PATRIOT INSURANCE AGENCY, INC.
DBA: Arizona Patriot Insurance Agency, Inc. in CA, NC, ND, NY
P.O. Box 17026
St. Petersburg, FL 33733
Toll Free Number: 800 859-2724
Fax: 520 842-2978

Email: wecare@patriot-insurance.com
www.patriot-insurance.com

DIRECTIONS FOR NON-PROFIT QUOTATION

Please find enclosed the application regarding Medical Malpractice coverage to be completed. Please follow these easy steps to expedite your request for a quotation:

1. Make sure that all questions are answered completely and as accurately as possible. Missing information will delay your quotation.
2. Make certain you sign the application. (Signing does NOT obligate you to purchase the coverage.)
3. Should you have prior coverage, please provide current loss runs (claims history report from carrier)
4. Medical Director Information (and any other additional Doctors or Physician Assistants):
    a. Copy of current license.
    b. Job Description.
    c. Copy of proof of Medical Malpractice (if Doctor has current coverage for volunteering).
    d. Claims/Allegations history for the past the (10) years. (This may be supplied via Loss Runs from their current insurance carrier or the following.) *If there are no incidents or claims, a statement on the physician's letterhead advising such is required.* This information must include:
        i. Date of Loss.
        ii. The status (open or closed).
        iii. Total paid out.
        iv. Reserves, if any.
5. Copy of all advertisements indicating medical services.
6. Checklist for Clinical Services, please provide additional information if indicated.

Upon receipt of the above information, a quotation is generally available within fifteen (15) business days.

Should we be of further assistance, please contact our Underwriting Department at 800.859.2724. Thank you.

Please mail all the above information:

Patriot Insurance Agency, Inc.
PO Box 17026
St. Petersburg, FL 33733

Thank you for allowing us to service your insurance needs and we look forward to working with you in the near future.

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WARRANTY: It is warranted to Spirit Mountain Insurance Company Risk Retention Group, Inc. that the information contained herein is true and that shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of the application by issuance of a policy. We hereby authorize the release of claim information from any prior Insurer to Spirit Mountain Insurance Company Risk Retention Group, Inc. **Revocable Proxy**. The undersigned hereby appoints Ron Renzi and Erika Hill of the Board of Directors of The International Association of Community Service Organizations (the "Association"), and each of them, as proxy, with full power of substitution, to cast all votes that the undersigned Member is entitled to cast at any meeting of the Association and to act with respect to all votes that the undersigned would be entitled to cast until the earlier of the time that this proxy isrevoked or three years from the date that this instrument is executed and delivered to the Association.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force.

FRAUD STATEMENT: 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, which is a crime.

Applicant's Signature_____ Date_____

Printed Name_____ Position_____

One signed copy will be attached to the policy, cover note or certificate, if issued.

* SIGNING THIS FORM AND TENDERING PREMIUM DOES NOT BIND THE APPLICANT, THE COMPANY, OR THE

UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.

MEDICAL MALPRACTICE APPLICATION

I. General Information:

Applicant (Center) _____

Mailing Address _____

_____

Effective Date _____ Date Quotation Desired? _____

	Location Premises (Put "Same" if same as above)	Applicant's Interest (Own/Lease)	Sq. Ft.	# of Stories
Loc. 1				
Loc. 2				
Loc. 3				

If any of the above is mobile unit site, additional information will be necessary, please call for details.

