Supplemental Questionnaire: **Comprehensive Fertility Services**

Instructions:

1. This application must be completed in conjunction with the Pro-Praxis Allied Healthcare Application.
2. Answer ALL questions completely, leaving No blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.
3. This application must be completed, dated and signed by a Principal or Officer of your firm. Underwriters will rely on all statements made in this application.

Applicant Name: _____

1. Is your business involved in: ☐ Lab Services ☐ IVF Services ☐ Sperm/Egg Bank

2. Where do you provide services?
   Free Standing Facility ___% Doctor's Office/Clinic ___% Hospital ___%
   Mobile Unit ___% Other ___%

3. Do you:
   a. Have a formal equipment maintenance program in place? ☐ Yes ☐ No
   b. Train employees to properly operate medical equipment? ☐ Yes ☐ No
   c. Have age limitations for egg and sperm donors: ☐ Yes ☐ No
   d. Verify clinical criteria for donors: ☐ Yes ☐ No

4. If Lab, check which apply: ☐ n/a
   ☐ Semen Analysis ☐ Hormone Testing ☐ Transvaginal Ultrasound
   ☐ Post Cortal Testing ☐ Hydrosonogram ☐ Genetic Testing
   ☐ Thyroid Evaluation Prenatal Testing ☐ Pre-Implantation Genetic Diagnostics, including

5. Do you:
   a. Maintain CLIA certification? ☐ Yes ☐ No
   b. Participate in clinical research? ☐ Yes ☐ No
   c. Perform drug & alcohol testing? ☐ Yes ☐ No
   d. Projected Annual Number of Lab Tests: _____

6. If IVF Services, check which apply: ☐ n/a
   ☐ Conventional IVF ☐ Sperm microinjection (ICSI) ☐ PESA/TESA
   ☐ Embryo Transfer ☐ Intrauterine (IUI) ☐ Assisted Embryo Hatching
   ☐ Sex Selection ☐ Advanced Reproductive Surgery (including Laparoscopy)

7. Are your physicians board certified: ☐ Yes ☐ No

Projected Annual Number of Patients: _____	Projected Annual Number of Surgeries: _____	Projected Annual Number of IVF Cycles: _____

8. If Bank/Storage Services, check all that apply: ☐ n/a
   ☐ Egg Donor ☐ Elective Egg Storage (oocyte preservation) ☐ Sperm Bank

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This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: _____ DATE: _____ _____