As part of your professional liability policy, certain services you provide may (or may not) be eligible for coverage. In order to help us determine eligibility, and the associated premium, it is essential that you complete in full this questionnaire and return it with your Individual application.

NAME APPLYING FOR COVERAGE:

1. Please provide the percentage of revenue reported on your application that applies to:
   a. Direct Patient Care* provided in any setting (i.e., office, hospital, nursing home, etc.)?
      __________%  
   b. Consultation, Financial, Education, Legal or other services provided that require a review of patient charts, medical history, or other patient-specific records/information?
      __________%  
   c. Consultation, Education, Legal, or other ancillary services provided unrelated to and/or without the review of patient-specific records/information?
      __________%  
   d. Other services not addressed above (Describe): _________________________________
      __________%  

*Note: Direct Patient Care is defined as hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and monitoring. For the purpose of this definition, it extends to telemedicine/telehealth consultation or service provided to clients in a healthcare provider/patient relationship.

2. Do you contract staff:  
   a. Attorneys?  
      □ Yes □ No  
   b. Accountants?  
      □ Yes □ No  
   c. Other Non-Medical, Licensed Professionals and not already addressed in the application or this questionnaire (i.e. Social Security Consultants)?  
      □ Yes □ No  
      Describe: ______________________________________

3. Clientele – Please provide a percentage breakdown of types of clients you serve (total should equal 100%):

   Direct Patient Care – Cash Only  __________%  Direct Patient Care – Health Insurance  __________%  
   Auto Insurance Companies  __________%  Law firms or Expert Witness Cases  __________%  
   Worker’s Comp Insurance Companies  __________%  Governmental Agencies  __________%  
   Referrals from ACOs/MCOs  __________%  Charities/Religious  __________%  
   Other (Describe): ______________________________________  __________%
4. Contracts – What percentage of your work is performed under contract to another entity/individual? _______%

   a. What percentage of contracts currently in force utilize your own standard template contract? _______%
      Please submit a copy of your standard contract template if you have one.

   b. How many client contracts are currently in force?  
      ☐ Fewer than 5 ☐ Between 5 and 10 ☐ More than 10

   c. Please list your top three clients, annual revenue and a brief description of responsibilities below:

      | CLIENT | ANNUAL REVENUE | SERVICES PROVIDED |
      |--------|----------------|------------------|
      |        |                |                  |
      |        |                |                  |
      |        |                |                  |

As a supplement to the application, the undersigned recognizes that he/she has a continuing obligation to declare to the best of his/her knowledge and belief that the statements contained herein are true and are the basis of the acceptance of the risk or the hazard assumed by the Insurer under this Policy. It is further agreed by the undersigned, that if the Insurer issues the coverage for services which the applicant is requesting in the Policy, it is in reliance upon the truth of such representations. It is agreed that, although the signing of this Supplement to the Application does not commit the undersigned to purchase such additional insurance, the statements made herein shall be included with those made in the Application and become the basis of the Policy should one be purchased. The Insurer is hereby authorized to make any investigation and inquiry in connection with the Application and all supplements thereto, as it deems necessary.

Signature of Applicant       Title       Date

Name of individual signing this application (printed)