Rockwood Programs, Inc.
3001 Philadelphia Pike
Claymont, DE 19703
Tel: 800-365-0816 • Fax: 302-764-9125
sales@rockwoodinsurance.com

MEDICAL CLINICS
Supplemental Application

This is an application for claims-made insurance. It is important that you report any currently known facts, incidents, situations or circumstances that could result in a claim to your current insurer or purchase an extended reporting period endorsement to cover such known facts, incidents, situations or circumstances. Protective Specialty Insurance Company will not provide coverage for known facts, incidents, situations, circumstances or claims of which you are aware prior to the inception date of this coverage.

Instructions for completing this application:

1. Please answer all the questions. This information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
2. If a question is not applicable, state "N/A". If more space is required to answer a question, please attach an exhibit with the question number.
3. The application must be signed and dated by a named insured or authorized person.
4. PLEASE ATTACH THE FOLLOWING:
    a. Brochures or other descriptive literature about the applicant's services or operations.
    b. Resume of principals or officers and key professional staff.
    c. A copy of your letterhead.
    d. Supplemental application(s) if applicable.
5. Return this and all supplemental applications to:
   sales@rockwoodinsurance.com
   OR
   Rockwood Programs, Inc
   3001 Philadelphia Pike
   Claymont, DE 19703

Proposed Effective Date: From _____ to _____

I. GENERAL INFORMATION

1. (a) Full name of Applicant: _____

   (b) Principal practice address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) Location: Stand alone _____ Hospital _____ School _____ Correctional Facility _____ Other _____

   (d) (i) Phone:_____

   (ii) E-Mail Address:_____ (iii) Website Address: _____

   (e) Date Established: _____
   Attached a proforma business plan if the Applicant is newly established.

2. Applicant is a:

   [ ] professional corporation
   [ ] joint venture
   [ ] limited liability company
   [ ] professional association
   [ ] other _____
   [ ] partnership

3. Name(s) of all partners or members of the clinic who provide professional services: _____

   _____

4. Does any owner, partner or director operate or administer, wholly or in part, any hospital, nursing home or other institution where medical services are rendered? ..... [ ] Yes [ ] No
   If Yes, provide details, including name, location, size and number of beds. _____

5. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... [ ] Yes [ ] No
   If Yes,
   (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? ..... [ ] Yes [ ] No
   (b) Provide the name and title of the Applicant's Privacy Officer. _____

II. OPERATIONS

1. Days/hours of operation: _____

2. (a) Provide the name and specialty of the Applicant's Medical Director: _____
   (b) Does the Applicant's Medical Director have direct patient contact? ..... [ ] Yes [ ] No
   (c) Is the Applicant's Medical Director full-time or part-time? _____

3. Applicant's professional specialty: _____

4. Provide the percentage of patients/clients:

Bariatrics	_____%	Holistic medicine	_____%	Sleep Disorders	_____%
Communicable Disease	_____%	Obstetrical	_____%	Stress Testing	_____%
Correctional Medicine	_____%	Oncology	_____%	Students	_____%
Dental	_____%	Pain Management	_____%	Substance Abuse	_____%
Disability Evaluation	_____%	Pediatric	_____%	Surgical	_____%
Family Planning	_____%	Physical Rehabilitation	_____%	Urgent Care	_____
Free Clinic	_____%	Psychiatric	_____%		
Hemodialysis	_____%	Research or Experimental	_____%		

5. List all Locations where Applicant is registered and licensed to operate:

   Location 1: _____

   Location 2: _____

   Location 3: _____

   Location 4: _____

6. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: _____

7. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered? ..... [ ] Yes [ ] No
   If Yes, provide details. _____

8. List all accreditations and association memberships held by Applicant's facility and include a copy of the most recent report: _____

9. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism? ..... [ ] Yes [ ] No

10. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")? ..... [ ] Yes [ ] No
    If Yes, what percentage of services are provided under the FTCA? _____

11. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.? ..... [ ] Yes [ ] No

12. Applicant's Gross Revenues:

	Last Twelve Months	Next Twelve Months
Fee for Service	$_____	$_____
Medicare/Medicaid Funds	$_____	$_____
Research	$_____	$_____
Other (describe)	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

13. Number of outpatient/client visits:

	Last Twelve Months	Next Twelve Months
Clinics	_____	_____
Laboratory	_____	_____
X-ray/Imaging	_____	_____
Pharmacy	_____	_____
TOTAL VISITS:	_____	_____

NOTE: If Applicant provided services for correctional facilities, provide number of inmates: _____

