

Agency _____ Insured _____

A. Have you ever had any professional liability insurance refused, canceled or non-renewed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Do you work as an emergency room physician, other than for maintaining hospital privileges?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Are you a proprietor, owner, director, partner, superintendent, executive officer, administrative officer, medical director or attending physician of any of the following? Please circle as applicable. Hospital, Sanitarium, Nursing Home, Surgi-Center, Clinic with bed and board facilities, Laboratory (independent or outside), Blood Bank, Prepaid Health Plan or Health Maintenance Organization, Other medical facilities If you have answered "Yes"/circled any of the foregoing, please list the names of the facilities and your affiliation with them in the space provided at the end of this section.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Do you practice medicine at this/these institution(s)? Please explain.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Do you maintain any overnight patient facilities in your own office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. Do you render patients unconscious for treatment in your office or other non-hospital facility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. Do you ever enter into arbitration or similar agreements with your patients? If "Yes," submit copies and describe circumstances in which they are used.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Explanations: _____

VII. Previous Insurance

Attach current letter(s) from prior carrier(s), verifying claims reported during the last ten (10) years.

Have you ever been without insurance? If "Yes," explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

To your knowledge have you ever been insured with an insolvent carrier? If "Yes," explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

VIII. Claims Information

Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of circumstances that might reasonably lead to such a claim or suit? If "Yes," complete a claims supplement for each claim.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total Number of Claims: _____ Open / Reserved: _____ Closed: _____		
Brief explanation of claims: _____ _____		

IX. Prior Acts Coverage

You are not eligible for Prior Acts Coverage unless you maintained continuous claims-made professional liability insurance with your own limits of liability during the entire requested Retroactive or Prior Acts Coverage period. You must provide a complete copy of your expiring professional liability policy Declarations Page.

NOTE: Prior Acts Coverage is subject to separate underwriting approval. For your protection, do not forfeit your right to purchase extended reporting coverage from your current carrier until you are specifically notified in writing that your request for Prior Acts Coverage has been approved.

Requested Retroactive Date: _____ NOTE: The requested retroactive date must equal the retroactive date on your current policy. The period between the requested retroactive date and requested effective date defines the prior acts period.

X. Practice History

Did you practice with other physicians in an employer-employee relationship, ostensible or formal partnership, professional association or medical corporation during the period for which you are requesting Prior Acts Coverage? If "Yes," list the full name(s) of the entity(ies) and physician(s) with whom you practiced and the period of each such association. Attach additional pages as needed.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Non-Physician Health Care Providers Desiring Coverage

Did you employ, contract with or supervise any non-physician health-care providers (i.e., physician assistants, nurse practitioners, CNM's, CRNA's, etc.) during the period for which you are requesting Prior Acts Coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Profession(s) _____ Total Number _____		

Changes in Practice:

Was your practice during the period for which you are requesting Prior Acts Coverage different in any way from your practice as described in this Application for Medical Professional Liability Claims-Made Coverage? For instance, did your practice formerly include obstetrical care or emergency room services that you are no longer providing, or did you ever perform silicone implants of any kind? If "Yes," please describe the changes in your practice, including all applicable dates.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Did any of your policies contain any coverage restrictions? If "Yes," please describe the coverage restrictions, including all applicable dates. Attach additional pages as needed.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

NOTE: Adequate Prior Acts Coverage is contingent upon your description of your former practice.

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on page 16 of this Application to (present date) have been reported to my current insurance carrier:

Carrier: _____

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, or should be aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to my current carrier prior to the effective date of such coverage and are listed previously or by supplemental form attached below.