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PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

MEDICAL PROFESSIONAL APPLICATION

NOTICE TO APPLICANT: THE COVERAGE FOR WHICH THE APPLICANT IS REQUESTING WILL APPLY ONLY TO CLAIMS ARISING WHILE IN THE COURSE OF THEIR EMPLOYMENT FOR THE NAMED INSURED.

SECTION I – GENERAL INFORMATION

Applicant's Last Name:_____ First Name:_____ M.I.:_____
Applicant's Mailing Address:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Applicant's Legal Residence:_____
Street Address:_____ City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____
Physicians Website (if applicable): www._____ E-Mail:_____
Date of Birth:_____

Current Medical Licenses Issuing State:	License Number:	Status:	% time in each state
			%
			%
			%

1. Is Applicant a U.S. citizen? ☐Yes ☐No If no, please explain: _____
2. Status: ☐Employed ☐Contracted ☐Volunteer
3. Does the Applicant have a private practice? ☐Yes ☐No
4. Does the Applicant treat patients with unconventional therapy, (i.e., treatment not considered to be mainstream treatment)? ☐Yes ☐No
   If yes, please describe:_____

SECTION II - EDUCATION AND TRAINING

1. Profession:
   ☐Chiropractor ☐Optometrist ☐Physician ☐Psychiatrist
   ☐Clinical Nurse Specialist ☐Pharmacist ☐Physicians Assistant ☐Psychologist
   ☐Nurse Practitioner ☐Physical Therapist ☐Podiatrist ☐Other:_____
2. Name and location of medical school granting degree:_____
   Medical School Name:_____
   City:_____ State:_____ Country:_____
   Year of graduation from professional school:_____
   Applicant's degree:_____
3. If Applicant is a graduate of a non-US medical school, have they obtained a Professional / License Designation or an ECFMG Certificate? ☐Yes ☐No
4. Independent memberships and professional societies:
   a._____
   b._____
5. What is the Applicant's medical specialty:

Specialty	Is Applicant American Board Certified?	Date Certified	% of Applicant's practice devoted to Applicant's specialty
	☐Yes ☐No		
	☐Yes ☐No		
	☐Yes ☐No		

6. Please identify any specialty that Applicant no longer practices:
   _____
7. Has the Applicant participated in any Risk Management Seminar(s) during the last 12 months? ☐Yes ☐No

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SECTION III - INSURANCE AND PROFESSIONAL HISTORY

1. Has the Applicant ever been denied professional liability insurance coverage? ☐Yes ☐No
   NOTE: MISSOURI APPLICANTS DO NOT RESPOND
   If yes, please attach a separate sheet containing a complete explanation.
2. Has the Applicant's professional liability insurance coverage ever been canceled or refused renewal? ☐Yes ☐No
   NOTE: MISSOURI APPLICANTS DO NOT RESPOND
   If yes, please attach a separate sheet containing a complete explanation.
3. Has the Applicant's application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions? ☐Yes ☐No
   If yes, please attach a separate sheet containing a complete explanation.
4. a. Does the Applicant participate in a compensation fund or other similar program of state-sponsored liability insurance? (Example: MCARE in Pennsylvania) ☐Yes ☐No
   b. If yes, how many years did the Applicant participate in a State CAT fund? _____
   c. What is State CAT fund group number? _____
5. Is the Applicant a member of a professional corporation, a professional association or a partnership that is entirely owned by healthcare providers that participates in a state-sponsored professional liability fund? ☐Yes ☐No
   If yes, please explain.

   _____
6. Has the Applicant's medical license ever been suspended or revoked? ☐Yes ☐No
   If yes, please attach a separate sheet containing a complete explanation.
7. Has the Applicant ever been convicted of a crime? ☐Yes ☐No
   If yes, please attach a separate sheet containing a complete explanation.
8. Has the Applicant ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any court or administrative agency or ever been the subject of any ethics investigation at local, state or national level? ☐Yes ☐No
9. Prior Insurance - List Applicant's insurers or Applicant's employers' Insurers for the past five (5) years. Attach additional pages as needed.

