

5. CLAIMS/HISTORY

- a. Have you or any of your employees ever: (If Yes, please attach full description.)
 - (i) been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? [] Yes [] No
 - (ii) been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [] Yes [] No
 - (iii) had any professional liability insurance canceled, declined, refused, renewal or accepted only on special terms? [] Yes [] No
- b. Are you licensed in accordance with all applicable state and federal laws? [] Yes [] No
 - (i) Approved by National Institute on Drug Abuse (NIDA) if lab is involved in drug testing? [] Yes [] No
 - (ii) CLIA approved? [] Yes [] No

If no to either of the above, provide detailed explanation.

- (iii) Have you or any of your employees had any professional licensed refused, suspended, revoked, renewal refused or accepted only on special terms or have you or any of your employees voluntarily surrendered any professional license? [] Yes [] No
- c. Has any claim or suit for alleged malpractice been brought against you and/or any of your employees? [] Yes [] No
- d. Has any claim or suit for alleged malpractice been made against you and/or any of your employees that has NOT been reported to a prior Insurer? [] Yes [] No
- e. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you and/or any of your employees? [] Yes [] No

If Yes to any questions, c - e above, please complete Supplemental Claim Information Form SM 174.

- f. (i) List prior professional liability insurance carried for each of the past five years. If none, check here [].
- (ii) Attach a copy of the Declarations Page from your most recent coverage.

Insurance Co.	Limits of Liability	Premium	Inception Mo./Day/+-Yr.	Exp. Mo./Day/Yr.	Was this a Claims Made Policy Form?		Retroactive Date
					Yes	No	
_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	[]	[]	_____
_____	_____	_____	_____	_____	[]	[]	_____

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.**

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.



SHAND MORAHAN & COMPANY, INC.

Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY

(Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:

(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:

(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:

(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: