



Atlantic Specialty Lines, Inc.

SUPPLEMENT FOR POST MORTEM SERVICES

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant:

2. (a) Services provided by the Applicant and percentage of gross revenues derived:

Percentage

- (i) Embalming Yes No _____%
- (ii) Cremation Yes No _____%
- (iii) Funeral Director Yes No _____%
- (iv) Funeral Home Yes No _____%
- (v) Cemetery Yes No _____%
- (vi) Pre-Need Sales Yes No _____%
- (vi) Casket and Other Product Sales Yes No ___%
- (vii) Other (specify) _____%
- TOTAL 100%

(b) If only embalming and cremation services are provided answer the following.

(i) Is the Applicant an owner of or an employee of a funeral home? Yes No
If Yes, provide the name of the funeral home and advise of the general and professional liability insurance and limits of liability they maintain.

(ii) Does the embalmer have a contract with any funeral home? Yes No
If Yes, provide the name of the funeral home and advise of the general and professional liability insurance and limits of liability they maintain.

(c) If any pre-need sales are provided answer the following:

(i) Are pre-need sales insured?[Yes No

(ii) If No, provide complete details of how such sales are financed.

(iii) If Yes, provide the names of all insurance companies that insurance is placed with.

(iv) Attach a copy of the Applicant's insurance license(s).

3. Does the Applicant contract with any out of state funeral homes?.....[Yes No
If Yes, list the states.

4. Is the Applicant responsible for:

(a) picking up remains from hospitals, hospices or nursing homes?.....[Yes No

(b) shipping remains out of state?.....[Yes No

(c) picking up remains from any means of transportation?.....[Yes No

5. Is the Applicant licensed in all states where services are performed?.....[Yes No

6. Where are embalming services done:

Percentage

- (i) At the embalmer's own facility? [] Yes [] No _____%
- (ii) At another location? (specify) _____ [] Yes [] No _____%

7. How many bodies are handled per year?

8. Describe the procedures that are used to ensure that bodies are given the arranged-for post mortem treatment.

9. Attach a copy of the consent form used by the embalmer to obtain the family's permission to cremate remains (if applicable).

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

Name of Applicant

Title

Signature of Applicant

Date



Atlantic Specialty Lines, Inc.

APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS FOR PROFESSIONAL LIABILITY INSURANCE (Claims Made Basis) APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full name of Applicant (include professional degree if applicant is an individual): _____

b. Principal business premise address: _____
(Street) (County)

(City) (State) (Zip)

Please attach a list of additional office addresses.

c. Number of Employees: Full time _____ Part time _____ Seasonal _____ Total _____

d. Business Phone: (____) _____ Home Phone: (____) _____

e. Date of Birth: _____ Place of Birth: _____

Are you a U.S. citizen? [] Yes [] No. If No, your status, date of entry into USA: _____

f. Square feet of total office space (all locations): _____

g. Your practice:

- [] Solo practitioner (unincorporated) [] Professional corporation (for profit)
- [] Solo practitioner (incorporated) [] Professional corporation (non-profit)
- [] Partnership [] Employee of _____
- [] Professional Association (Give name of employer)
- [] Other (please describe) _____

h. Formal business, corporate or partnership name:

i. Please list the names of all partners or members of your professional association/corporation who provide professional services: _____

j. Please attach a copy of your letterhead.

k. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [] Yes [] No

If yes,

- (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?.....[] Yes [] No
- (ii) Provide the name and title of the Applicant's Privacy Officer. _____

Our Business Associate Agreement is available at www.shand.com or by fax by calling (847) 572-6268 (Form No. ZZ50002). This is the only Business Associate Agreement we will recognize.

2. EDUCATION/EXPERIENCE (Individual Applicant Only)

Institution Name and Address	<u>Years of Training</u>	<u>Degree or Certification Attained</u>
_____	From _____ To _____	_____
_____	From _____ To _____	_____
_____	From _____ To _____	_____

(i) Where have you practiced your profession during the last ten years?

In _____	From _____ To _____
In _____	From _____ To _____
In _____	From _____ To _____

(ii) Have you ever failed any professional licensing or specialty organization examination?[] Yes [] No
If yes, please attach a detailed explanation including the dates and location.

3. APPLICANT PRACTICE

a. Please list all the states where you are licensed to practice. If NONE, please attach an explanation. _____

b. Please indicate your professional specialty (CHECK ONE):

- | | | |
|---|--|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Naprapath | <input type="checkbox"/> Pharmacist |
| <input type="checkbox"/> Counselor (Describe)
_____ | <input type="checkbox"/> Nurse, Licensed Practical | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Nurse, Registered | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Hearing Aid Fitter | <input type="checkbox"/> Nurses Registry | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Home Health Care Agcy. | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Inhalation Therapist | <input type="checkbox"/> Optician | <input type="checkbox"/> Veterinarian |
| <input type="checkbox"/> Laboratory Technician | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Visiting Nurse Assoc. |
| <input type="checkbox"/> Medical Personnel Pool | <input type="checkbox"/> Orthotist | <input type="checkbox"/> X-ray Technician |
| | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Other (Specify) _____ |

c. Please indicate the sources and amounts of actual and projected revenue:

<u>Source</u>	<u>Amount This Fiscal Year</u>	<u>Amount Next Fiscal Year</u>
(i) Charitable Contributions:	\$ _____	\$ _____
(ii) Government Funding:	\$ _____	\$ _____
(iii) Fee for Services:	\$ _____	\$ _____
(iv) Other: _____	\$ _____	\$ _____
TOTAL GROSS REVENUE	\$ _____	\$ _____

d. Please provide the number of patient or client visits:

