

DIAGNOSTIC IMAGING CENTERS SUPPLEMENTAL APPLICATION

INSTRUCTIONS

- This Application is in addition to the Healthcare Organizations New Business Application, or the Healthcare Organizations Renewal Application, which should be completed first by the Applicant.
- Answer ALL questions completely, leaving no blanks. If any questions, or any part thereof, do not apply, show "N/A" in the appropriate space.
- This Application must be completed and signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application.

I. APPLICANT INFORMATION

1.1	Applicant (Proposed Named Insured):
1.2	Applicant Business Address: City, State, Zip:
1.3	Contact Person: Email:
1.4	Website(s):

II. GENERAL BUSINESS INFORMATION

2.1	Does the Applicant provide any services, including other medical services, other than outpatient diagnostic imaging services? If yes, please provide details (use a separate sheet if needed):	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.2	Does the Applicant have a formalized employee verification program, including background checks performed prior to hire? If yes, are any negative findings discovered in this process investigated and duly considered in the hiring process?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2.3	Do the Applicant and all medical professionals working on Applicant's behalf maintain current professional licenses or certifications in accordance with applicable local, state and federal laws and regulations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.4	Does the Applicant employ any radiologists who provide primary or secondary reads? If yes, please indicate the number of radiologists which the Applicant currently employs: If yes, are those radiologists required to carry their own medical malpractice coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2.5	Does the Applicant perform teleradiology services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.6	Does the Applicant have a written emergency transport policy and procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.7	Does the Applicant have a formalized fall prevention policy and procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.8	Does the Applicant have a formalized patient complaint review committee and procedure? If yes, does the Committee recommend appropriate changes in procedures and staffing based on its findings?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2.9	Please indicate the Applicant organizations current accreditations: <input type="checkbox"/> AAHCB <input type="checkbox"/> AAAASF <input type="checkbox"/> JCAHO <input type="checkbox"/> ACR	
2.10	If the Applicant is a member of any state or national professional organizations, please provide the names:	

III. PROFESSIONAL SERVICES

Please conduct due diligence prior to completing the information below to ensure that it is accurate. The following information is critical to make an accurate assessment of the Applicant's exposure.

3.1	Please indicate the percentage of Annual Gross Receipts derived from each type of service listed below, for the current policy period and the next projected policy period:	
	Annual Gross Receipts (in dollars)	
	Current Policy Period	Next Projected Policy Period
Type of Service		
Computerized Tomography (CT)	\$	\$
Fetal Ultrasound	\$	\$
Interventional Radiology	\$	\$
Magnetic Resonance Imaging (MRI)	\$	\$
Mammography	\$	\$
Mobile Imaging (if Applicant provides these services, please provide specifics):	\$	\$

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Nuclear Medicine	\$	\$
Position Emission Tomography (PET)	\$	\$
Teleradiology Services	\$	\$
Ultrasound (excluding fetal)	\$	\$
X-Ray:	\$	\$
Other, please describe:	\$	\$

3.2 With respect to Mobile Imaging Services, if they are provided by the Applicant:

a. Please indicate what percentage of Applicant's Mobile Imaging Services are provided in each type of facility listed below (should total 100%):

Type of Facility		Type of Facility	
Assisted Living		% Mental Health Facilities	%
Corporations		% Physician Offices	%
Correctional Facilities		% Psychiatric Hospitals	%
Home Health Care		% Rehabilitation Clinics	%
Hospitals		% Sports Teams / Events	%
Industrial Facilities		% Surgical Centers	%
Nursing Centers		% Other, please describe:	%
b. Detail the percentage of Mobile Imaging Services for:		Cardiovascular Imaging:	%
		Electrocardiogram (EKG) Services	%

IV. CLAIMS AND INCIDENTS

Please respond to the following questions to the best of your knowledge and belief, after conducting due diligence and inquiry with any individuals who may have knowledge or information about the matters described below.

The term "Applicant" as used below, means any proposed insured, including any individual or entity for whom coverage is sought.

