



- Ace American Insurance Company
- Illinois Union Insurance Company
- Westchester Surplus Lines Insurance Company

**Healthcare/Miscellaneous Facilities**  
**Liability Application**  
**Laboratory Supplement**

**Instructions:**

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use Y for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

**NOTICE: This supplement is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions. All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Loss Experience, Coverage Requested, Exposures (prospective and historical Professional Liability, General Liability, Home Health Care and/or Hospice Services, Staffing Agency Services, Aircraft Liability, Automobile Liability, Watercraft Liability, and Employer's Liability), Excess Liability, Professional Employees and Staff, License/Certification Information, Risk Management, Employment Practices, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

**SECTION A. – APPLICANT/OWNERSHIP**

1. List all partners, members or stockholders/owners of the applicant and their respective percentage of ownership interest:

Name	Ownership %	Name	Ownership %
	%		%
	%		%
	%		%
	%		%

2. Indicate the percentage of laboratory services provided in a physician's office: %
3. Are any physician-owners making self-referrals to the facility?  
Yes No

If Yes, what percentage of total receipts is generated from self-referrals? %

**SECTION B. – EXPOSURES**

1. Provide gross receipts for all exposures applicable to the applicants. Receipts should not be adjusted for uncollectible accounts or other obligations.

*Gross Receipts		
Services	% of Service	Projections for Requested Coverage Period
Chemistry	\$	\$
Clinical Research	\$	\$
Cytology	\$	\$
DNA/Genetic Testing	\$	\$
Endocrinology	\$	\$
Forensic	\$	\$
Hematology	\$	\$
Histology	\$	\$
Immunology	\$	\$
Microbiology	\$	\$
Molecular Diagnostics	\$	\$
Parasitology	\$	\$
Paternity Testing	\$	\$
Pathology	\$	\$
Serology	\$	\$
Toxicology	\$	\$
Urology	\$	\$
Virology	\$	\$
Other; please explain:	\$	\$
Total	\$	\$

\*If you provide services in multiple states, please provide a breakdown of gross receipts by state.

2. Does the applicant operate a blood bank? Yes No
3. Does the applicant assist in reproductive treatment? Yes No
4. Have you ever received an FDA warning letter? Yes No
5. Do you provide management services to others? Yes No  
If so, please explain:
6. Are other labs utilized to perform certain tests? Yes No
- If so, what tests?
- What % of operations are other labs utilized?

**SECTION C. – PROFESSIONAL EMPLOYEES AND STAFF**

1. Does the Medical Director carry his/her own professional liability insurance? Yes No  
If so, indicate the limits of professional liability:
2. Has there been any review by a state medical board or other federal, state, or non-governmental oversight entity of any medical director at the organization? Yes No

2. Has there been any review by a state medical board or other federal, state, or non-governmental oversight entity of any medical director at the organization? Yes No
3. Has the medical director's license ever been suspended, revoked, or voluntarily surrendered? Yes No

**SECTION D. – RISK MANAGEMENT/POLICIES AND PROCEDURES**

1. What % of services is provided by physician order? %
2. Who is responsible for providing tests results to the patient?  
Is this required to be documented? Yes No  
If Yes, how is it documented?
3. Is there a process for communicating results to the patient and the patient's practitioner? Yes No  
If Yes, describe the process:
4. Are any test results provided directly to the patient? Yes No  
If Yes, describe the process:
5. Are all standard operating procedures in place for each test performed? (SOPs should include detailed instructions for obtaining specimens, specimen identification, handling, packaging, labeling, testing and analysis, reporting, record keeping, and communication with clients.) Yes No

**SECTION E. – EQUIPMENT**

1. Concerning the inspection and maintenance of all equipment, does the applicant have the following on file?

A plan or contract that specifically identifies when inspections and maintenance will occur:	Yes No
A log of dates of when inspections and maintenance are completed:	Yes No
A file of all past and current correction action measures taken as recommended:	Yes No

**The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.**

**The Applicant understands that this form is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions.**

The Applicant understands that this form is part of the main HealthCareMechanicals License  
**Liability Application and is subject to the same warranties, representations and conditions.**

Signature of Applicant

Title

Date

PF-33241 (02/11)

Page 1 of 4