8722 S. Harrison St. Sandy, UT 84070
P.O. Box 4439 Sandy, UT 84091
877-585-2853 • Fax 877-585-2854
quotes@primeis.com

DIAGNOSTIC & X-RAY LABORATORY PROFESSIONAL

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

☐	$50,000/$100,000	☐	$25,000/$50,000/$100,000

☐	$150,000/$300,000	☐	$75,000/$150,000/$300,000
☐	$250,000/$1,000,000	☐	$100,000/$250,000/$1,000,000
☐	$500,000/$1,000,000	☐	$250,000/$500,000/$1,000,000
☐	Other: ________________	☐	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 or 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