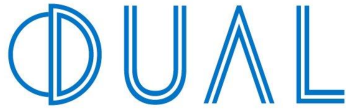
DUAL COMMERCIAL LLC 	APPLICATION PROFESSIONAL LIABILITY INSURANCE MISCELLANEOUS MEDICAL (CLAIMS-MADE FORM)

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

2. a) MAILING ADDRESS:____

CITY, STATE & ZIP CODE:______________________________PHONE NO.____________
(If multiple name and locations, please attach list)

b) Square feet of total office space (all locations)______________________________

3. a) DATE ESTABLISHED__________Corp.______Partnership__________Prof. Assoc.________Individual_______

b) In what state 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	(e) ______	Nurse Practitioner
(b) _____	Laboratory Technicians	(f) ______	Nurses Registered
(c) _____	Nurse Anesthetists	(g) _____	Opticians
(d) _____	Nurses, License Practical	(h) _____	Optometrists

NUMBER	Type of Profession	NUMBER	Type of Profession
(i) _____	Perfusionists	(m) _____	Physiotherapists
(j) _____	Pharmacists	(n) _____	Social Workers
(k) _____	Physicians-minor surgery	(o) ______	Speech Therapists
(l) _____	Physicians-no surgery	(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 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)? C._____ _____
Describe procedure:

D. Closed reduction of compound fractures and/or Normal Deliveries and/or Dermabrasion? D._____ _____

E. Injection of radioisotopes and/or use of irradiated substances? E._____ _____
Describe:

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: YES NO

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. Cryosyrgery (other than use on benign or pre-malignant dermatological lesions)?
Describe:______________________________ J._____ _____

K. Silicone Implants? Describe:______________________________ K._____ _____

L. Sterilization Procedures? Describe:______________________________ L ._____ _____

M. Biopsies and/or endoscopies? List types performed:______________________________ M ._____ _____

N. Sex change operations? Describe and advise the number performed:______________________
____ N._____ _____

O. Other Surgery? Describe:______________________________ O._____ _____

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 treatments? _____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. State 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	Est. Amount this Policy Year
A. Charitable Contributions	$_______________________	$_______________________
B. Government Funding	$_______________________	$_______________________
C. Fee for service	$_______________________	$_______________________
D.______________________	$_______________________	$_______________________
E.______________________	$_______________________	$_______________________
TOTAL GROSS REVENUE	$_______________________	$_______________________

18. Number of patient encounters last 12 Months ____________ and/or patient tests carried out ______________________
(Note: "Patient encounters" refers to number if *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 facility (eg. MD,RN,PHD)**
_________________	__________	________	____________	________	_________________
_________________	__________	________	____________	________	_________________

21. 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?____

22. Is the Applicant currently insured under a Commercial General Liability Policy? Yes___________ No.________________
If yes, please give details:

Insurance Company	**Type of Coverage**	**Limits BI**	**Limits PD**	**Effective From**	**Effective To**
______________________	______________	____________	____________	____________	______________

23. 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:____
____

24. Has any claim ever been made against the firm or any of its employees? Yes______ No_________ If yes, please attach 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.

25. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers? Yes__________ No________ If yes, please give full details on the same basis as item 23.

26. Has any insurer cancelled or refused to renew any similar insurance during the past five years?_________________________
____

27. Limits of Liability requested_________________________________ Deductible_____________________________________

28. Desired term of policy: From_________________________________ To____

29. The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made part of the policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

____ ____

Date Signature of Applicant Title

Producer____