Allied Healthcare Professional Package Product: Miscellaneous Class Supplemental Application

Complete the following only for the professions for which you are applying for coverage. Professions not listed here may require a separate supplemental application.

Name of applicant: _____

A. Dental Assistant

1. Does the applicant work under a dentist's supervision? ○ Yes ○ No
2. Does the applicant administer any form of anesthesia (including local, general or sedation)? ○ Yes ○ No

B. Dental Hygienist

1. Does the applicant work under a dentist's supervision? ○ Yes ○ No
2. Does the applicant administer general or sedative anesthesia? (do not answer "Yes" if local anesthesia only) ○ Yes ○ No

C. EEG Technician/Technologist

1. Is the applicant CPR certified or have CPR certified staff on duty? ○ Yes ○ No
2. What percent of services involves pediatric patients?_____%

D. First Aid/CPR Training

1. Does the applicant provide services creating evacuation plans or compliance with fire/safety regulations? ○ Yes ○ No
2. Does the applicant provide training other than first aid/CPR? ○ Yes ○ No
3. Does the applicant specialize in consulting services for earthquake, terrorism, weapons of mass destruction or similar catastrophic events? ○ Yes ○ No

E. Health Educator

1. Does the applicant provide abortion counseling, adoption screening or foster care screening? ○ Yes ○ No
2. Does the applicant specialize in emergency preparedness/catastrophic/mass epidemic consulting? ○ Yes ○ No

F. Lactation Consultant

1. Does the applicant specialize in consulting for premature infants? ○ Yes ○ No

G. Medical Office Assistant

1. Does the applicant provide services as a Physicians Assistant? ○ Yes ○ No
2. Is the applicant involved in utilization review, peer review/case management services or making managed care treatment decisions? ○ Yes ○ No
3. Does the applicant provide clinical services including medical treatment, prepare/administer medication, remove sutures or assist in physical exams? ○ Yes ○ No

H. Opticians & Optometric Assistants

1. Does the applicant provide any services as an ophthalmologist or optometrist? ○ Yes ○ No
2. Does the applicant fit prosthetic ocular devices? ○ Yes ○ No

I. Patient Intake Technician

1. Does the applicant provide peer review/case management services, make managed care treatment decisions or provide utilization review services? ○ Yes ○ No
2. Does the applicant work in an emergency room? ○ Yes ○ No

J. Speech Language Pathologist

1. Does the applicant perform suctioning or emergency procedures? ○Yes ○No

This supplemental application is incorporated into and is deemed a part of the other application(s) submitted in connection with the requested insurance. Any and all notices and representations included in such other application(s) are incorporated by reference in this supplemental application as though fully set forth herein.

Applicant's Signature_____ Title_____ Date_____

(Principal, Partner or Officer)

Print Name _____

Agent's signature: _____

(Required in New Hampshire)