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

Diagnostic Facility/Laboratory
Application for Claims-Made Professional Liability Insurance

- Answer all questions. Indicate N/A if not applicable
- Have Officer/Director sign and date pages 5 and 6

IMPORTANT NOTICE

You are applying for coverage under MIEC's claims-made policy. If your application is accepted by MIEC, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to MIEC either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

FACILITY INFORMATION / REQUESTED COVERAGE / LIMITS — ANSWER 1-3

1. FACILITY INFORMATION

Name of Facility

Mailing Address | City | State | Zip Code

Telephone Number | Fax Number | Website Address

Administrator | Medical Director

Contact Person (if other than Administrator) | Contact Person's E-mail

Type of Facility:

☐ Diagnostic X-ray
☐ MRI
☐ Other (specify:_______________________________________)
☐ Sleep center
☐ Laboratory
☐ Computer assisted tomography

2. REQUESTED EFFECTIVE COVERAGE DATE

Date (mm/dd/yyyy)

I request that this insurance commence at 12:01 A.M. on the above date. I understand that all MIEC policies have an annual expiration date of February 1. In light of this, I understand that my initial policy period may be for a term of less than one year, and that my premiums will be pro-rated accordingly.

FACILITY INFORMATION / REQUESTED COVERAGE / LIMITS, cont'd. ANSWER 1-3

3. **REQUESTED LIABILITY LIMITS**

Check one. Limit Per Claim / Annual Aggregate

☐ $500,000 / $1,500,000 ☐ $2,000,000 / $4,000,000 ☐ $4,000,000 / $6,000,000

☐ $1,000,000 / $3,000,000 ☐ $3,000,000 / $5,000,000 ☐ $5,000,000 / $7,000,000

Coverage and actual effective date are subject to the approval of MIEC's Underwriting Department

OWNERSHIP / LOCATION(S) / HOURS / PROCEDURES ANSWER 4-11

4. **OWNERSHIP**

Please describe the ownership of the facility (in detail), i.e., sole proprietor, partnership, corporation. Provide names of owners, partners, or shareholders.

____

____

____

5. **LOCATION(S)**

Location(s) of the facility. Do you wish to be covered for Premises Liability as defined in Part III of MIEC's policy? If yes, check appropriate box.

Address ____________ City ____________ State ______ Zip Code ______

Premises Liability: ☐ Yes ☐ No

Address ____________ City ____________ State ______ Zip Code ______

Premises Liability: ☐ Yes ☐ No

Do you carry Comprehensive General Liability Insurance on each of the above locations? ☐ Yes ☐ No

If yes, please provide name(s) of the carrier(s) and limits of liability.

Name of Carrier ____________ Limits of Liability ____________

Name of Carrier ____________ Limits of Liability ____________

6. **HOURS**

What are your hours of operation?______________________________

7. **SERVICES**

Attach brochure, business plan, or narrative which describes specific services offered by your facility.

8. **LICENSURE**

Is the facility licensed? ☐ Yes ☐ No

If yes, please attach a copy of the license and provide license number and state of licensure.____________ ____________

License Number State of Licensure

OWNERSHIP / LOCATION(S) / HOURS / PROCEDURES, cont'd. ANSWER 4-11

9. ACCREDITATION
   Is the facility accredited? ☐ Yes ☐ No

   If yes, by whom?____________________

10. PROCEDURES

    What is the estimated annual number of procedures or tests performed? If multiple facility, break down by type.

11. GROSS RECIEPTS

    What are the estimated annual gross receipts?____________________

HEALTHCARE PERSONNEL ANSWER 12-13

12. PHYSICIAN PROVIDERS

    A. List all physicians who render medical services for or on behalf of the facility, the date they joined the facility, and their weekly hours worked. Have each physician complete a Special Practice Application.

Name	Effective Date	Hours per Week

    B. Do the above physicians have separate professional liability insurance coverage? ☐ Yes ☐ No

    If yes, give name of company, policy number, limits of liability and expiration date.

Name of Company	Policy Number	Limits of Liability	Expiration Date

13. NON-PHYSICIAN HEALTHCARE PROVIDERS

    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 each category.

Type	Hours per Week
Nurses (RN, LVN, LPN)	
Medical assistants (give injections, draw blood, etc.)	
Laboratory technicians	
X-Ray technicians	
Other technicians	

Other (please specify)____________________

14. INSURANCE HISTORY

List all prior professional and general liability carriers which have insured the facility in the past ten (10) years. Attach a separate sheet, if necessary.