14. Does the Applicant maintain any beds for overnight occupancy:

(a) On the Applicant's premises? ..... [ ] Yes [ ] No
If Yes,
(i) No. of beds: ____
(ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

(b) Off the Applicant's premises? ..... [ ] Yes [ ] No
If Yes,
(i) No. of beds: ____
(ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

III. STAFF

1. Indicate the number of professional employees, independent contractors and volunteers. If None, state None.

	Employees		Independent Contractors		Volunteers	
	Full-Time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures						
Physicians: Minor surgery or obstetrical procedures not constituting major surgery						
Anesthesiologists						
Obstetrics-Gynecologists						
Oncologists						
Ophthalmologists						
Urologists						
Dentists						
Chiropractors						
Nurse Anesthetists						
Nurse Practitioners						
Optometrists						

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Pharmacists						
Physician Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Other(describe):						

NOTE: If the Applicant requires any of the above to be Insureds, submit a separate application for each such individual.

2. Are all of the above persons licensed in accordance with applicable state and federal regulation? ..... [ ] Yes [ ] No
   If No, attach explanation.

3. Do all professional staff maintain a Professional Liability Insurance Policy? ..... [ ] Yes [ ] No
   If Yes, what are the minimum limits of liability that the Applicant requires?
   $_____each claim / $_____ aggregate

IV. PROFESSIONAL SERVICES

1. Does the Applicant's employees or independent contractors:
   (a) Perform any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? ..... [ ] Yes [ ] No
   If Yes, list all minor/invasive procedures _____

   _____

   (b) Perform any anti-aging procedures, including Botox or other injectables? ..... [ ] Yes [ ] No
   If Yes, complete a Supplement for Medical Spa/Anti-Aging Clinics (SM31001).

   (c) Perform abortions and/or menstrual extractions? ..... [ ] Yes [ ] No
   If the Applicant provides pregnancy termination complete a Supplement for Abortion Centers (SM31002)

   (d) Perform any experimental procedures or research testing? ..... [ ] Yes [ ] No
   If Yes, are they FDA approved? ..... [ ] Yes [ ] No
   If No, attach a description.

   (e) Perform any chelation therapy services? ..... [ ] Yes [ ] No
   If Yes, explain: _____

   (f) Administer anesthesia other than topical or local infiltration? ..... [ ] Yes [ ] No
   If Yes, attach detailed explanation.

   (g) Use drugs for weight reduction for patients? ..... [ ] Yes [ ] No
   If Yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs and quantity dispensed.

   (h) Administer any methadone treatment? ..... [ ] Yes [ ] No
   If Yes,
   (i) Provide the number of treatments during the:
   Last 12 months _____ Next 12 months _____
   (ii) Attach a description of treatment and controls used.

   (i) Provide teleradiology services? ..... [ ] Yes [ ] No
   If Yes, provide description of services and for whom services are provided._____

   (j) Offer professional advice to the public via the internet, newspapers or broadcasts? ..... [ ] Yes [ ] No
   If Yes, provide details._____

   (k) Advertise professional services in any manner other than a simple listing in a telephone directory? .... [ ] Yes [ ] No
   If Yes, attach a copy of all advertisements.

2. Does the Applicant use a collection agency: ..... [ ] Yes [ ] No
   If Yes,
   (i) Name of agency: _____
   (ii) Does the agency have authority to file a collection suit on behalf of the Applicant? ..... [ ] Yes [ ] No

V. CLAIMS AND HISTORY

1. Has the Applicant or any of its employees ever:
   (a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency? ..... [ ] Yes [ ] No
   (b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses? ..... [ ] Yes [ ] No
   If Yes, provide details._____

   (c) Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders? ..... [ ] Yes [ ] No
   If Yes, provide details._____

   (d) Had any professional license or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license? ..... [ ] Yes [ ] No
   If Yes, provide details._____

2. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance? ..... [ ] Yes [ ] No
   If Yes,
   (i) How many? _____
   (ii) Provide details._____

3. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer? [ ] Yes [ ] No
   If Yes, explain._____

4. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?.. [ ] Yes [ ] No
   If Yes,
   (i) How many? _____
   (ii) Provide details._____

5. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years? ..... Yes [ ] No [ ]
   If Yes, attach a copy of such insurer's notice.

