

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:
 

	<b>Current Year</b>	<b>Est. Next Year</b>
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: \_\_\_\_\_