
| g) Hemodialysis (_____) (_____ %) | q) Surgical (_____) (_____ %) |
| h) Holistic Medicine (_____) (_____ %) | r) Tubercular (_____) (_____ %) |
| i) Medical (_____) (_____ %) | s) Other _____ (_____) (_____ %) |
| j) Mentally Retarded (_____) (_____ %) | |

7. a. List the number and type of applicant's employees and volunteers: If None State None.

NUMBER	Type of Profession	NUMBER	Type of Profession
a) _____	Inhalation Therapists	i) _____	Perfusionists
b) _____	Laboratory Technicians	j) _____	Pharmacists
c) _____	Nurse Anesthetists	k) _____	Physicians – Minor Surgery
d) _____	Nurses, Licensed Practical	l) _____	Physicians – No Surgery
e) _____	Nurse Practitioner	m) _____	Physiotherapists
f) _____	Nurses Registered	n) _____	Social Workers
g) _____	Opticians	o) _____	Speech Therapists
h) _____	Optometrists	p) _____	Other

b. List the number and type of independent contractors who provide professional services on behalf of the applicant.

IF NONE, STATE NONE. _____

C. Are all the above individuals licensed in accordance with applicable state and federal regulations? ___ Yes ___ No
If no, attach explanation.

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the above employees:

- | | YES | NO |
|---|----------|-------|
| a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? | a) _____ | _____ |
| b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? | b) _____ | _____ |
| c) Ever been treated for alcoholism or drug addiction? | c) _____ | _____ |
| d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? | d) _____ | _____ |

8. Does the applicant perform:
- | | YES | NO |
|---|----------|-------|
| A. Acupuncture or acupuncture anesthesia? Explain: _____ | A. _____ | _____ |
| B. Angiography/Arteriography/Venography? Describe: _____ | B. _____ | _____ |
| C. Catheterization (other than urinary or umbilical)?
Describe procedure: _____ | C. _____ | _____ |
| D. Closed reduction of compound fractures and/or Normal Deliveries and/or Dermabrasion? | D. _____ | _____ |
| E. Injection of radioisotopes and/or use of irradiated substances?
Describe: _____ | E. _____ | _____ |
| F. Radiation Therapy and/or Chemotherapy? Describe: _____ | F. _____ | _____ |
| G. Psychiatric shock therapy? | G. _____ | _____ |
| H. Silicone Injections/ Describe: _____ | H. _____ | _____ |
| I. Spinal Anesthesia (other than saddle blocks or caudals)? | I. _____ | _____ |
| J. Laser treatment? Describe: _____ | J. _____ | _____ |

9. Does the applicant perform any:
- | | | |
|--|----------|-------|
| A. Surgery other than incision of superficial boils or suturing superficial fascia? | A. _____ | _____ |
| B. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? | B. _____ | _____ |
| C. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections? | C. _____ | _____ |
| D. Cosmetic Plastic Surgery? Describe: _____ | D. _____ | _____ |
| E. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? | E. _____ | _____ |
| F. Hysterectomies? | F. _____ | _____ |
| G. Open reduction of fractures? Describe: _____ | G. _____ | _____ |
| H. Surgery for weight reduction of patients? | H. _____ | _____ |
| I. Abortions and/or menstrual extractions? Describe (include trimester, method and number of Abortions performed per month): _____ | I. _____ | _____ |
| J. Silicone Implants? Describe: _____ | J. _____ | _____ |
| K. Sterilization Procedures? Describe: _____ | K. _____ | _____ |
| L. Biopsies and/or endoscopies? List types performed: _____ | L. _____ | _____ |
| M. Sex change operations? Describe and advise the number performed per year: _____ | M. _____ | _____ |
| N. Other Surgery? Describe: _____ | N. _____ | _____ |

10. Does the applicant perform hospital emergency room care?
a) for its own regular patients? ___ Yes ___ No b) for patients not its own? ___ Yes ___ No
c) If answer to (b) is yes, please specify: the percentage of its time devoted to this work = _____%, the number of hours per month devoted to this work = _____ hrs.

11. Does the applicant use drugs for weight reduction of patients? ___ Yes ___ No If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs, and quantity dispensed by applicant.

12. Does the applicant administer any methadone treatment? ___ Yes ___ No If yes, describe treatment and controls used and indicate number of treatments during last 12 months _____ Next 12 months _____

13. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? ___ Yes ___ No If yes, attach detailed explanation.

14. Does the applicant maintain any beds for overnight occupancy? ___ Yes ___ No If yes, total number: _____

15. State number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both. Ste by whom treatment is given and number of procedures: _____

16. Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? _____ Yes _____ No If yes, give details, including name, location, size and number of beds. _____

17. State sources and amounts of total revenue:

Source	Amount Last Policy Year	Ext. Amount This Policy Year
A. Charitable Contributions	\$ _____	\$ _____
B. Government Funding	\$ _____	\$ _____
C. Fee for Services	\$ _____	\$ _____
D. _____	\$ _____	\$ _____
E. _____	\$ _____	\$ _____
TOTAL GROSS REVENUE:	\$ _____	\$ _____

18. Number of patient encounters last 12 months _____ and/or patient test carried out _____
 (NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

19. Number of estimated patient encounters next 12 months _____ and/or patient tests carried out _____
 (NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

20. If applicant has a training school, complete the following.

Specify profession for which students are being trained	Max. No. of students per session	No. of sessions per year	% of Time involved in clinical setting	Number of students	Qualifications of faculty (eg. MD, RN, PHD)
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

21. If applicant is an ambulance services, please complete the following.

Number of Ground Ambulances _____ Number of Emergency Calls (per year) _____
 Number of Air Ambulances _____ Number of Non-Emergency Calls (per year) _____
 Radius of Services _____

22. Give Professional Liability coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a claims made policy, what is the retroactive date? _____

23. Is the Applicant currently insured under a Commercial General Liability Policy? Yes _____ No _____ If yes, please give details:

Insurance Company	Type of Coverage	BI	Limits	PD	From	To
_____	_____	_____	_____	_____	_____	_____

24. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business

or present Partners ever been declined or has the insurance ever been cancelled or renewal refused?
_____ Yes _____ No If yes, please give details: _____

25. Has any claim ever been made against the applicant or any persons named in question 1? Yes _____ No _____
If yes, how many? _____ Please attach currently valued company loss runs for the past 5 years and 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 involved including reserves; and 6) final disposition.

26. Is the Applicant aware of any circumstances which may result in any claim against the applicant or any persons named in
question 1? Yes _____ No _____ If yes, how many? _____ Please attach currently valued company loss runs for
the past 5 years and 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 involved including reserves; and 6) final disposition.

27. Has any insurer cancelled or refused to renew any similar insurance during the past five years? _____

28. Limits of Liability requested _____ Deductible _____

29. Desired term of policy: From _____ To _____

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed
or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated
by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be
the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant
declares that if the information supplied on this application changes between the date of this application and the time when the
policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any
outstanding quotations and/or authorization or agreement to bind the insurance.

Date

Signature of Applicant

Title

Producer