6. List prior Professional Liability Insurance for each of the last five (5) years, including the current year:
   If None, check here. [ ]

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

7. List prior General Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

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VI. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					

2. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:
   - (a) Complete Sprinkler System? ..... [ ] Yes [ ] No
   - (b) At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
   - (c) Self-closing fire doors on each floor? ..... [ ] Yes [ ] No
   - (d) Automatic fire alarm system connected to a local fire department? ..... [ ] Yes [ ] No
   - (e) Smoke detectors? ..... [ ] Yes [ ] No
   - (f) Emergency electrical system? ..... [ ] Yes [ ] No
   - (g) Heat sensors? ..... [ ] Yes [ ] No
   - (h) Fire escape(s)? ..... [ ] Yes [ ] No
   - (i) Posted emergency evacuation procedures? ..... [ ] Yes [ ] No
   - (j) Properly maintained fire extinguishers? ..... [ ] Yes [ ] No

   If any of the above are answered No, provide details by attachment.

4. Does the Applicant have a written safety program in place? ..... [ ] Yes [ ] No
   If Yes, attach a copy of the written safety program.

5. Does the Applicant have written procedures for incident reporting? ..... [ ] Yes [ ] No

6. Do any of the Applicant's locations have any:
   - (a) Exposure to flammables, explosive, chemicals? ..... [ ] Yes [ ] No
   - (b) Catastrophe exposure? ..... [ ] Yes [ ] No
   - (c) Exposure to radioactive materials? ..... [ ] Yes [ ] No

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7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? ..... [ ] Yes [ ] No

8. Does the Applicant sell or lease any medical equipment or products to patients/clients or others in connection with Applicant's operation? ..... [ ] Yes [ ] No

   If Yes, Total Annual Sales $_____

   Total Annual/Lease Rental Receipts $_____

9. Does the Applicant:

   (a) Loan or rent machinery or equipment to others? ..... [ ] Yes [ ] No
   (b) Own any elevators or escalators? ..... [ ] Yes [ ] No
   (c) Own or rent any parking facility? ..... [ ] Yes [ ] No
   (d) Provide any recreational facility? ..... [ ] Yes [ ] No
   (e) Have a swimming pool on the premises? ..... [ ] Yes [ ] No
   (f) Sponsor any sporting or social events? ..... [ ] Yes [ ] No

10. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? ..... [ ] Yes [ ] No

    If Yes, answer the following:
    Provide three year loss history for claims under $100,000 Loss and Expense and ten years for claims $100,000 and greater. Attach further sheets if needed.

Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved and Paid	Amount of Expenses Reserved and Paid	Open (O) or Closed (C)

11. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? ..... [ ] Yes [ ] No

    If Yes, provide details for each incident._____

VII. ADDITIONAL INFORMATION

As part of this Application attach the following:

1. A CV of Medical Director including specialty and board certification.
2. Five (5) years of currently valued Professional Liability Insurance and General Liability Insurance claim runs from current and prior insurers or complete a Supplemental Claim Information form (SM6236) for each claim.
3. A list of any activities or procedures performed that are not otherwise described in this Application.
4. Credentialing, Risk Management protocols.
5. Most recent annual financial statements, both a balance sheet and a revenue and expense statement. If the Applicant is newly established attached proforma financial statements.
6. Complete an Additional Insured Supplement for any additional insured that coverage is being requested for under General Liability Coverage.

Please provide additional comments that would further clarify the information above or address characteristics of your practice not specifically addressed herein.

_____

_____

_____

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SIGNATURE

By signing this application, you represent and agree to each of the following four (4) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your company is aware of any actual or alleged fact, circumstance, situation, incident, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in the Claim Activity section of this application; and
2. Each of the statements and answers given in this application, and any supplemental applications, are:
   a. Accurate, true and complete to the best of your knowledge and no material facts have been suppressed or misstated;
   b. Representations you are making on behalf of all persons and entities proposed to be insured;
   c. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.
3. This application, along with any supplemental applications, are hereby deemed to be attached to the policy and incorporated into the policy, whether or not any of the supplemental applications are physically attached to a particular copy of the policy, and regardless of whether any of the supplemental applications are signed or dated.
4. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this application, or in any supplemental application, that may occur or be discovered after the completion date of said application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

FRAUD WARNING: Any person who knowingly and with the 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 purposes of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO MARYLAND AND LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND PENALTIES.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage. Please see IMPORTANT NOTICE in the Claim Activity section above.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

An authorized representative who is an active owner, officer or partner of your firm must sign this application within thirty (30) days prior to the policy inception date.

If additional space is needed, please provide details on a separate attachment.
I understand the information submitted herein becomes a part of my professional liability insurance application and is subject to the same warranties and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

_____

Signature of Owner, Officer or Partner Date

_____

Printed or Typed Name and Title

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