<u>Type of Visit</u>	<u>Number of Visits Last 12 Months</u>	<u>Next 12 Months</u>
Clinic _____	_____	_____
Laboratory _____	_____	_____
Other (specify) _____	_____	_____
TOTAL NUMBER OF VISITS	_____	_____

e. Please specify any professional societies or associations in which you are a member: _____

f. Are you associated with or do you work for a physician or surgeon?.....[] Yes [] No
If yes, please give the name and the specialty of the physician: _____

g. Please give the approximate percentage of time spent in the following work locations:

_____ % Administrative Office	_____ % Laboratory	_____ % Hospital Ward (specify)
_____ % Classroom	_____ % Operating Room	_____
_____ % Emergency Dept of Hospital	_____ % Outpatient Clinic	_____ % Professional Office (specify profession)
_____ % Nursing Home	_____ % Patient's Home	_____
_____ % Other (specify) _____		

h. Please indicate the approximate division of your patients or clients among:

_____ % Hemodialysis	_____ % Psychiatric	_____ % Bariatrics
_____ % Holistic Medicine	_____ % Drug Addicts	_____ % Physical Rehabilitation
_____ % Surgical	_____ % Alcoholics	_____ % Disability Evaluation
_____ % Stress Testing	_____ % Obstetrical	_____ % Research or Experimental
_____ % Communicable	_____ % Dental	_____ % _____
_____ % Family Planning	_____ % Pediatric	_____ % _____

i. Please indicate the number and type of your employees and/or volunteers. IF NONE, STATE NONE.

<u>Type of Profession</u>	<u>No.</u>	<u>Type of Profession</u>	<u>No.</u>
Inhalation Therapists	_____	Opticians	_____
Laboratory Technicians	_____	Optometrists	_____
Nurse Anesthetists	_____	Perfusionists	_____
Nurses, Licensed Practical	_____	Pharmacists	_____
Nurse Practitioner	_____	Physiotherapists	_____
Nurses, Registered	_____	Social Workers	_____
Speech Therapists	_____	Other (please specify)	_____

j. Are all of the above individuals licensed in accordance with applicable state and federal regulations?.....[] Yes [] No
If no, please attach an explanation.

4. APPLICANT PROCEDURES

a. Do you render professional services directly to patients? [] Yes [] No. If yes, please describe in detail and indicate the extent of supervision by others.

<u>Percent of Description of Professional Services</u>	<u>Qualifications Time Supervised</u>	<u>of Supervisor</u>
_____	_____ %	_____
_____	_____ %	_____
_____	_____ %	_____

b. Do you render professional services that do not involve contact with a patient? [] Yes [] No. If yes, please describe these services in detail.

c. (i) Do you perform or assist in any surgical procedures? [] Yes [] No

(ii) Please list ALL surgical procedures performed (including minor surgery): _____

(iii) Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? [] Yes [] No. If yes, please attach a detailed explanation.

(iv) Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? [] Yes [] No. If yes, please attach a detailed explanation.

d. Do you perform radiation therapy?.....[] Yes [] No

e. Do you perform psychiatric shock therapy?[] Yes [] No

f. Do you compound in bulk, manufacture or wholesale medicine?.....[] Yes [] No
If yes, please provide a detailed explanation. _____

institutions where medical services are customarily rendered?.....[] Yes [] No
 If yes, please give details including the name, location, size and number of beds.

h. If you have a training school, please complete the following. Attach a separate sheet if needed.

Specify Profession For Which Students Are Being Trained	Max. No. Of Students Per Session	No. of Sessions Per Year	% of Time Involved in Clinical Setting	Number of Faculty	Qualifications of Faculty (e.g. MD, RN, PhD, etc.)
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- i. (i) Do you use a collection agency?.....[] Yes [] No
 If yes, please state the name of the agency
- (ii) Does the agency have the authority to file a collection suit at its discretion?.....[] Yes [] No

7. APPLICANT HISTORY/CLAIMS

(Attach a detailed explanation for any YES answers)

a. Have you or any of your employees:

- (i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?.....[] Yes [] No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?.....[] Yes [] No
- (iii) Ever been treated for alcoholism or drug addiction?.....[] Yes [] No
- (iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same?.....[] Yes [] No
- (v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?[] Yes [] No

b. Please list prior professional liability insurance carried for each of the past four years. IF NONE, STATE NONE.

<u>Policy Insurance Carrier</u>	<u>Policy Number</u>	<u>Limits of Liability</u>	<u>Deductible (If any)</u>	<u>Premium</u>	<u>Inception Mo./Day/Yr.</u>	<u>Was this a Expiration Mo./Day/Yr.</u>	<u>Claims Made Policy Form?</u>	<u>Retro Date</u>
_____							[] []	_____
_____							[] []	_____
_____							[] []	_____
_____ []	[]							

c. Has any claim or suit been brought against you and/or any of your employees?.....[] Yes [] No

If yes, a Supplemental Claim Information Form must be completed for each claim or suit.

d. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees?.....[] Yes [] No
 If yes, please give details on a separate sheet.

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.**

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.



Atlantic Specialty Lines, Inc.

BROKER RISK SUMMARY (Medical Malpractice and Specified Medical)

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:
(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:
(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:
(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: