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P.O. Box 4439 Sandy, UT 84091
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**DIAGNOSTIC & X-RAY
LABORATORY
PROFESSIONAL
APPLICATION**

A. General Information

Proposed Effective Date: _____

Applicant's Name: _____

Applicant's Mailing Address: _____

City: _____ State: _____ Zip: _____

E-Mail: _____ County: _____

Business Telephone Number: _____ Fax: _____

Physical Location of Business (if different): _____

Population within 50 miles: _____

Other Locations Used:

Physical Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Please list any other names the business is or has been known by: _____

Contact Person: _____ Producer's Name: _____

Detailed description of business activities (specifically, and by location): _____

Applicant is: Individual Corporation Partnership Joint Venture Other: _____

Is this a new business? Yes No

Please list the business owner(s) of the business applying for insurance and identify how many years experience the owner(s) has in this type of business: _____

Please list the manager(s) of the business applying for insurance and identify how many years experience the manager(s) has in this type of business: _____

Annual Payroll: \$ _____ Total Number of Employees: _____ Full-Time: _____ Part-Time: _____

Please describe the business's drug policy and what the procedure is when an applicant or employee fails a drug test: _____

Does your company have within its staff of employees, a position whose job description deals with product liability, loss control, safety inspections, engineering, consulting, or other professional consultation advisory services? Yes No

If yes, please tell us:

Employee Name: _____

E-Mail: _____ Business Telephone No.: _____

Fax: _____ Years with Company: _____

Employee's Responsibilities: _____

B. Insurance History

Who is your current insurance carrier (or your last if no current provider)? _____

Provide name(s) for all insurance companies that have provided Applicant insurance for the last three years:

	Coverage:	Coverage:	Coverage:
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

Has the Applicant or any predecessor ever had a claim? Yes No

Attach a five year loss/claims history, including details. (REQUIRED)

Have you had any incident, event, occurrence, loss, or Wrongful Act which might give rise to a Claim covered by this Policy, prior to the inception of this Policy? Yes No

If yes, please explain: _____

Has the Applicant, or anyone on the Applicant's behalf, attempted to place this risk in standard markets? Yes No

If the standard markets are declining placement, please explain why: _____

C. Other Insurance

Please provide the following information for all other business-related insurance the Applicant currently carries.

	1	2	3
Coverage Type			
Company Name			
Expiration Date			
Annual Premium	\$	\$	\$

D. Desired Insurance

Per Act/Aggregate OR Per Person/Per Act/Aggregate

<input type="checkbox"/>	\$50,000/\$100,000	<input type="checkbox"/>	\$25,000/\$50,000/\$100,000
<input type="checkbox"/>	\$150,000/\$300,000	<input type="checkbox"/>	\$75,000/\$150,000/\$300,000
<input type="checkbox"/>	\$250,000/\$1,000,000	<input type="checkbox"/>	\$100,000/\$250,000/\$1,000,000
<input type="checkbox"/>	\$500,000/\$1,000,000	<input type="checkbox"/>	\$250,000/\$500,000/\$1,000,000
<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	Other: _____

Self-Insured Retention (SIR): \$1,000 (Minimum) \$1,500 \$2,500 \$5,000 \$10,000

Does Applicant wish to extend coverage to employees (excluding physicians, osteopaths, surgeons, dentists, podiatrists, nurse anesthetists, etc.) as Additional Insureds? Yes No

E. Business Activities

1. Does the laboratory or any of its branches operate on a part time basis? Yes No

If yes, please explain: _____

2. Is the Applicant licensed in accordance with state law? Yes No

If no, please explain: _____

3. Please provide the following information:

Total square feet occupied: _____ Annual Payroll: \$ _____

Annual # of tests: _____ Gross Receipts last 12 months: \$ _____

Annual # of patient contacts: _____ Gross Receipts next 12 months: \$ _____

Breakdown by type of service: _____

4. Please provide number of employees in each of the following categories:

For each professional staff member below, please attach resumes or list that includes age, education, work experience, license/certification(s), and professional association memberships.

Employee Type	Part-time	Full-time	Employee Type	Part-time	Full-time
Physicians			Registered Nurses		
Pathologists			LPN's		
Interns			LVN's		
X-Ray Technicians			Other:		
Laboratory Technicians			Other:		
Radiologist Technicians			Other:		

5. Has the Applicant or any current professional staff member ever been formally accused of professional negligence or had their license(s) suspended? Yes No

If yes, please explain in detail: _____

6. Please fully describe procedures and services provided by Applicant's facility (attach copy of brochure or other printed information): _____

7. Specimens (blood, urine, etc.):
_____ % taken direct from patient _____ % received from other sources

8. Service is provided for:
Hospitals: _____ % Industrial Facilities: _____ %
Nursing Homes: _____ % Other (describe): _____ %
Doctors: _____ % Other (describe): _____ %

9. Is Applicant involved in any blood bank, holding service, or depot operations? Yes No
If yes, please describe: _____

10. Is Applicant involved in any experimental or research operations? Yes No
If yes, please describe: _____

11. Does Applicant provide any diagnosis? Yes No
If yes, please describe: _____

12. Does Applicant provide any multi-phase testing of the general public? Yes No
If yes, please describe: _____

13. Does Applicant use injected or ingested materials? Yes No
If yes, please list: _____

If yes, what type of emergency procedures are provided for possible adverse reaction? _____

What is the likelihood of reaction to each substance used? _____

14. Does Applicant provide any therapy or treatment? Yes No
If yes, please describe: _____

15. Does Applicant utilize any mobile units? Yes No
If yes, please describe on-site tests provided: _____

Please list usual premises where mobile unit(s) are stationed: _____

16. Does Applicant own or operate any portable laboratory equipment? Yes No

17. Is Applicant owned by a practicing physician(s) or osteopath(s) (individual or group)? Yes No

If yes, does Applicant occupy same or contiguous space with physician's/osteopath's place of practice?
 Yes No

If yes: Percentage of total gross receipts derived from testing on behalf of physician's/osteopath's personal practice: _____%

18. Does Applicant use any radioactive material other than normal x-ray equipment? Yes No

If yes, please describe: _____

19. Please describe Applicant's procedures for delivery and disposal of radioactive substance: _____

20. Please advise frequency of testing or air/water discharges: _____

21. Does Applicant manufacture, distribute, or mix antibiotics, chemicals, or drugs? Yes No

If yes, please describe: _____

22. Please describe Applicant's equipment maintenance procedures: _____

23. If maintenance is subcontracted, does Applicant require Certificates of Insurance from the subcontractors?
 Yes No

If yes, what minimum General Liability limit is required? _____

24. Please describe Applicant's record keeping procedures including how long records are kept: _____

REPRESENTATIONS AND WARRANTIES

The "Applicant" is the party to be named as the "Insured" in any insuring contract if issued. By signing this Application, the Applicant for insurance hereby represents and warrants that the information provided in the Application, together with all supplemental information and documents provided in conjunction with the Application, is true, correct, inclusive of all relevant and material information necessary for the Insurer to accurately and completely assess the Application, and is not misleading in any way. The Applicant further represents that the Applicant understands and agrees as follows: (i) the Insurer can and will rely upon the Application and supplemental information provided by the Applicant, and any other relevant information, to assess the Applicant's request for insurance coverage and to quote and potentially bind, price, and provide coverage; (ii) the Application and all supplemental information and documents provided in conjunction with the Application are warranties that will become a part of any coverage contract that may be issued; (iii) the submission of an Application or the payment of any premium does not obligate the Insurer to quote, bind, or provide insurance coverage; and (iv) in the event the Applicant has or does provide any false, misleading, or incomplete information in conjunction with the Application, any coverage provided will be deemed void from initial issuance.

The Applicant hereby authorizes the Insurer and its agents to gather any additional information the Insurer deems necessary to process the Application for quoting, binding, pricing, and providing insurance coverage including, but not limited to, gathering information from federal, state, and industry regulatory authorities, insurers, creditors, customers, financial institutions, and credit rating agencies. The Insurer has no obligation to gather any information nor verify any information received from the Applicant or any other person or entity. The Applicant expressly authorizes the release of information regarding the Applicant's losses, financial information, or any regulatory compliance issues to this Insurer in conjunction with consideration of the Application.

The Applicant further represents that the Applicant understands and agrees the Insurer may: (i) present a quote with a Sub-limit of liability for certain exposures, (ii) quote certain coverages with certain activities, events, services, or waivers excluded from the quote, and (iii) offer several optional quotes for consideration by the Applicant for insurance coverage. In the event coverage is offered, such coverage will not become effective until the Insurer's accounting office receives the required premium payment.

The Applicant agrees that the Insurer and any party from whom the Insurer may request information in conjunction with the Application may treat the Applicant's facsimile signature on the Application as an original signature for all purposes.

The Applicant acknowledges that under any insuring contract issued, the following provisions will apply:

1. A single Accident, or the accumulation of more than one Accident during the Policy Period, may cause the per Accident Limit and/or the annual aggregate maximum Limit of Liability to be exhausted, at which time the Insured will have no further benefits under the Policy.
2. The Insured may request the Insurer to reinstate the original Limit of Liability for the remainder of the Policy period for an additional coverage charge, as may be calculated and offered by the Insurer. The Insurer is under no obligation to accept the Insured's request.
3. The Applicant understands and agrees that the Insurer has no obligation to notify the Insured of the possibility that the maximum Limit of Liability may be exhausted by any Accident or combination of Accidents that may occur during the Policy Period. The Insured must determine if additional coverage should be purchased. The Insurer is expressly not obligated to make a determination about additional coverage, nor advise the Insured concerning additional coverage.
4. The Insurer is herein released and relieved from any and all responsibility to notify the Insured of the possible reduction in any applicable Limit of Liability. The Insured herein assumes the sole and individual responsibility to evaluate, consider, and initiate a request for additional coverage or reinstatement of the annual aggregate Limit of Liability which may be exhausted by any single Accident or combination of Accidents during the Policy Period.

Dated: _____

Dated: _____

Applicant:

Agent/Broker:

Signature

Signature

Print Name

Print Name