DOCTORS professional liability

Additional Insured Application for Corporations

All information below must be completed and all questions answered "Yes" or "No". Please provide any extra explanations on a separate page.

Full Legal Name of Entity | Federal Tax ID | Number Date of Incorporation

Mailing Address | Office Phone Number

Primary Insured | Entity Contact Person | Email Address

Corporation Questions: (Please explain all "Yes" answers on separate page)

1. Does anyone other than the Primary Insured own this entity? ○ Yes ○ No
2. Do any other medical providers practice medicine under this entity? ○ Yes ○ No
   If yes, do they carry their own medical professional liability insurance? ○ Yes ○ No

   Limits: _____
3. Has this entity ever been named in a claim or had any other action brought against it for professional negligence? ○ Yes ○ No
4. Has this entity ever had a gap in coverage for medical professional liability insurance? ○ Yes ○ No
5. Are you aware of any negative outcomes that could potentially bring a claim against this entity? ○ Yes ○ No
6. Does this entity practice under multiple names or have multiple locations? If yes, please list all on a separate page. ○ Yes ○ No

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I FURTHER ACKNOWLEDGE ANY MISREPRESENTATION OR LACK OF NOTIFYING THE CARRIER OF CHANGES IN MY PRACTICE MAY RESULT IN COVERAGE BEING VOIDED.

Authorized Representative Signature | Date

Print Name

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