



Boston Insurance Brokerage, Inc.

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**ALLIED MEDICAL - CLINICS
SUPPLEMENTAL APPLICATION**

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

Please see the Argo Pro Allied Medical General Application to complete a schedule of physicians associated with this facility. No liability coverage for physicians will be included with this quote unless a physician application is submitted and coverage is specifically included on the quote.

I. APPLICANT INFORMATION

1. Applicant Name: _____
2. Mailing Address: _____
3. City, State, Zip: _____
4. County: _____ 5. Telephone Number: _____
6. Indicate type of clinic:

<input type="checkbox"/> Abortion Center	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Alternative Medicine	<input type="checkbox"/> Occupational Health
<input type="checkbox"/> Family Practice/General Practice	<input type="checkbox"/> Sleep Studies
<input type="checkbox"/> Free Clinic	<input type="checkbox"/> Urgent Care
<input type="checkbox"/> Immunization	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Other (please describe): _____	

II. OPERATIONS

1. a. Does the Applicant perform any surgery besides incision of boils and superficial abscesses or suturing skin and superficial fascia? Yes No
 b. If Yes, list all invasive procedures: _____

2. a. Does the Applicant perform any anti-aging procedures, including Botox or other injectibles? Yes No
 b. If Yes, completion of a Medical Spa/Anti-Aging Clinics Supplemental Application is required.
3. Does the Applicant perform abortions and/or menstrual extractions? Yes No
4. a. Does the Applicant administer anesthesia other than topical or local infiltration? Yes No
 b. If Yes, please explain: _____

5. a. Does the Applicant prescribe or provide drugs for weight reduction for patients? Yes No
 b. If Yes, please indicate percentage of practice devoted to weight reduction: _____ %
 c. If Yes, please list medications prescribed or used: _____

6. a. Does the Applicant administer any methadone treatment? Yes No
- b. If Yes, indicate the number of treatments administered during the:
 Last 12 Months: _____ Next 12 Months: _____
- c. If Yes, please attach a description of treatment and controls used.
7. a. Does the Applicant provide imaging services? Yes No
- b. If Yes, provide a description of services, and indicate whether images are interpreted by the Applicant:

8. Indicate percentage of patients/clients: _____ % Bariatrics _____ % Pain Management
- _____ % Communicable Disease _____ % Pediatric
- _____ % Dental _____ % Physical Rehabilitation
- _____ % Disability Evaluation _____ % Psychiatric
- _____ % Family Planning _____ % Research/Experimental
- _____ % Free Clinic _____ % Sleep Disorders
- _____ % Hemodialysis _____ % Stress Testing
- _____ % Holistic Medicine _____ % Substance Abuse
- _____ % Obstetrical _____ % Surgical
- _____ % Oncology _____ % Urgent Care
- _____ % Other – Please describe: _____

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Authorized Signature on behalf of Applicant

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.