

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application
For
Abortion Clinics

1. Name of Applicant (Include names of owners & job titles) _____
 Street Address _____ City _____ State _____ Zip _____
 Applicant's Web Site Address _____
2. No. of locations (attach list) _____ No. of years in operation _____
3. Profit or Non-profit _____ Corp. _____ Partnership _____
4. Gross Sales \$ _____ No. of abortions annually _____
5. No. of M.D.'s _____ Surgeons _____ Anesthetists _____ Anesthesiologists _____
 R.N.'s _____ L.P.N.'s _____ Counselors _____ Other employees _____
 EMT/Paramedic Qualified _____
6. Type of abortions performed and number:
 D&C _____ D&E _____ Vacuum _____ Saline _____
 Prostaglandin _____ Other (Describe) _____
7. No. of vasectomies _____ No. of tubal ligations _____
8. No. of abortions performed during:

	Current Year	Est. Next Year
First Trimester	_____	_____
Second Trimester	_____	_____
Third Trimester	_____	_____
9. Types of anesthesia used and estimated percentage:
 Local (type) _____ %
 General (type) _____ %
 Other (type) _____ %
10. Physical exam prior to abortion Yes No
 Test for V.D. Yes No
 Other tests (Describe) _____
11. Hospital affiliation (name) _____
 Distance from clinic _____ (miles) Estimated travel time _____
12. Emergency procedures when complications arise? (attach copy) _____
13. Registered and approved by state and/or local health department? Yes No
14. Patient care procedures: (attach copy) _____

15. List name and specialization of M.D.(s), **including insurance coverage:**

	NAME	LIMITS	POLICY #	CARRIER	EXPIRATION
1.					
2.					
3.					
4.					
5.					

Are all M.D.(s) graduates of USA Schools? Yes No
 Are all M.D.(s) board certified eligible? Yes No

16. Does clinic perform services other than abortions and related counseling? Yes No
 Describe _____

17. Do any doctors have claims pending or paid as respects their personal practice during last five (5) years? If so, describe each claim. Yes No

18. Does the clinic or any employee have a claim pending or a claim settled that occurred during last five (5) years? If so, describe each claim. Yes No

Has any carrier cancelled, declined or refused to renew professional liability insurance? Yes No
 If so, provide details. _____

19. **LIMITS OF INSURANCE REQUESTED:**

General Aggregate Limit (Other than Products-Completed Operations) \$ _____
 Products – Completed Operations Aggregate Limit \$ _____
 Personal and Advertising Injury \$ _____ any one person or organization
 Each Occurrence Limit \$ _____
 Damage to Premises Rented to You (up to \$50,000 limit available) \$ _____ any one premise
 Medical Expense Limit (up to \$5,000 limit available) \$ _____ any one person
 Each Professional Incident Limit (If applicable) \$ _____

Effective Dates Desired: From _____ To _____

Applicant's Signature: _____ Date: _____

Title: _____ Producing Agent: _____