This is an application form for a **CLAIMS MADE** policy

INSTRUCTIONS:

1. Please answer all questions (if not applicable, show N/A) and attach all additional information/explanations as required for each location.
2. Please date and have two signatures on the applications.
3. "Applicant" refers to the company, its predecessors, and all proposed Insureds, including Subsidiaries.
4. PLEASE READ STATEMENT AT THE END OF APPLICATION CAREFULLY.
5. For multiple locations, please complete a separate application for each.
6. Please do not leave prior insurance coverage blank - these applications will not be quoted.

SECTION I - APPLICANT'S INFORMATION

1. Name: _____

2. Address: _____
_____

3. Email Address:_____
Website Address (if applicable): www. _____

4. Current Medical Malpractice Carrier: _____

Expiration Date: _____

Limits: $_____ Deductible: $_____ Premium: $_____

5. Please list all non-patient professional services rendered for a fee for which you wish to have professional liability coverage:
_____
_____

6. Annual Gross Revenues for services rendered in question 5. above (please project for current year).

Estimated Current Year: $_____Most Recently Completed Year: $_____

7. With respect to the services mentioned in question 5. above, please indicate the Applicant's two largest jobs/projects during the past three years, showing client's name, services provided and gross revenues for each:

_____

_____

_____

8. Please provide total number of independent reviews performed in most recent previously completed year_____ estimated for current year_____

9. Please provide total current number of full time employees _____ and part time employees _____

10. Please detail principle exposures and reasons for purchasing insurance.

_____
_____
_____
_____

11. Are any significant changes in the nature or size of the Applicant's business anticipated over the next 12 months? Or have there been any such changes in the past 12 months?
Yes_____ No_____

If yes, please explain: _____
_____
_____

12. Does the Applicant use a written contract?
Always _____ Sometimes _____ Never _____

If not always, please explain how the scope of services to be provided is agreed:
_____
_____

13. Give Professional Liability coverage for last five years for the firm (which is different from the Medical Malpractice Policy per Question 4): If none, check here: □

Carrier	Limit	Deductible	Premium	Expiration (day/mo/yr)

14. Please answer each question below. Please provide additional information for any "Yes" answers:

a. Does the Applicant have a parent Company? Yes □ No □
b. With respect to your answer to Question 6, was a revenue other than Total Gross Revenues (i.e. net revenue) entered as exposures? Yes □ No □
c. Does the insured require coverage for additional insureds? Yes □ No □
d. Does the insured have employees in locations outside of the United States? Yes □ No □
e. Is the insured a public company? Yes □ No □
f. Does the insured have an ultimate parent that is a public company? Yes □ No □
g. In the past 18 months or anticipated in the next 12 months, has the Applicant been involved in an actual or attempted merger, acquisition or divestiture Yes □ No □

16. With regard to the coverages for which the Applicant is applying, have any claims been made against any party proposed for coverage within the last 5 years? Yes □ No □
If yes please complete attached claims supplement.

17. Is any party proposed for coverage aware of any fact, circumstance or event which could give rise to a claim? Yes □ No □ If yes, please provide further details.

18. During the past five years, has the Applicants Professional Liability coverage been cancelled or non-renewed (for a reason other than the insurer withdrawing from a sate or no longer providing coverage) Yes □ No □

The Applicant and all Insureds acknowledge that any Claims, or Claims later arising from circumstances reported, or that should have been reported in connection with questions reflected in this application will be excluded from coverage:

Please ensure that additional information is attached where applicable.

The Applicant warrants after full investigation and inquiry that the statements set forth herein are true and include all material information.

The Applicant on behalf of all proposed Insureds further warrant that if the information supplied on this application changes between the date of this application and the inception date of the Policy, it will immediately notify Underwriters of such change. Signing of this application does not bind Underwriters to offer, nor the Applicant to accept, insurance, but it is agreed that this application shall be the basis of the insurance and will be attached and made a part of the Policy should a policy be issued.

Please note that this application will not be reviewed unless it is signed and dated.

_____ _____
Date Signature of Applicant's Authorized Principal or Officer

_____
Title

_____ _____
Date Signature of Applicant's Administrator or Medical Director

_____
Title

MISCELLANEOUS MEDICAL PROFESSIONAL LIABILITY

ATTACHMENT 'A' - Claims

Please complete this form if the applicant is aware of any errors, omissions or circumstances (including any circumstances reported to previous insurers which have not developed into claims) during the last ten years.

1. Name of Applicant: _____

2. Name of Member of Staff involved in claim: _____

3. Name of (potential) claimant: _____

4. Date of Incident: _____ Date claim made: _____

5. Under which policy was the claim made? Carrier:
_____
Policy No:
_____

6. Status of claim: Closed_____(Please indicate total loss) _____
Open _____ (Please complete questions 7,8,& 9)

7. Total defence costs and expenses to date:
_____

8. Damages or other relief south by the claimant(s):
_____

9. Please advise the following details:

i) The specific act, error or omission upon which the claimant bases the claim.
ii) A brief description of the claim.
iii) Details of the current status and proposed strategy for handling the claim.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

SIGNED : _____ ***DATE :*** _____