



**APPLICATION FOR COMMERCIAL GENERAL
LIABILITY AND PROFESSIONAL LIABILITY**

**CLINICAL TRIALS - PHARMACEUTICALS
AND MEDICAL DEVICES**

This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.

I. GENERAL INFORMATION

1 Applicant Name: _____
 Entity Name _____
 Primary Office Address: _____ Telephone No.: _____
 City: _____ County: _____
 State: _____ ZIP: _____
 Email: _____ Website: _____
 Corporation Partnership Proprietorship Other

Years in business under present name: _____

Has Applicant ever engaged in this or similar biotech enterprises under a different name?
 If YES, provide complete details.

Current Insurance Coverage:

<input type="checkbox"/> Lower Back/Spine	%	<input type="checkbox"/> Degeneration disc disease	%
<input type="checkbox"/> Arthritis	%	<input type="checkbox"/> Cancer Pain	%
<input type="checkbox"/> Crohn's Disease	%	<input type="checkbox"/> Fibromyalgia	%
<input type="checkbox"/> Headaches / migraines	%	<input type="checkbox"/> Jaw Pain / TMJ	%
<input type="checkbox"/> Sport Related Injuries	%		
<input type="checkbox"/> Other, please specify:	%		

3 Have these percentages differed by more than 20% in any area, in any annual period, during the last 3 years?
 Yes No If Yes, please explain on letterhead.

III. TYPES OF PROCEDURES

Procedures	Projected Next Year	Current Year	Last Year	Location of Procedure Clinic (C), Hospital (H), Surgery Center (S)
<input type="checkbox"/> Drug Treatment – Opioids, corticosteroids, antidepressants, anticonvulsants				
<input type="checkbox"/> TENS				
<input type="checkbox"/> Counseling				
<input type="checkbox"/> Biofeedback				
<input type="checkbox"/> Massage				
<input type="checkbox"/> Physical Therapy				
<input type="checkbox"/> Acupuncture				
<input type="checkbox"/> PCA Pumps				
<input type="checkbox"/> Trigger Point Injections				
<input type="checkbox"/> Electro Thermal Therapy				
<input type="checkbox"/> Nerve Blocks				

<input type="checkbox"/> Facet Joint Blocks				
<input type="checkbox"/> Chiropractic without anesthesia				
<input type="checkbox"/> Epidural Injections – Not Obstetric related				
<input type="checkbox"/> Chiropractic Manipulation/Adjustment under anesthesia				
<input type="checkbox"/> Spinal Cord Stimulation				
<input type="checkbox"/> Spinal Drug Delivery System				
<input type="checkbox"/> Other: please specify				

Is a crash cart available at each location procedures are preformed? Yes No

VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

This applicant declares that the information contained in this supplemental application is true and that no material facts have been suppressed or misstated. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. This applicant understands that incorrect information could void coverage.

Signature:	Date:
Printed Name:	Title/Position (Officer, Partner, etc):