

United National Group

MEDICAL TESTING LABORATORIES APPLICATION

Return to:

INSTRUCTIONS:

- A. Please type or print clearly. Answer ALL questions completely.
- B. If any question, or part thereof, does not apply, print "N/A" in the space provided.
- C. If more space is needed, continue on a separate sheet of your firm's letterhead, indicating question number.
- D. To this application, please attach copies of
 - Marketing or advertising brochures.
 - Descriptive materials provided to clients.
 - Copy of all accreditation reports, or other similar, if applicable.
 - Other attachments as required in response to application questions.
 - Most current annual financial statement prepared by a CPA.
- E. All materials submitted or required shall be held in confidence.

GENERAL INFORMATION

1. Insured _____
Main Location Address

Street City State/Zip County

2. Tax Identification Number _____ Telephone Number (____) _____

3. Years in Business _____ Are you currently enrolled in a PCF Yes No

4. Mailing Address (if different than above)

Street City State/Zip County

5. List all locations and areas of operations

Street City State/Zip County

Street City State/Zip County

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

Name	Description	% Owned	Date Acquired	Prior Acts Date

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

8. Applicant is: Individual Partnership Corporation Other _____

9. Describe operations:

10. Does the applicant provide any overnight bed facilities? Yes No

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

COVERAGE REQUESTED

12. Requested Effective Date _____
 (If new venture, please provide owner's resume' and description of related industry experience.)

13. _____ **Professional Liability** Occurrence Claims Made Prior Acts Date _____

(Attach copy of prior claims made policy Declarations if requesting prior acts.)

- \$ 100,000 per Incident / \$ 300,000 Aggregate
- \$ 250,000 per Incident / \$ 750,000 Aggregate
- \$ 500,000 per Incident / \$ 500,000 Aggregate
- \$1,000,000 per Incident / \$1,000,000 Aggregate
- \$1,000,000 per Incident / \$2,000,000 Aggregate
- \$1,000,000 per Incident / \$3,000,000 Aggregate
- \$2,000,000 per Incident / \$4,000,000 Aggregate
- \$3,000,000 per Incident / \$5,000,000 Aggregate

14. _____ **General Liability** Occurrence Claims Made Prior Acts Date _____

(Attach copy of prior claims made policy Declarations if requesting prior acts.)

- Each Occurrence (cannot be excess PL limit) \$ _____
- Medical Expense Limit (Per Person) \$ _____
- Fire Damage Limits of Liability (Any one Fire) \$ _____
- Products / Completed Operation Aggregate \$ _____
- General Aggregate (Other than Products) \$ _____

For the next two coverage parts, please input the exposure information on page 8.

15. ____ Employee Benefits Liability / Claims Made (General Liability Coverage must be selected)

Each Person \$ _____

Total Limit \$ _____

Prior Acts Date _____

(Attach copy of prior claims made policy Declarations, if applicable.)

16. ____ Stop Gap Liability (General Liability Coverage must be selected)

Each Person \$ _____

Each Disease \$ _____

Total Limit \$ _____

17. Per Claim Deductible

(Same deductible must be selected for both Professional and General Liability.)

none \$1,000 \$5,000

\$10,000 \$25,000 Other _____

18. 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.							

19. 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

20. 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.

21. Has any company cancelled, declined or refused to issue similar insurance? Yes No

If **Yes**, please explain:

GROSS RECEIPTS AND NUMBER OF TREATMENTS

22. Total Annual Gross Receipts last 12 months \$ _____
 Total Annual Gross Receipts next 12 months \$ _____
 (Please attach financial statement prepared by a CPA.)

