SHAND MORAHAN
MARKEL® & COMPANY, INC.
Ten Parkway North, Deerfield, IL 60015
(847) 572-6000 Fax (847) 572-6137
Underwriting Manager
A Markel Company

- DEERFIELD INSURANCE COMPANY
- EVANSTON INSURANCE COMPANY
- ESSEX INSURANCE COMPANY
- MARKEL AMERICAN INSURANCE COMPANY
- MARKEL INSURANCE COMPANY

SUPPLEMENT FOR HOME HEALTH CARE, NURSE REGISTRY, INFUSION THERAPY OR OTHER MEDICAL STAFFING FOR PROFESSIONAL LIABILITY INSURANCE FOR SPECIFIED MEDICAL PROFESSIONS

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

2. Type of Firm (check all that apply): _____ Home Health Care _____ Infusion Therapy _____ Visiting Nurse Agency _____ Nurse Registry _____ Other Medical Staffing (specify) _____

3. Date Established: _____

4. Location(s) where services are provided (total must equal 100%):
_____%Home _____%Hospice _____%Nursing Home _____%Assisted Living Facility _____%Hospital
_____%Clinic/Doctor's Office _____%Adult Day Care _____% Other Facility (specify)_____

5. Employees/Independent Contractors – Annual Staffing:

Type of Employee/Independent Contractor	No. Full-Time	No. Part-Time	Billable Hours Per Year
Employed Registered Nurse			
Contracted Registered Nurse			
Employed Licensed Practical Nurse			
Contracted Licensed Practical Nurse			
Employed Certified Nurse Assistant			
Contracted Certified Nurse Assistant			
Employed Nurse Practitioner/Physician Assistant			
Contracted Nurse Practitioner/Physician Assistant			
Employed Companion/Home Health Aide			
Contracted Companion/Home Health Aide			
Employed Social Worker			
Contracted Social Worker			
Employed Physical Therapist			
Contracted Physical Therapist			
Employed Other Medical (specify) _____			
Contracted Other Medical (specify) _____			

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

_____ _____
Name of Applicant Title

_____ _____
Signature of Applicant Date

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APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS FOR PROFESSIONAL LIABILITY INSURANCE
(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full name of Applicant (include professional degree if applicant is an individual): _____

_____

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

Please attach a list of additional office addresses.

c. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____

d. Business Phone: (___) _____ Home Phone: (___) _____

e. Date of Birth: _____ Place of Birth: _____

Are you a U.S. citizen? [ ] Yes [ ] No. If No, your status, date of entry into USA: _____

f. Square feet of total office space (all locations): _____

g. Your practice:

[ ] Solo practitioner (unincorporated)
[ ] Solo practitioner (incorporated)
[ ] Partnership
[ ] Professional Association
[ ] Other (please describe)_____
[ ] Professional corporation (for profit)
[ ] Professional corporation (non-profit)
[ ] Employee of _____
(Give name of employer)

h. Formal business, corporate or partnership name:

i. Please list the names of all partners or members of your professional association/corporation who provide professional services: _____

_____

j. Please attach a copy of your letterhead.

k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No

If yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .....[ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

2. EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	Years of Training	Degree or Certification Attained
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

(i) Where have you practiced your profession during the last ten years?

In _____ From _____ To _____
In _____ From _____ To _____
In _____ From _____ To _____

(ii) Have you ever failed any professional licensing or specialty organization examination? .....[ ] Yes [ ] No
If yes, please attach a detailed explanation including the dates and location.