I.
Name of Carrier (not broker or agent) ______ Limits of Liability ______

Address of Carrier ______ City ______ State ______ Zip Code ______

Policy Effective Date ______ Cancellation/Expiration Dates ______ Policy Number ______ ☐ Claims Made ☐ Occurrence Basis

II.
Name of Carrier (not broker or agent) ______ Limits of Liability ______

Address of Carrier ______ City ______ State ______ Zip Code ______

Policy Effective Date ______ Cancellation/Expiration Dates ______ Policy Number ______ ☐ Claims Made ☐ Occurrence Basis

15. INSURANCE

Has any insurance carrier <u>ever</u> denied, declined, canceled, refused to renew, restricted, or placed a surcharge on the premium of your professional liability insurance? ☐ Yes ☐ No

If yes, please provide full details including dates, actions taken, and reasons. ______

16. CLAIMS

Has the facility or any health care professional rendering service on its behalf ever been notified of involvement in a general or professional liability claim, suit, or incident, resulting either directly or indirectly from the operation of the facility? ☐ Yes ☐ No

If yes, complete a Claims Information Form for each incident (page 7).

AUTHORIZATION TO RELEASE INFORMATION FOR PRIOR CARRIERS / MEDICAL ASSOCIATIONS

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my prior professional liability insurance carriers, or from my past and present medical association or society.

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	Title	Date

Print Name

Address	City	State	Zip Code

APPLICATION FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

The undersigned hereby applies to MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," for professional liability insurance. Submission of this application does not bind MIEC to issue coverage.

The undersigned hereby represents that all statements and answers in this application are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

The undersigned understands that the professional liability insurance for which this application is made applies only to claims covered by the policy and first made against the insured and reported to MIEC within the policy period or any renewal or reporting period.

The undersigned has been advised that MIEC offers limits of liability at various levels and has voluntarily elected to choose the limits option checked on this application.

The undersigned shall cooperate with MIEC in all respects in matters pertaining to this insurance and, upon request of MIEC, shall provide information, attend hearings and trials, and assist in making settlements, securing and giving evidence, obtaining the attendance of witnesses, and otherwise facilitating the conduct of any proceeding in connection with the subject matter of this insurance, including a review of the claim or lawsuit by a medical review and advisory committee or similar committee of a professional society or organization as may be selected by MIEC.

Signature	Date

Title

SUBSCRIBER'S AGREEMENT – A LEGAL REQUIREMENT FOR INSURANCE WITH MIEC

For and in consideration of the benefits to be derived therefrom, the subscriber covenants and agrees with MEDICAL INSURANCE EXCHANGE OF CALIFORNIA, herein called "MIEC," and other subscribers thereto through their and each of their Attorney-in-Fact, MEDICAL UNDERWRITERS OF CALIFORNIA, herein called "MUC," to exchange with all other subscribers policies of insurance or reinsurance containing such terms and conditions therein as may be specified by said Attorney-in-Fact and approved by MIEC's Board of Governors or its Executive Committee for any loss insured against, and subscriber hereby designates, constitutes and appoints MUC to be Attorney-in-Fact for subscriber, granting to it power to substitute another in its place and in subscriber's name, place and stead to do all things which the subscriber or subscribers might or could do severally or jointly with reference to the operation and management of MIEC and the business of inter-insurance; subscriber further agrees that from subscriber's premiums there shall be paid to MUC as compensation for its becoming and acting as Attorney-in-Fact, such fees as may be agreed upon by said Board and MUC.

The remaining portion of the subscriber's premiums shall be applied to the payment of the losses and expenses and to the establishment of reserves and general surplus. Such reserves and surplus may be invested and reinvested by or under the supervision of a Board of Governors duly elected by and from subscribers, which Board or its Executive Committee or an agent or agency appointed by written authority of said Executive Committee shall have full powers to negotiate purchases, sales, trades, exchanges and transfers of investments, properties, titles and securities, together with full powers to execute all necessary instruments. The expenses above referred to shall include all reinsurance, taxes, government charges, allocable claims expense and attorneys' fees and legal expenses and charges, expenses of members and Board of Governors, meetings, and such other specified fees, dues and expenses as may be authorized by the Board of Governors. All other expenses incurred in connection with the conduct of MIEC and such of the above expenses as shall from time to time be agreed upon by and between MUC and the Board of Governors or its Executive Committee shall be borne by MUC.

The principal office of MIEC and its Attorney-in-Fact shall be maintained in the County of Alameda, State of California.

It is intended that by compliance with *Section 1399* and *1400* or *1401* or *1401.5* of the *Insurance Code of the State of California* subscribers will have no contingent liability to assessment by reason of membership in the exchange. If because of non-compliance with said code sections a contingent liability arises, it shall not be more than an amount equal to and in addition to the amount of the premium deposit provided in the policy or the annual premium earned thereon, whichever is greater.

