MIEC

6250 Claremont Avenue • Oakland, California 94618-1324 • Phone: 510-428-9411 • Toll Free: 800-227-4527 • Fax: 510-654-4634 • www.miec.com

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE BLOOD BANK

- Answer all questions. Indicate N/A if not applicable.
- Sign the release on the last page where indicated.
- Have Officer/Director sign and date Subscriber's Agreement.

❑ New Application ❑ Renewal Application (existing MIEC policyholder)
Policy number_____

1. Name of Blood Bank_____
   Mailing Address_____
   Address City State Zip
   Telephone Number ( )_____ Fax Number ( )_____
   Administrator_____
   Medical Director_____, MD
   Contact Person (if other than Administrator)_____
2. Who owns the Blood Bank?_____
3. Is the Blood Bank ❑ for profit? ❑ not for profit?
4. Is the Blood Bank sponsored by a medical society? ❑ Yes ❑ No
   If yes, which one?_____
5. Is the Blood Bank a member of the California Blood Bank System? ❑ Yes ❑ No
   If no, list any other professional or national affiliations.

_____

_____

_____

6. How long has the Blood Bank been in operation?_____

7. Number of donations and pheresis procedures.

	In past 12 mos.	Estimated for in next 12 mos.
Regular donations	_____	_____
Autologous donations	_____	_____
Directed donations	_____	_____
Pheresis procedures	_____	_____

8. Estimated annual gross receipts from:
   A. Whole blood, red cells, and blood components _____
   B. Serum _____
   C. Other blood products and derivatives _____

9. List all physicians who render medical services for or on behalf of the Blood Bank, their employment status (paid or volunteer), and their weekly hours worked. Include the medical director if he/she renders medical services. Have each physician complete a Special Practice Application.

Name	Status	Hours per week
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Do you employ personnel in the following categories to render medical services? ❑ Yes ❑ No
    If yes, indicate the combined number of hours worked per week in that category.

Type	Hours Per Week
Nurse (RN, LVN, LPN)	_____
Medical assistants (give injections, draw blood, etc.)	_____
Laboratory technicians	_____
Other technicians	_____
Nurse practitioners*	_____
Physician's assistants*	_____
Other (please specify)_____	

*Please have each nurse practitioner and physician's assistant complete a Nurse Practitioner/Physician's Assistant Questionnaire.

11. List all premises locations. Indicate whether location is rented, leased or owned.

Location	R/L/O
_____	_____
_____	_____
_____	_____

12. Do you carry Comprehensive General Liability Insurance on each of the above locations? ❑ Yes ❑ No
If so, please provide name(s) of the carrier(s) and limits of liability.

Name of Carrier	Limits of Liability

13. Number of mobile units:_____. List all primary mobile unit sites. Indicate whether site is rented, leased, or owned.

Location	R/L/O

14. List all hospitals which you serve and the cities in which they are located.

Hospital	City

15. Do you rent, sublet, or lease property to others? ❑ Yes ❑ No

16. Do you own or lease any office equipment, furniture and fixtures, or technical or professional equipment? ❑ Yes ❑ No
If you answered "yes" to question 14 or 15, you should consult your insurance agent or broker for recommendations concerning insurance coverage as MIEC is unable to provide coverage for these types of liability.

17. Submit an outline of your protocol for testing blood and infectious disease and/or immunological testing, i.e., which tests are administered? Are these tests performed on all blood donations? ❑ Yes ❑ No
If no, list all exceptions.

18. Do you accept untested units from other facilities? ❑ Yes ❑ No
If yes, list all facilities from which you accept untested blood.

Does your facility test these units prior to releasing them? ❑ Yes ❑ No
If yes, which tests are administered?_____

19. Are laboratory services or testing available for blood other than donated blood? ❑ Yes ❑ No
If yes, what types of services and/or tests are available? How many such services are performed each year?

20. Submit a brief summary of your donor screening procedures.

21. List all prior professional and general liability carriers which have insured the Blood Bank in the past ten (10) years. Include:
    a. Name and address of carrier (not broker or agent)
    b. Policy effective and cancellation/expiration dates
    c. Limits of liability
    d. Policy number
    e. Whether policy was/is on a claims-made or occurrence basis
    f. Did the policy have a deductible? How much?

22. Has any prior carrier canceled, refused to renew, or imposed surcharges from standard rates, or reduced the scope of your liability coverage in the past ten (10) years? ❑ Yes ❑ No
    Please provide full details including dates, actions taken, and reasons.

23. Has the Blood Bank or any health care professional rendering services on its behalf ever been notified of involvement in a general professional liability claim, suit, or incident resulting either directly or indirectly from the operation of the Blood Bank? ❑ Yes ❑ No
    If yes, complete a Claim Information form for each incident or submit a claim history listing each case.

24. Requested Effective Date of Coverage_____

I authorize the release to Medical Insurance Exchange of California of information by prior carriers involving past and future underwriting and claim matters. I further agree that the organization releasing the information, its agents, servants, and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions, or mistakes contained in such released information.

_____ _____

Signature Date of Signature

_____

Title

Blood Bank Claim Information Form
(Attach to your application)

PLEASE COMPLETE ONE FORM FOR EACH PAST OR PENDING PROFESSIONAL LIABILITY CLAIM, SUIT AND ARBITRATION PROCEEDING IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

IF YOU NEED ADDITIONAL FORMS, PLEASE MAKE PHOTOCOPIES.

1. Name, age and sex of patient/claimant.

   Name_____ Age_____ Sex_____

2. Condition and diagnosis of patient prior to treatment and/or surgery.

3. Date(s) and type of treatment and/or surgery rendered. Specify which health care professional(s) rendered the services.

4. Condition of patient subsequent to above treatment and/or surgery.

5. Nature of allegation or suit.

6. Specify whether and when a suit was ever filed, and if so, was it served? Which individuals and entities were named defendants?

7. Names of other doctors and hospital, if any, involved in claim or suit.

8. Disposition or current status of claim or suit (be specific). If settled or tried to plaintiff verdict, give amounts and dates of settlement or verdict.

9. Name of insurance carrier defending you. _____

10. Name of attorney defending you._____

Dated:_____ Signed:_____