HISCOX PRO™

Medical Imaging & Testing Laboratories

Mainform Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone number:

4. Website: Email:

5. Date established:

6. Applicant's practice is a:

☐ Solo practitioner (unincorporated)	☐ Solo practitioner (incorporated)
☐ Corporation (for-profit)	☐ Corporation (non-profit)
☐ Professional Association	
☐ Other (please describe):	

7. Please provide a detailed description of operations:

8. Please state sources and amounts of total revenue:

	in last 12 months	for next 12 months
Charitable contributions	$	$
Government funding	$	$
Fee for services	$	$
Product sales	$	$
Other – specify:	$	$

Operations and Activities

9. The applicant facility is: ☐ Mobile ☐ Stationary

10. a. Is the applicant accredited? ☐ Yes ☐ No

b. Please list all service or organizational certifications:

11. Provide the percentages of services provided for:

Hospitals	%	Nursing Homes	%	Industrial Facilities	%
Vet Clinics	%	Physician Offices	%	Private Pay Individuals	%
Other – please describe:					%

12. Please indicate the number of tests:

Type of Test	in last 12 months	for next 12 months
Bone density scans		

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CAT/CT scans		
EKG/EEG		
Mammograms		
MRI		
PET scans		
Ultrasound/sonography		
X-ray		
Genetic testing		
Diagnostic laboratory testing		
Advanced Diagnostic Testing Lab tests		
Drug testing		
Pathology		

If performing any drug testing, please provide percentage of revenue for each:

Employment screening	%
Substance abuse program compliance	%
Pain management	%
Therapeutic Drug Monitoring	%
N/A [ ]	

13. Is the applicant involved in:

a. the use of contract media injections and localization markers? Yes ☐ No ☐

b. the use of any radioactive material other than used in x-ray equipment? Yes ☐ No ☐

c. therapy or treatment procedures? Yes ☐ No ☐

d. environmental analysis? Yes ☐ No ☐

e. blood banking or cross matching? Yes ☐ No ☐

f. clinical research testing? Yes ☐ No ☐

h. manufacturing, dispensing, or testing pharmaceuticals? Yes ☐ No ☐

i. manufacturing and/or selling laboratory equipment or supplies, reagents, or software? Yes ☐ No ☐

j. intravenous transfusions of blood or in the procurement of blood or blood products? Yes ☐ No ☐

k. pre-implantation genetic testing or embryology Yes ☐ No ☐

If Yes to any of the above, please provide a full description:

14. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes ☐ No ☐

If Yes, please explain in the comments section.

15. a. Provide percentage of specimens:

i. collected directly from patients by the applicant	%
ii. received by the applicant from outside sources	%

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b. Describe types of specimens collected N/A [ ]:

Staffing Information

16. a. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted
Nurses		
Phlebotomists		
Physicians		
X-ray technicians		
Other – specify:		

i. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes ☐ No ☐

If No, please explain in the comments section.

ii. Do you require all employed/contracted radiologist physicians to carry their own medical liability insurance? Yes ☐ No ☐

If Yes, what limits of insurance do you require?

iii. Do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

b. Has the applicant or have any of the above 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 refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

If Yes to any of the above, please explain in the comments section.

17. Provide the name of the applicant's Medical Director and attach a copy of his/her Curriculum Vitae (CV).

Risk Management Procedures

18. Questions applicable to all professional services performed:

a. Is there a quality assurance/safety program that includes calibrating equipment, identifying irregularities, and utilizing controls? Yes ☐ No ☐

b. Is there complete documentation of proper use and maintenance of equipment? Yes ☐ No ☐

c. How are patient samples and results labeled and verified for patient identification accuracy?

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19. Medical Imaging Services Questions: (If not an Imaging Lab, please tick box) ☐

a. Are there policies/procedures in place for the use, administration, and proper disposal of radio-pharmaceuticals? Yes ☐ No ☐

b. Is informed consent for special procedures including injection of contrast or other media obtained? Yes ☐ No ☐

c. Is there a written policy for handling allergic reactions including cardiac or respiratory arrests? Yes ☐ No ☐

If No to any of the above, please explain in the comments section.

20. Medical Testing Lab Services questions: (If not a Testing Lab, please tick box) ☐

a. Do you comply with all CMS lab fee reporting requirements? Yes ☐ No ☐

b. Do you use delta checks for quality control that compare tests results to results obtained from prior samples for the same patient? Yes ☐ No ☐

c. Do you implement occasional external quality assessments of lab results? Yes ☐ No ☐

Insurance and Claims History

21. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please explain in the comments section.

22. Does any person to be insured have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

If Yes, please attach complete details including a description of the incident(s).

23. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐

If Yes, please complete a supplemental claims information form for each claim.

24. How many claims have been made in the last five (5) years? ☐

25. a. List prior professional liability insurers for the past five years (if none, please tick box) ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date? ☐

26. a. Is the applicant currently insured under a commercial general liability

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policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

Comments Section

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APPLICATION DISCLOSURES:

If there is any material change in the answers to the questions in this Application before the proposed policy inception date, you must notify us in writing and any outstanding quote for insurance coverage may be modified or withdrawn.

Your submission of this Application does not obligate us to issue, or you to purchase, a policy. You authorize us to make any inquiry in connection with this Application.

All written statements and materials furnished to us in conjunction with this Application are incorporated into this Application and made a part of it.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:	
Signature of person authorized to execute on behalf of the applicant:	
Name/title of person authorized to execute on behalf of the applicant:	
Date:	

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated.
Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.