



Swett & Crawford

PROFESSIONAL LIABILITY - MEDICAL

1. NAME OF APPLICANT _____

ADDRESS _____

ADDRESS OF LOCATION TO BE INSURED (IF SAME AS ABOVE PLEASE STATE SO)

INDIVIDUAL

PROFESSIONAL ASSOCIATION

CORPORATION

SELF EMPLOYED

PARTNERSHIP

OTHER _____

(Please explain)

2. LIST FULL NAMES OF INDIVIDUAL OR PARTNERS AND THEIR INTERESTS _____

3. DATE ESTABLISHED: _____

4. INDICATE APPLICANT'S PROFESSIONAL SPECIALTY (BE SPECIFIC): _____

FULL DESCRIPTION OF OPERATIONS: _____

5. ARE YOU IN PRIVATE PRACTICE? _____ OR AN EMPLOYEE? _____

INDICATE PERCENT OF TIME SPENT IN THE FOLLOWING WORK LOCATIONS:

ADMINISTRATIVE OFFICE

OUTPATIENT CLINIC

CLASSROOM

LABORATORY

EMERGENCY DEPT. OF HOSPITAL

PATIENT'S HOME

HOSPITAL WARD (SPECIFY)

PROFESSIONAL OFFICE

OPERATING ROOM

NURSING HOME

OTHER

6. IF SERVICES PERFORMED ARE COUNSELING, PLEASE INDICATE TYPE:

FAMILY PLANNING

DRUG DETOXIFICATION

V.D.

ABORTION

DRUG METHADONE

ALCOHOL

LEGAL

FAMILY

OTHER

MARTIAL

CRIMINAL

CHILD ABUSE/SEXUAL OFFENDERS

CRISIS INTERVENTION

NARCOTICS

HOT LINE





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7. INDICATE NUMBER OF:

RECEIPTS _____ PAYROLL _____ OTHER _____
OUTPATIENT VISITS _____ PARTICIPANTS _____
(Number of Patient encounters per year)

IS APPLICANT ENGAGED IN, ASSOCIATED WITH OR INVOLVED IN ANY OTHER ENTERPRISE? Yes No
(IF YES, ATTATCH FULL DETAILS)

8. LIST ANY PROFESSIONAL ASSOCIATION IN WHICH APPLICANT IS A MEMBER: _____

DESCRIBE ANY PROFESSIONAL TRAINING, LICENSING OR CERTIFICATION NEEDED FOR THIS OPERATION: _____

9. IF YOU ARE AN EMPLOYEE, PLEASE ADVISE IF YOU HAVE ANY MANAGEMENT OR SUPERVISORY DUTIES? _____

IF SO, WHAT ARE THEY? _____

10. DO YOU ADMINISTER ANY ANESTHESIA? Yes No

11. IF YOU CONTRACT YOUR SERVICES TO OTHERS ON AN INDEPENDENT CONTRACTOR BASIS, PLEASE ADVISE TO WHOM YOU CONTRACT YOUR WORK? _____

12. HAS APPLICANT HAD PREVIOUS INSURANCE FOR THIS ENTERPRISE? Yes No (If yes, please complete the following)

INSURANCE COMPANY	POLICY PERIOD	LIMITS OF LIABILITY	PREMIUM	TYPE OF COVERAGE	OCCURENCE OR CLAIMS MADE

DURING THE PAST (5) YEARS, HAVE ANY CLAIMS BEEN PRESENTED TO YOUR CURRENT OR PRIOR INSURANCE CARRIER?
 Yes No (If yes, please provide full details below) (Include description of claim, amounts paid and reserves)

13. IS THE APPLICANT, OR ANY OTHER PERSON FOR WHOM INSURANCE IS BEING REQUESTED, AWARE OF ANY CIRCUMSTANCES WHICH MAY RESULT IN A CLAIM? Yes No (If yes, please provide full details below)

14. HAS APPLICANT, OR ANY OTHER PERSON FOR WHOM COVERAGE IS BEING REQUESTED, HAD ANY APPLICATION FOR LIABILITY INSURANCE DENIED, POLICY CANCELLED OR NONRENEWED IN THE PAST (5) YEARS? Yes No
(If yes, please provide full details below)

APPLICANT'S SIGNATURE: _____

TITLE: _____

DATE: _____

PRODUCING AGENT _____

