# Florida Doctors Insurance Company
# Healthcare Facility Professional Liability
# Medical / Pathology Laboratory Supplement

**The supplement is not a complete application for insurance. It must be submitted in conjunction with Florida Doctors Insurance Company's Healthcare Facility Professional Liability Insurance Application and all other required information.**

Facility Name: ______________________________

Type of Services Provided:

**The data provided should be projected for the 12 months to be covered under the policy.**

| Type of Service Provided | Annual Gross Revenue |
|---|---|
| Assisted Reproductive Treatment / Techniques | $ |
| Blood Bank | $ |
| Blood Gas | $ |
| Chemistry | $ |
| Cytology | $ |
| DNA / Genetic Testing | $ |
| Endocrinology | $ |
| Hematology | $ |
| Histology | $ |
| Immunology | $ |
| Microbiology | $ |
| Molecular Diagnostics | $ |
| Parasitology | $ |
| Paternity Testing | $ |
| Pathology | $ |
| Serology | $ |
| Sperm Bank | $ |
| Toxicology | $ |
| Urology | $ |
| Virology | $ |
| Other (describe): | $ |

| | | |
|---|---|---|
| Are you performing drug and alcohol testing? | Yes | No |
| If yes, are DOT rules adhered to? | Yes | No |
| Are you approved by the National Institute on Drug Abuse (NIDA) if the lab is involved in drug testing? | Yes | No |
| Are you performing cryopreservation? | Yes | No |
| Are you a reference lab? | Yes | No |
| Are you a research lab? | Yes | No |
| Are any other labs used to provide certain tests? | Yes | No |

If yes, please describe which tests are provided: ____________________

____________________

| | | |
|---|---|---|
| Are hold harmless agreements and indemnification clauses included in the contract? | Yes | No |
| Does the contracted lab carry professional liability limits at least equal to yours? | Yes | No |

**SUPPLEMENTAL WAIVER AND RELEASE**

As authorized representative for the facility, I hereby acknowledge that the foregoing information constitutes a part of my application for insurance with Florida Doctors Insurance Company (FLDIC). If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. If it is determined that I failed or refused to disclose any relevant fact or information or misled, defrauded or lied to FLDIC, I understand that the policy shall be null and void. However, unintentional errors or omissions do not affect my rights under the policy, if issued. I understand that no insurance will be afforded unless and until a complete application is accepted by FLDIC and the facility is notified of said acceptance.

____________________ ____________________
Signature of Authorized Representative Date

____________________ ____________________
Printed Name of Authorized Representative Title of Authorized Representative

This application form duly completed together with any supplementary information must be signed in ink by an authorized representative of the applicant. A signature on the form does not bind the applicant or FLDIC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

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