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

b. Please indicate your professional specialty (CHECK ONE):

[ ] Chiropractor
[ ] Counselor (Describe)
_____
[ ] Dental Hygienist
[ ] Hearing Aid Fitter
[ ] Home Health Care Agcy.
[ ] Inhalation Therapist
[ ] Laboratory Technician
[ ] Medical Personnel Pool
[ ] Naprapath
[ ] Nurse, Licensed Practical
[ ] Nurse, Registered
[ ] Nurses Registry
[ ] Occupational Therapist
[ ] Optician
[ ] Optometrist
[ ] Orthotist
[ ] Perfusionist
[ ] Pharmacist
[ ] Physical Therapist
[ ] Psychologist
[ ] Social Worker
[ ] Speech Therapist
[ ] Veterinarian
[ ] Visiting Nurse Assoc.
[ ] X-ray Technician
[ ] Other (Specify) _____

c. Please indicate the sources and amounts of actual and projected revenue:

Source	Amount This Fiscal Year	Amount Next Fiscal Year
(i) Charitable Contributions:	$_____	$_____
(ii) Government Funding:	$_____	$_____
(iii) Fee for Services:	$_____	$_____
(iv) Other:_____	$_____	$_____
TOTAL GROSS REVENUE	$_____	$_____

d. Please provide the number of patient or client visits:

Type of Visit	Number of Visits Last 12 Months	Number of Visits Next 12 Months
Clinic	_____	_____
Laboratory	_____	_____
Other (specify)_____	_____	_____
TOTAL NUMBER OF VISITS	_____	_____

e. Please specify any professional societies or associations in which you are a member: _____
_____

f. Are you associated with or do you work for a physician or surgeon?.....[ ] Yes [ ] No
If yes, please give the name and the specialty of the physician: _____

g. Please give the approximate percentage of time spent in the following work locations:

_____% Administrative Office
_____% Classroom
_____% Emergency Dept of Hospital
_____% Nursing Home
_____% Other (specify) _____

_____% Laboratory
_____% Operating Room
_____% Outpatient Clinic
_____% Patient's Home

_____% Hospital Ward (specify) _____
_____% Professional Office (specify profession) _____

h. Please indicate the approximate division of your patients or clients among:

_____% Hemodialysis
_____% Holistic Medicine
_____% Surgical
_____% Stress Testing
_____% Communicable
_____% Family Planning

_____% Psychiatric
_____% Drug Addicts
_____% Alcoholics
_____% Obstetrical
_____% Dental
_____% Pediatric

_____% Bariatrics
_____% Physical Rehabilitation
_____% Disability Evaluation
_____% Research or Experimental
_____% _____
_____% _____

i. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

Type of Profession	No.	Type of Profession	No.
Inhalation Therapists	_____	Opticians	_____
Laboratory Technicians	_____	Optometrists	_____
Nurse Anesthetists	_____	Perfusionists	_____
Nurses, Licensed Practical	_____	Pharmacists	_____
Nurse Practitioner	_____	Physiotherapists	_____
Nurses, Registered	_____	Social Workers	_____
Speech Therapists	_____	Other (please specify)	_____

j. Are all of the above individuals licensed in accordance with applicable state and federal regulations? .[ ] Yes [ ] No
If no, please attach an explanation.

4. APPLICANT PROCEDURES

a. Do you render professional services directly to patients? [ ] Yes [ ] No. If yes, please describe in detail and indicate the extent of supervision by others.

Description of Professional Services	**Percent of Time Supervised**	**Qualifications of Supervisor**
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____

b. Do you render professional services that do not involve contact with a patient? [ ] Yes [ ] No. If yes, please describe these services in detail. _____

c. (i) Do you perform or assist in any surgical procedures? [ ] Yes [ ] No

(ii) Please list ALL surgical procedures performed (including minor surgery): _____

(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? [ ] Yes [ ] No. If yes, please attach a detailed explanation.

(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? [ ] Yes [ ] No. If yes, please attach a detailed explanation.

d. Do you perform radiation therapy? .....[ ] Yes [ ] No

e. Do you perform psychiatric shock therapy? .....[ ] Yes [ ] No

f. Do you compound in bulk, manufacture or wholesale medicine? .....[ ] Yes [ ] No
If yes, please provide a detailed explanation. _____

g. (i) Do you perform veterinary services?.....[ ] Yes [ ] No
If yes, please indicate the approximate division of your work among the following categories.