1. How long has applicant been in operation (years)? _____
2. Organized as a non-profit corporation? ☐Yes ☐No If no, Describe: _____
3. Name of Director? _____
4. Medical Director? _____
5. Annual Budget $ _____
6. In what states is the applicant (Center) registered and licensed to practice? (If none, attach explanation)

   _____
7. Indicate professional societies or associations in which applicant is a member: _____

   _____
8. Does applicant assure that all personnel have mandated background inquires? ☐Yes ☐No
9. Have any employees been subject of a child/abuse/neglect/improper supervision investigation (other than initial screening?) ☐Yes ☐No If yes, have the investigations resulted:
   - ☐ A. Confirmed finding of abuse/neglect/improper supervision
   - ☐ B. No Finding
   - ☐ C. Other: _____
10. Is facility certified for Medicare? ☐Yes ☐No
11. Is medication or drugs given? ☐Yes ☐No
    1. Only under a physician's written orders? ☐Yes ☐No
    2. Only by authorized medical professionals? ☐Yes ☐No

    If drugs are given and the answer to 1 or 2 above is NO, please explain:_____

    _____
12. Is a complete medical history of each patient or client retained on premises? ☐Yes ☐No
13. Are medical records released to third parties without the written consent of the patient or clients?

    ☐Yes ☐No If Yes, please explain:_____

II. Patient/Treatment Information :

A. Is a complete physician's examination done, to include sonogram? ☐Yes ☐No

B. Does the facility afford off-premises services? ☐Yes ☐No

If Yes, please attach a description of the services rendered in detail and location(s)

C. Any limit on the number of the patients clinic is licensed to serve? ☐Yes ☐No

D. If the facility engaged in vocational training activities/services? ☐Yes ☐No

If Yes, please attach a description of the vocational training activities in detail:

III. Services Provided

Provide number of outpatient visits:

Type of Visit	Number of Visits Last 12 Mo.	Estimated Number of Visits Next 12 Mo.
Clinic	#_____	#_____
Laboratory	#_____	#_____
_____	#_____	#_____

IV. Employee, Volunteer and Independent Contractors

1. Indicate the number of professional employees, volunteers and independent contractors.
IF NONE, STATE NONE.

	No. of Employees and Volunteers	No. of Independent Contractors		No. of Employees and Volunteers	No. of Independent Contractors
(a) Physicians: NO surgery (other than incision of boils, suturing of skin) or obstetrical procedures	_____	_____	(g) Physicians & Surgeon's Assistants, Nurse Practitioners (describe duties on separate sheet)	_____	_____
(b) Physicians: Minor Surgery or obstetrical procedures not constituting major surgery	_____	_____	(h) Unlicensed Interns	_____	_____
(c)Proctologists, Ophthalmologists and Urologists	_____	_____	(i) Dentist (no oral surgery)	_____	_____
(d) General Surgeons, Cardio Surgeons and Surgeon, and Otolaryngologists (no plastic surgery)	_____	_____	(j) Orthodontists	_____	_____
(e) Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery	_____	_____	(k) Oral Surgeons	_____	_____
(f) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons	_____	_____	(l) Optometrists, Optic lens	_____	_____
			(m) Pharmacists	_____	_____
			(n) RNs, LPNs	_____	_____
			(o) RDMS (sonographer)	_____	_____
			(p) _____	_____	_____

2. Are all of the above individuals licensed in accordance with applicable state and federal regulation?
☐ **Yes** ☐ **No.** If no, attach explanation.

V. Physician and/or any Medical Staff Personnel Credential

1. What limit of Medical Malpractice Insurance is carried by the Physician(s) above? Please attach Certificates of Medical Malpractice Insurance for each physician.

2. Please confirm that the Doctors are Volunteers. The time and labor they provide are given on a pro bono basis. *This does not imply that they may not be reimbursed for personal expenses they incur.*

3. Have you thoroughly reviewed all past and present hospital affiliations?

4. Ever been subject of disciplinary or investigatory proceedings or reprimand by a governmental or an administrative agency, hospital or professional association?

5. Any voluntary or involuntary reduction, limitation or loss of clinical privileges at any other hospital?

6. Any involvement in past and pending malpractice and professional misconduct claims/allegations? Minimum ten (10) year history. *A Loss Run or Statement from Physician is required.*

7. Any previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration or the voluntary relinquishment of any such licensure or registration)?

8. Do any of the physicians have a history of treatment for drug, alcohol or substance dependency?

9. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?

