



## 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.**

<b>Type of Service Provided</b>	<b>Annual Gross Revenue</b>
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.)

FLORIDA DOCTORS INSURANCE COMPANY  
4655 Salisbury Road, Suite 110  
Jacksonville, Florida 32256  
Phone: 800-FLA-DOCS (352-3627) FAX: 904-296-1013  
[www.FLDIC.com](http://www.FLDIC.com)