Insurance carrier	Policy Period	Policy Number	Limits of Liability	Premium Amount	Coverage Type (Occurrence / Claims-Made)
				$	
				$	
				$	
				$	

SECTION IV - COVERAGE REQUEST

1. Type of Coverage: ☐Occurrence ☐Claims-Made
2. If Claims-Made, complete Section VII and the below:
   a. Has Applicant purchased the Extended Reporting Period Endorsement on their prior policy? ☐Yes ☐No
      If yes, please complete the below: _____
      Name of carrier: _____
      Policy effective dates: _____ Policy number: _____
      # of years for ERP: _____ ERP expiration date: _____
   b. If Applicant declines to purchase Extended Reporting Period Endorsement on their previous claims-made policy, it should be understood that they may be uninsured for the period in which their prior claims-made policy existed. Furthermore, the Applicant understands that because of this there may be a gap in the Applicant's insurance coverage.
   c. If claims-made coverage is added, it should be clearly understood that the applicable retro date will be the latter of the medical professional's date of hire or the date that the medical professional coverage is added to the named insured's' policy.

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SECTION V – PRACTICE LOCATIONS

1. Prior Practice Locations:
List ALL locations at which Applicant has practiced in the last five (5) years. Attach additional page if needed.
Explain any gaps in time.

Name of Practice	City	State	From (MM/YY) To (MM/YY)

2. Current Practice Locations:
Please complete a section for **EACH** practice location. Copy this page for additional locations as needed.

Entity Name: _____
Street Address: _____ City: _____ State: _____ Zip: _____ County: _____
Office Phone Number: _____ Additional Contact Number: _____
Hours of Practice:
Full Time (≥ 35 hours per week of ALL covered professional activities and locations)
Part-Time (< 35 hours per week and ≥ 10 of ALL covered professional activities and locations)
Average Number of patients per week: _____

This location is a:

- ☐ Community Mental Health Center
- ☐ Detention Facility (Jail, Prison, Home for Juveniles, half-way houses for those convicted of or awaiting trial or criminal charges, or institutions for the treatment and confinement of those found "not guilty by reason of insanity", "guilty but mentally ill", etc.)
- ☐ For-Profit Hospital, Clinic or Nursing Home
- ☐ Mental Health Facility - Outpatient
- ☐ Mental Health Facility - Residential
- ☐ Not-For-Profit Hospital, Clinic or Nursing Home
- ☐ Primary Care Health Center
- ☐ Substance Abuse Facility
- ☐ Other (Specify): _____

a. Does the Applicant serve as the Medical Director or Chief of Psychiatry at this location? ☐ Yes ☐ No
b. Does the Applicant create and maintain medical records for each patient under their care? ☐ Yes ☐ No
If no, please explain:

_____

c. Does the Applicant have admitting privileges? ☐ Yes ☐ No
d. Does the Applicant prescribe controlled substances? ☐ Yes ☐ No
e. Does the Applicant obtain an informed consent, whether signed by patient or guardian before prescribing controlled substances? ☐ Yes ☐ No
f. Does the Applicant supervise any other physician or other mental health care providers? ☐ Yes ☐ No
g. Does the Applicant's practice include telemedicine activities, e.g., the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved? ☐ Yes ☐ No
   i. If yes, what is the percent of the Applicant's total practice time devoted to this activity? _____%
   ii. If yes, on a separate sheet, please explain the exact type of telemedicine.
   iii. Is telemedicine done outside the U.S. Territories? ☐ Yes ☐ No
h. Does the Applicant engage in any clinical and/or pharmaceutical research? ☐ Yes ☐ No
   i. **If yes**, does the sponsor agree in writing to indemnify the Applicant for such research activities? ☐ Yes ☐ No
   ii. **If no**, please explain type and extent of such activities:

_____

i. If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization? ☐ Yes ☐ No
j. If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization? ☐ Yes ☐ No
k. Does the Applicant teach at this location? ☐ Yes ☐ No
If yes: ☐ Classroom Teaching ☐ Clinical Teaching

