GeneralStar™ DVA®

SUPPLEMENTAL APPLICATION FOR BLOOD / DONOR BANKS

MISCELLANEOUS HEALTHCARE FACILITIES PROGRAM

NOTE – Coverage is not afforded by this policy to any resident, intern, physician, surgeon, dentist, psychiatrist, licensed or certified registered nurse anesthetist, nurse midwife, podiatrist or chiropractor for rendering or failure to render professional services.

Instructions to the Applicant.

A. Please answer **all** the questions on this supplemental application(s). The information is required to make an underwriting and pricing evaluation. Your answers hereunder are considered legally material to that evaluation.
B. If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
C. The application must be signed and dated by an owner, partner, officer or director of your facility.

I. GENERAL INFORMATION

Applicant's / Entity Name:_____

II. OPERATIONS:

1. Type and Number of Annual Exposures: (check all that apply)

Blood and Blood-related	Annual Donations Projected	Current	Past Year
☐ Paid Blood Donations			
☐ Volunteer Blood Donations			
☐ Autologous Blood Donations			
☐ Foreign (not USA) Donations Purchased			
☐ Pheresis Procedures			
☐ Outpatient Transfusions			
☐ Therapeutic Plasma Exchange			
☐ Stem Cell Harvesting			
☐ Other _____			

Other Banking and Harvesting	Annual Receipts Projected	Current	Past Year
☐ Organ Banking – Direct Processing			
☐ Organ Banking – No Direct Processing			
☐ Tissue Banking			
☐ Sperm Banking			
☐ Egg Banking			
☐ Other _____			

3. Are there any research activities? ☐ Yes ☐ No
   If yes, please describe _____
4. Do you provide testing for other donor facilities? If yes, ☐ Yes ☐ No
   a. Type of Test _____ Estimated # of Each _____
   _____ _____
   _____ _____
   _____ _____
   b. Do you require the other facility to carry professional liability limits equal to your limits? ☐ Yes ☐ No

5. Does another facility test blood for you? ☐ Yes ☐ No

a.

Name of Facility	Type of Test	Estimated # of Each

b. Do you require the other facility to carry professional liability limits equal to your limits? ☐ Yes ☐ No

6. Do you check with the Donor Register before the donor's blood is taken or transfused? ☐ Yes ☐ No

7. Have you implemented the FDA recommendations for questions related to potential donors regarding the following:

a. HIV Testing? ☐ Yes ☐ No
b. Hepatitis Testing? ☐ Yes ☐ No
c. Smallpox? ☐ Yes ☐ No
d. Anthrax? ☐ Yes ☐ No
e. Other infectious diseases? ☐ Yes ☐ No

I understand the information submitted herein becomes a part of my General Star Insurance Application and is subject to the same warranty and conditions.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

Signature of Owner, Officer or Partner	Print or Type Name and Title	Date (month-day-year)