DOCTORS professional liability

# Application for Additional Insureds

All information below must be completed and all questions answered "Yes" or "No". Please provide any extra explanations on a separate page. Submit this form with a copy of state license, CV and signed No Known Loss.

| Effective Date | Additional Insured Name | Date of Birth |
|---|---|---|
| Professional Degree | School of Professional Degree | Year of Graduation |
| Social Security Number | License Number | Email Address |

Primary Insured

## Additional Insured Questions: (Please explain all "Yes" answers on separate page)

1. In the past 10 years, have you been named a suit or subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? ○ Yes ○ No
2. Have you ever had any insurance canceled, declined or refused to renew? ○ Yes ○ No
3. Have you ever been convicted of a felony? ○ Yes ○ No
4. Have you ever sought treatment for drug or alcohol addiction? ○ Yes ○ No
5. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any other named insured? ○ Yes ○ No
6. Do you administer any anesthesia? ○ Yes ○ No
7. Do you perform or assist in any surgical procedures? (List All) ○ Yes ○ No
8. Years at my current company? _____
9. Years of professional experience? _____
10. Number of hours worked per week? _____
11. Number of patients seen per week? _____
12. Do you work for any other company or location other than the one applying for this coverage? ○ 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

Printed Name

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