VI. Revenue

1. State sources and amounts of total revenue:

Source	Amount This Fiscal Year	Estimate Amount Next Fiscal Year
A. Charitable Contributions	$_____	$_____
B. Government Funding	$_____	$_____
C. Fee for Service	$_____	$_____
D. _____	$_____	$_____
TOTAL GROSS REVENUE	$_____	$_____

2. Does the applicant advertise its professional services in any manner? (other than a simple listing in a telephone directory.) ☐ **Yes** ☐ **No.** If yes, attach a copy of ALL of the advertisements.

3. Is the applicant associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? ☐ **Yes** ☐ **No.** If yes. attach detailed explanation and a copy of ALL of the advertisements.

4. Is the applicant (Center) employed by any individual or entity other than that shown in Question 1(a) above?
☐ **Yes** ☐ **No.** If yes, attach detailed explanation.

5. Is the applicant (Center) under contract to any individual or entity other than shown in Question 1(a)?
☐ **Yes** ☐ **No.** If this contract contains a hold-harmless agreement, copy of contract must be attached.

6. Is the applicant (Center) in the employ of any federal governmental entity? ☐ **Yes** ☐ **No.** If yes, attached explanation.

7. Is the applicant (Center) under contract to any federal governmental entity? ☐ **Yes** ☐ **No.** If yes, attached explanation.

8. Name and give locations of any hospitals or institutions the applicant (Center) uses in practice:_____

9. Has any claim or suit been brought against the applicant and/or any of its employees ☐ **Yes** ☐ **No.**
If yes, a supplemental claim information form must be completed for each claim or suit.

10. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against the applicant or any of its employees? ☐ **Yes** ☐ **No**. If yes, give details on separate sheet.

11. 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 Exp. Mo/Day/Yr	Expiration Mo/Day/Yr	Was this a Claims MadePolicyForm?
							☐ Yes ☐ No.
							☐ Yes ☐ No.

12. If prior professional liability insurance was on a claims made basis, advise the retroactive exclusion date of the coverage. _____

CHECKLIST FOR CLINICAL SERVICES

Account Number: _____ **Contact Name:** _____

Telephone Number: _____ **Fax Number:** _____

Email Address: _____ **Website:** _____

Employer's/Federal Identification Number: _____

Services Provided:

☐ **SONOGRAM:**
- ☐ **Vaginal Probe:** ☐ **1ST** ☐ **2ND** ☐ **3RD TRIMESTER**
- ☐ **External Probe:** ☐ **1ST** ☐ **2ND** ☐ **3RD TRIMESTER**

☐ **DOPPLER**

☐ **TESTING FOR SEXUAL TRANSMITTED DISEASES**

***Please provide in full detail the following on a separate sheet of paper:**

1. **Provide the name of the individual who will order the treatment/prescription option(s) for your clients.**
2. **Approximate number of patient contacts**
3. **Please provide a list of your responses to the following questions:**
   1. **What diseases are being testing?**
   2. **How will the specimen be collected?**
   3. **Who is performing the Lab Work?**
   4. **What treatment is being afforded?**

☐ **BLOOD WORK**

**IF YES, PLEASE DESCRIBE THE PURPOSE.

☐ **PHYSICAL EXAM**

**IF YES, PLEASE DESCRIBE WHAT IS INCLUDED

☐ **LAMINARY REMOVAL**

☐ **I.U.D. REMOVAL**

☐ **URINE PREGNANCY TESTS**
- ☐ **Self-Administed**
- ☐ **Medical Staff Administered**

☐ **ANY PRE NATAL CARE**

IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES

☐ **GYNOCOLOGIST SERVICES**

IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES

☐ **OTHER SERVICES:** _____

IF YES, PLEASE DESCRIBE IN DETAIL OF THE SERVICES

☐ **DOCTOR(S) TO BE INCLUDED: Name of Doctor(s):**

_____

If to be included, please provide a copy of the Medical license and also a description of the type of services they will be providing. Also please provide description of any claims/allegations within the past ten (10) years.

Applicants Signature_____ Date_____