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SECTION VI - CLAIMS HISTORY

IMPORTANT: *This section must be completed in its entirety.* ***Any*** *malpractice claims or suits in which Applicant has been involved in during the past seven (7) years must be reported.* ***Any*** *incidents or circumstances of which the Applicant is aware of that are likely to give rise to a claim must be reported. Provide copies of suit papers or claimant letters. If the claim is closed, provide copies of settlement or judgment documents or order of dismissal. If reporting more than one incident, suit or claim, photocopy this form for each.*

☐ N/A (Please proceed to signature section)

1. Has the Applicant ever had any malpractice claim or suit been brought against them? ☐ Yes ☐ No
2. Is the Applicant aware of any circumstances, which may result in a malpractice claim or suit, being made or brought against them? ☐ Yes ☐ No
   If Yes, please provide the details below:
   a. Name of Patient: _____
   b. Allegation/Incident: _____
   c. Incident Date: _____ Report Date: _____
   d. Was suit filed? ☐ Yes ☐ No
   e. Jurisdiction? _____
   f. Names of Co-Defendants: _____ ☐ N/A
   g. Insurance Carrier(s) covering claim: _____
   h. Policy Period(s): _____
   i. Final outcome of claim (*This information may be obtained by inquiry of the Applicant's current or past insurer. Please note that the Applicant must personally contact their insurance carrier.)*

      ☐ **Open**: (still pending) Indemnity reserve placed by insurer: $ _____
      Defense cost reserve placed by insurer: $ _____

      ☐ **Closed**:
      Method of closing: ☐ Dismissed ☐ Withdrawn ☐ Judgment ☐ Settlement
      Total Expenses: Amount of settlement or judgment: $ _____ Defense cost: $ _____

SECTION VII – CLAIMS MADE

Notice: This section is being completed as an application for a Claims-Made policy. Only claims which are first made against the Applicant and reported to us during the policy period or Extended Reporting Period will be covered, subject to policy provisions. Various provisions in the policy restrict coverage. Read the entire policy carefully to determine the Applicant's rights, duties and what is and is not covered.

☐ N/A (Please proceed to signature section)

Policy Effective Date: _____
Line of Business: _____

1. Within the past 5 (five) years has the Applicant given written notice under the provisions of any current or prior policy providing similar insurance of any claim or of any specific facts or circumstances which might give rise to a claim being made against the Applicant? ☐ Yes ☐ No
   If yes, please provide details:

   _____

2. With respect to the coverages applied for, upon inquiry of any of person qualifying as a Named Insured under the proposed policy, are there any facts, circumstances, or situations which might give rise to a claim under the coverage(s) for which the Applicant is applying? ☐ Yes ☐ No
   If yes, please provide details:

   _____

FRAUD NOTICE STATEMENTS

NOTICE TO APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF ALASKA APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

RESIDENTS OF ARKANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF ARIZONA APPLICANTS: "FOR YOUR PROTECTION ARIZONA LAW REQUIRES THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF COLORADO APPLICANTS: "IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES."

RESIDENTS OF DISTRICT OF COLUMBIA APPLICANTS: "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

RESIDENTS OF FLORIDA RESIDENTS APPLICANTS: "ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY "MATERIALLY" FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME."

RESIDENTS OF LOUISIANA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF MAINE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF MINNESOTA APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF NEW MEXICO APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

RESIDENTS OF NEW YORK APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

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RESIDENTS OF OKLAHOMA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

RESIDENTS OF OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

RESIDENTS OF PENNSYLVANIA APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF TEXAS APPLICANTS: IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICTION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

RESIDENTS OF VIRGINIA APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WASHINGTON APPLICANTS: **"**IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WEST VIRGINIA APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

Physician's Name _____ Date _____

Physician's Signature _____

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the **Applicant** and their respective Directors, Officers or other insured persons.

Produced By: (Section to be completed by Producer/Broker)

Producer _____ Agency _____

Producer License Number _____ Agency Taxpayer ID or SS Number _____

Address (Street, City, State, Zip) _____