Commonwealth Underwriters Ltd.
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ALLIED MEDICAL - CLINICS SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

Please see the Argo Pro Allied Medical General Application to complete a schedule of physicians associated with this facility. No liability coverage for physicians will be included with this quote unless a physician application is submitted and coverage is specifically included on the quote.

I. APPLICANT INFORMATION

1. Applicant Name: _____
2. Mailing Address: _____
3. City, State, Zip: _____
4. County: _____ 5. Telephone Number: _____
6. Indicate type of clinic:

- ☐ Abortion Center
- ☐ Alternative Medicine
- ☐ Family Practice/General Practice
- ☐ Free Clinic
- ☐ Immunization
- ☐ Mental Health
- ☐ Occupational Health
- ☐ Sleep Studies
- ☐ Urgent Care
- ☐ Weight Loss
- ☐ Other (please describe): _____

II. OPERATIONS

1. a. Does the Applicant perform any surgery besides incision of boils and superficial abscesses or suturing skin and superficial fascia? ☐ Yes ☐ No
   b. If Yes, list all invasive procedures: _____
2. a. Does the Applicant perform any anti-aging procedures, including Botox or other injectibles? ☐ Yes ☐ No
   b. If Yes, completion of a Medical Spa/Anti-Aging Clinics Supplemental Application is required.
3. Does the Applicant perform abortions and/or menstrual extractions? ☐ Yes ☐ No
4. a. Does the Applicant administer anesthesia other than topical or local infiltration? ☐ Yes ☐ No
   b. If Yes, please explain: _____
5. a. Does the Applicant prescribe or provide drugs for weight reduction for patients? ☐ Yes ☐ No
   b. If Yes, please indicate percentage of practice devoted to weight reduction: _____ %
   c. If Yes, please list medications prescribed or used: _____

6. a. Does the Applicant administer any methadone treatment? ☐ Yes ☐ No
   b. If Yes, indicate the number of treatments administered during the:
      Last 12 Months: _____ Next 12 Months: _____
   c. If Yes, please attach a description of treatment and controls used.
7. a. Does the Applicant provide imaging services? ☐ Yes ☐ No
   b. If Yes, provide a description of services, and indicate whether images are interpreted by the Applicant:

_____

_____

_____

8. Indicate percentage of patients/clients:

_____ %	Bariatrics	_____ %	Pain Management
_____ %	Communicable Disease	_____ %	Pediatric
_____ %	Dental	_____ %	Physical Rehabilitation
_____ %	Disability Evaluation	_____ %	Psychiatric
_____ %	Family Planning	_____ %	Research/Experimental
_____ %	Free Clinic	_____ %	Sleep Disorders
_____ %	Hemodialysis	_____ %	Stress Testing
_____ %	Holistic Medicine	_____ %	Substance Abuse
_____ %	Obstetrical	_____ %	Surgical
_____ %	Oncology	_____ %	Urgent Care
_____ %	Other – Please describe:	_____	

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

_____ _____
Authorized Signature on behalf of Applicant Sub-Producer

_____ _____
Title/Date Producer

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.