23. Gross Receipts by Category:
 Cytology _____ Imaging _____ Drug Testing _____ All Other _____

24. **Number of Treatments/Procedures**

	Last Year	Prior Year
Cytology		
Imaging		
Drug Testing		
All Other		

EMPLOYEES / INDEPENDENT CONTRACTORS

25. Types / Number of Employees / Contractors

Physicians	Full-Time _____ #	Part-Time _____ #
X-Ray technicians	Full-Time _____ #	Part-Time _____ #
Ultrasound/ Sonography Technicians	Full-Time _____ #	Part-Time _____ #
Laboratory technicians	Full-Time _____ #	Part-Time _____ #
Cytology technicians	Full-Time _____ #	Part-Time _____ #
ALL OTHERS:		
_____	Full-Time _____ #	Part-Time _____ #
_____	Full-Time _____ #	Part-Time _____ #

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

27. Reference lab name _____

28. Does the reference lab hold you harmless? Yes No

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

30. 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						
Name - Physician						
Name - Physician						

HIRING / SCREENING AND EMPLOYMENT PROCEDURES

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

32. Check all the following that apply if obtained, verified, and filed as part of each employee screening and hiring process:
Applications _____ Multi-State Registry _____
Drug / HIV / Hep. Testing _____ Criminal Background Checks _____
Education/Competency _____ Licenses/Annual Confirmation _____

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

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

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

36. 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

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

38. 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). _____

39. Is applicant certified for Medicare reimbursement? Yes No

RISK MANAGEMENT

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

41. Do you have a formal written quality assurance and risk management program? Yes No
Person Responsible: _____ Title: _____

42. Please indicate if the following policies and procedures are established and adhered to by all staff, including contractors and volunteers. Please explain in an attachment any "No" answers.

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

- 43. Does applicant enter into contractual agreements (i.e. hospitals, nursing homes)? Yes No
- 44. Do contractual agreements contain hold harmless or indemnification clauses favorable to the applicant? Yes No
- 45. 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.

46. 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 physicians, details of financial relationship, type of referrals).

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

GENERAL LIABILITY

- 42. Does applicant sponsor any sporting, fundraising or social events? Yes No
 Please explain _____
- 43. Does applicant sell any medical supplies and/or equipment? Yes No
 If Yes, Annual Receipts \$ _____
- 44. Does applicant rent or lease any medical supplies and/or equipment? Yes No
 If Yes, Annual Receipts \$ _____

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

EMPLOYEE BENEFITS LIABILITY

46. Number of total employees _____

47. Average professional turnover _____ % Average non-professional turnover _____%

48. Employee Benefits Provided: Health Life 401K Section 125

STOP GAP LIABILITY

52. Total Annual Payroll by State:

Complete the appropriate EKG, X-Ray, Cytology or Drug Testing questionnaires. If these are not applicable, please so indicate.

DRUG TESTING QUESTIONNAIRE

- 1. What are the expected receipts from drug testing? _____
- 2. Does applicant perform a second test if the first test is positive? Yes No
- 3. Does applicant or its client obtain the written consent of all people to be tested? Yes No
- 4. Do physicians review test results? Yes No
- 5. 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
- 2. Who reviews the tests? _____
- 3. Are the tests results sent to the treating physician for review? Yes No
- 4. Are abnormal, and 1 0% of normal, reviewed? Yes No
- 5. What are the expected receipts from cytology work? _____
- 6. Are technicians compensated on a per slide basis? Yes No

EKG QUESTIONNAIRE

- 1. Are all EKG tests performed per a physician's request? Yes No
- 2. Who interprets the EKG's? _____
- 3. Are they sent to the physician for review? Yes No
- 4. Are the tapes condensed by computer before being interpreted? Yes No
- 5. How is the EKG equipment maintained?

- 6. How often is it serviced?

- 7. Are portable holster monitors used? Yes No
- 8. What are the expected receipts from EKG work? _____

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
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 radio-ucldides.
Explain: _____
5. Indicate the frequency of testing of air and water discharge from the facility to ascertain local, state and federal standards of compliance.
Explain: _____
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
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
Or, under the name of the radiologist? Yes No
14. How is the x-ray equipment maintained?

15. How often is it serviced? _____
16. What are the expected receipts for x-ray work? _____

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.

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands that incorrect or incomplete information could void their protection.

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.

Underwritten by United National Insurance Company, Diamond State Insurance or any members of United National Group.

SIGNATURE OF APPLICANT X _____ **DATE X** _____

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

Producer: _____

Telephone Number: (____) _____

Producer's Address:

Street

City

State/Zip

Tax I.D. Number / New Jersey SL #:

Notice to New York Applicants: 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.