This instrument can be signed upon any number of counterparts with the same effect as if the signatures of all subscribers were upon and one and the same instrument; shall remain in effect as to all policies or insurance hereafter issued and accepted by subscriber; and shall be binding upon the parties thereto, severally and ratably as provided in policies issued. Wherever the word "subscriber" is used the same shall mean members of MIEC, the subscriber thereto, and all other subscribers to this and any other like agreements.

Signature ______________________ Date ______________________

Title ______________________

DIAGNOSTIC FACILITY / LABORATORY CLAIM INFORMATION FORM

☐ None [Please be sure to check here if no claims]

1. Last Name of Patient/Claimant ____________________ Gender ____________________ Age ________
2. Condition and diagnosis of patient prior to treatment and/or surgery:

____

____

3. Date(s) and type of treatment and/or surgery rendered by you. Indicate which health care professional(s) rendered these services.

____

____

4. Condition of patient subsequent to treatment and/or surgery by you:

____

____

5. Nature of allegation:

____

6. Was a suit ever filed against you? ☐ Yes ☐ No

   If yes, was it served? ☐ Yes ☐ No

   When? ____
7. Names of other doctors and hospital, if any, involved:

____

____

8. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

____

____

9. 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.

____

____________________	____________________
Name of Insurance Carrier Defending You	Name of Attorney Defending You

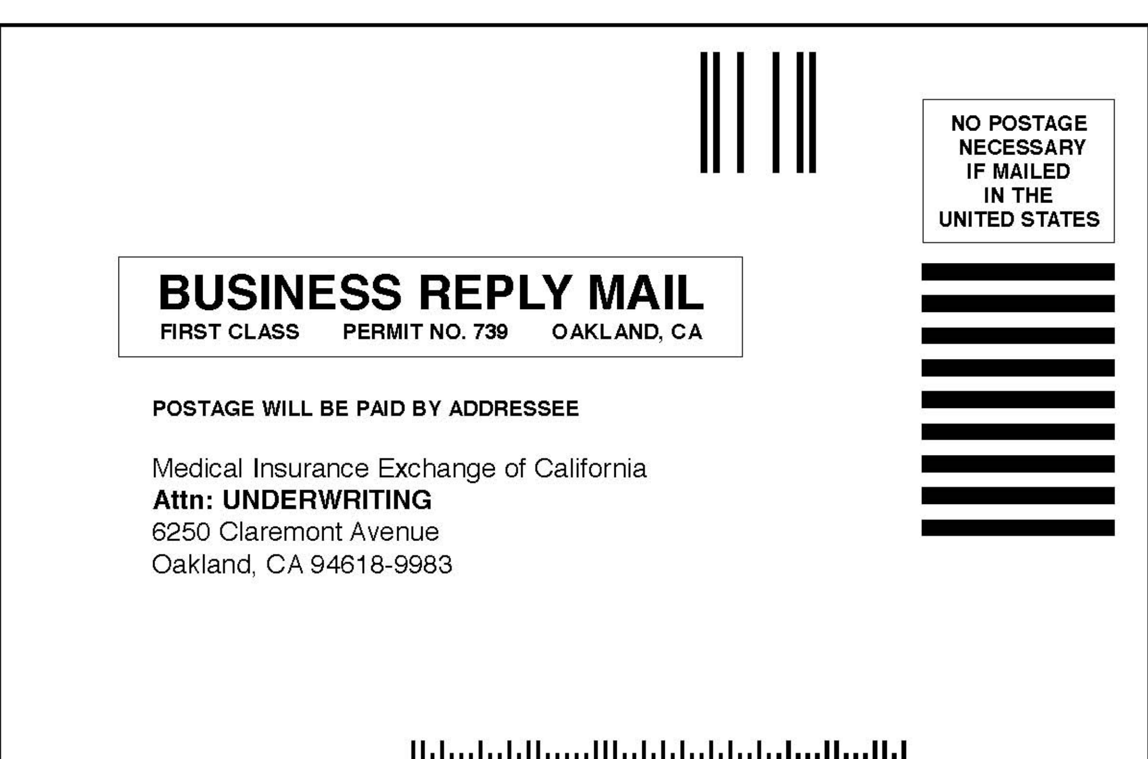
PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

MAKE ADDITIONAL COPIES AS NEEDED.

You can send in your application by:

1. Mail – [Print PRE-PAID Mailing Label]
2. Fax – (510) 318-6700
3. E-mail – underwriting@miec.com

(DETACH ALONG DOTTED LINE)



PRE-PAID MAILING LABEL – FIRMLY ATTACH TO YOUR ENVELOPE