_____ % Greyhounds _____ % Thoroughbreds

_____ % Animals valued over $5,000.

Please attach an explanation including the frequency and the type(s) of animals treated.

h. Do you administer artificial insemination?.....[ ] Yes [ ] No
If yes, please answer the following questions:

(i) What type(s) of animals are involved? _____

(ii) Are you responsible for the storage of the semen? .....[ ] Yes [ ] No
If yes, please explain. _____

_____

(iii) What percent of your practice is involved with artificial insemination? _____ %

i. Are you ever responsible for identifying contagious diseases in your locality and/or for recommending remedial action?.....[ ] Yes [ ] No
If yes, please attach a detailed explanation.

5. PERSONNEL

a. Please list the number and type of independent contractors who provide professional services on your behalf. IF NONE, STATE NONE.

No.	Type of Profession	No.	Type of Profession	No.	Type of Profession
_____	Inhalation Therapists	_____	Laboratory Technicians	_____	Nurse Anesthetists
_____	Nurses, Licensed Practical	_____	Nurse Practitioner	_____	Nurse, Registered
_____	Opticians	_____	Optometrists	_____	Perfusionists
_____	Pharmacists	_____	Physiotherapists	_____	Social Workers
_____	Speech Therapists	_____	Other (specify)_____		

b. Do you supervise any individuals who are not your own employees? [ ] Yes [ ] No. If yes, please provide a detailed explanation of responsibilities and relationships to the entity which employs these individuals.

c. Please indicate by profession the number of individuals you supervise.

No.	Type of Profession	No.	Type of Profession
_____	Physicians	_____	Laboratory technicians
_____	X-ray technicians	_____	Other (please specify):_____

6. APPLICANT AFFILIATIONS

a. Do you own or operate any business other than that shown in Question 1(a) above? .....[ ] Yes [ ] No
If yes, please give details on a separate sheet.

b. Are you employed by any individual or entity other than that shown in Question 1(a) above?.....[ ] Yes [ ] No
If yes, please attach an explanation describing details of your responsibilities.

c. Are you under contract to any individual or entity other than that shown in Question 1(a) above? .....[ ] Yes [ ] No
If yes, please attach an explanation describing details of your responsibilities. <u>If your contract contains a hold-harmless agreement, a copy of the contract must be attached.</u>

d. Are you employed by or under contract to any government entity? .....[ ] Yes [ ] No
If yes, please attach an explanation including the details of your responsibilities.

e. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)?.....[ ] Yes [ ] No
If yes, please attach a copy of ALL of your advertisements.

f. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients?.....[ ] Yes [ ] No
If yes, please attach a detailed explanation and a copy of ALL of your advertisements.

g. Do you own (wholly or in part), operate, or administer any hospital, nursing home or other institutions where medical services are customarily rendered? .....[ ] Yes [ ] No
If yes, please give details including the name, location, size and number of beds.

_____

_____

h. If you have a training school, please complete the following. Attach a separate sheet if needed.

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 Faculty**	**Qualifications of Faculty (e.g. MD, RN, PhD, etc.)**

i. (i) Do you use a collection agency? .....[ ] Yes [ ] No
If yes, please state the name of the agency

(ii) Does the agency have the authority to file a collection suit at its discretion? .....[ ] Yes [ ] No

7. APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

a. Have you or any of your employees:

(i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? .....[ ] Yes [ ] No

(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? .....[ ] Yes [ ] No

(iii) Ever been treated for alcoholism or drug addiction? .....[ ] Yes [ ] No

(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same? .....[ ] Yes [ ] No

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? .....[ ] Yes [ ] No

b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

Insurance Carrier	**Policy Number**	**Limits of Liability**	**Deductible (If any)**	**Premium**	**Inception Mo./Day/Yr.**	**Expiration Mo./Day/Yr.**	**Was this a Claims Made Policy Form? Yes**	**No**	**Retro Date**
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	

c. Has any claim or suit been brought against you and/or any of your employees? .....[ ] Yes [ ] No
If yes, a Supplemental Claim Information Form must be completed for each claim or suit.

d. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? .....[ ] Yes [ ] No
If yes, please give details on a separate sheet.