4.1	During the past five (5) years, has the Applicant received notice of any claim, suit, legal proceeding or regulatory/licensure action against any proposed insured relating to professional services, or for which coverage may be sought under the Policy applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.2	Is Applicant aware of ANY claims, suits, proceedings, investigations, complaints or allegations of negligence or misconduct (including those of abuse or molestation) made against Applicant organization, or against anyone working on Applicant's behalf, brought or made against any proposed insured in the past five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.3	Within the past five (5) years, has the Applicant given written notice to any current or prior professional or general liability insurance carrier of any claim, suit, legal proceeding or regulatory/licensure action, or of any facts, circumstances or situations which might give rise to a claim, suit, legal proceeding or regulatory/licensure action against any proposed insured relating to professional services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.4	Is the Applicant or any proposed insured aware of any facts, circumstances, situations, transactions, events, acts, errors or omissions which could reasonably be expected to give rise to a claim, suit, legal proceeding or regulatory/licensure action against any proposed insured relating to professional services, or for which coverage may be sought under the Policy applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.5	In the past five (5) years, has any proposed insured entity, or professional employee of Applicant, or other proposed insured, had their professional licenses or certifications suspended or revoked, or been investigated for professional misconduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.6	Applicant ever been investigated, audited or inspected by any governmental agency, insurance company or independent inspection firm?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, please provide details in an attachment, and a copy of the inspection report or other pertinent documentation. Include any deficiencies found and corrective actions taken.	
4.7	During the past three (3) years, has any professional or general liability insurance carrier cancelled or nonrenewed Applicant's insurance coverage, declined any application for coverage or refused to issue any policy to Applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IF THE RESPONSE WAS "YES" TO ANY OF THE ABOVE QUESTIONS IN SECTION IV. ABOVE, PLEASE PROVIDE A CLAIM SUPPLEMENT OR COMPLETE DETAILS IN AN ATTACHEMENT. PLEASE INCLUDE THE NAMES OF ALL PERSONS INVOLVED, THE ALLEGATIONS MADE, THE TIME, PLACE AND NATURE OF THE CIRCUMSTANCES OR INCIDENTS, AND A DESCRIPTION OF THE POTENTIAL LOSS OR DAMAGES CLAIMED.

The policy applied for, if issued, will not insure: any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation disclosed, or which should have been disclosed, in response to the above; or any claim, suit, legal proceeding, regulatory proceeding or investigation, or licensure action or investigation that arises from any fact, circumstance, situation, transaction, event, act, error or omission disclosed, or which should have been disclosed, in response to the above.

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FRAUD WARNINGS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects that person to criminal and civil penalties.

APPLICABLE IN AL, AR, DC, LA, MD, NM, RI AND WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

APPLICABLE IN CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN FL AND OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL only.

APPLICABLE IN KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

APPLICABLE IN KY, NY, OH AND PA

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 insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*.

*Applies in NY only.

APPLICABLE IN ME, TN, VA AND WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

APPLICABLE IN NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

APPLICABLE IN OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

APPLICABLE IN VT

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

REPRESENTATIONS AND SIGNATURE

By signing this Application, the undersigned represents, on behalf of the Applicant and all proposed insureds, the following:

- a. After conducting due diligence, the statements in the Application and Supplemental Application furnished to the Insurer are accurate and complete;
- b. Those statements furnished to the Insurer are representations Applicant makes on behalf of all proposed Insureds;
- c. Those representations are a material inducement to the Insurer to provide a premium proposal;
- d. If a policy is issued, the Insurer will have issued this Policy in reliance upon those representations;
- e. If there is any material change in the Applicant's condition or in the Applicant's activities, services, or answers provided in this Application that occurs or is discovered between the date this Application is signed and the Effective Date of any policy, if issued, Applicant will immediately report such material change to the Insurer in writing; and
- f. The Insurer reserves the right, upon receipt of such notice, to change or rescind any insurance proposal previously offered by the Insurer.

As used above, the term "Insurer" refers to Capitol Specialty Insurance Corporation.

NOTHING IN THIS APPLICATION SHOULD BE INTERPRETED TO MEAN THAT COVERAGE WILL BE OFFERED OR THAT ANY ITEMS REFERENCED IN QUESTIONS OR ANSWERS TO QUESTIONS WILL BE COVERED EVEN IF COVERAGE IS OFFERED AND BOUND.

This Application must be signed by an authorized partner, officer or other principal of Applicant shown in Question 1.1 of this Application.

Signature of authorized representative of Applicant

Title

Type / Print name of authorized representative

Date

Producer Signature

Date