* 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.

MARKEL®

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:

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SUPPLEMENTAL CLAIM INFORMATION

APPLICANT'S INSTRUCTIONS:
1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

1. Applicant Name _____
2. Claimant Name _____
3. Name of Individual(s) at your firm/Company involved in Claim: _____
4. Indicate whether: _____ Claim/Suit _____ Incident
5. Date of alleged error: _____ Date claim made against applicant: _____
6. Additional defendants: _____
7. Current Disposition of claim:
   - [ ] DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
   - [ ] ABANDONED (no activity from claimant for over 3 years)
   - [ ] WON by defense
   - [ ] WON by claimant Total Paid $_____ Amount Paid on your behalf $
     Indicate whether : [ ] Court judgment, or [ ] Out of court settlement
   - [ ] OPEN Claimant's settlement demand $_____
     Defendant's offer for settlement? $_____ Insurer's loss reserve $_____
8. Name of Insurer: _____
9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)
   a. Alleged act, error or omission upon which Claimant bases claim: _____
   b. Description of cases and events: _____
   c. Description of the type and extent of injury or damage allegedly sustained: _____
   d. If a medical claim provide type of injury claimed:
      [ ] Emotional Only [ ] Temporary Disability [ ] Death [ ] Cosmetic
      [ ] Permanent Disability [ ] Other (describe) _____
10. Explain what action has been taken by you to prevent recurrence of the same type of claim. _____

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

_____ _____
Name of Applicant* Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.

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SUPPLEMENT FOR EMPLOYEE BENEFITS LIABILITY COVERAGE

All questions MUST be completed in full. If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: _____

2. Total number of employees under the Applicant's Employee Benefits programs._____

3. Does the Applicant have a full-time human resource manager or department? ....[ ] Yes [ ] No

4. For elective Employee Benefit programs, does the Applicant obtain and retain a signed acceptance or rejection form from every eligible employee? .....[ ] Yes [ ] No

5. Is a written guide of the Applicant's Employee Benefits programs provided to every employee? .....[ ] Yes [ ] No
   If Yes, does the Applicant obtain and retain written acknowledgement of its receipt from every employee?.....[ ] Yes [ ] No

6. Has (have) any Employee Benefits Liability judgment(s), settlement(s), payment(s), claim(s), suit(s) or demand(s) been made against any person(s) or entity(ies) proposed for this insurance?.....[ ] Yes [ ] No
   If Yes, provide details._____

   _____

7. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any facts, circumstances or situations which might afford grounds for any Employee Benefits Liability claim? .....[ ] Yes [ ] No
   If Yes, provide details._____

   _____

8. Has any insurer declined, cancelled or nonrenewed any Employee Benefits Liability policy for any person(s) or entity(ies) proposed for this insurance? .....[ ] Yes [ ] No
   If Yes, provide details._____

   _____

9. Does the Applicant currently carry Employee Benefits Liability Insurance?.....[ ] Yes [ ] No
   If Yes, provide the following:

Name of Insurer	Limits	Policy Period	Deductible/Retention	Premium	Retro/Prior Acts Date

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

For the purpose of this supplement, the undersigned authorized agent of the person(s) and entity(ies) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this supplement and in any attachments, are true and complete. This supplement, information submitted with this supplement and all previous supplements and material changes thereto of which Shand Morahan & Company, Inc. receives notice is on file with Shand Morahan & Company, Inc. and is considered physically attached to and part of the policy if issued. Shand Morahan & Company, Inc. and the Company will have relied upon this supplement and all such attachments in issuing the policy.

Signing this supplement does not bind the Company to provide or the Applicant to purchase the insurance. It is understood that information submitted herein becomes a part of the application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent (within 60 days of the proposed effective date).

_____ _____
Name of Applicant Title

_____ _____
Signature of Applicant Date