# DOCTORS PROFESSIONAL LIABILITY

## Medical Professional Liability Policy Application

☐ APPLICATION MUST BE SIGNED AND DATED AT TIME FIRST COMPLETED AND SENT BACK TO US.

☐ Please provide your expiring insurer policy Declarations Page showing Retroactive Date – a must if requesting Prior Acts Coverage.

☐ Please provide copies of any applicable current policy endorsements that affect basis of coverage so that we are able to try and obtain coverage aspects equal to or better than what you currently have in place.

☐ Please provide a copy of an Up-to-date CV (curriculum vitae - also known as a resume).

☐ Please provide current (*i.e. obtained within 60 days of requested effective date*) Claims History / Loss Run reports from all Prior Insurance Companies over the last 10 years – WE WILL BE GLAD TO TRY AND HELP YOU OBTAIN THESE IF NECESSARY.

23276 S. Pointe Dr. Suite 204 Laguna Hills , California 92653 * P 888-959-9456 * F 888-600-6280 * W www.DPLRRG.com

DOCTORS professional liability

# Medical Professional Liability Policy Application

## I. PERSONAL INFORMATION

Full Name of Applicant: _____ _____ _____ _____
FIRST MIDDLE LAST SUFFIX

Professional Designation: ☐ **MD** ☐ **DO** Date of Birth: _____ _____ _____ Gender: ☐ Male ☐ Female
MONTH DAY YEAR

Place of Birth: _____ Social Security Number: _____

## II. OFFICE INFORMATION

Principal Office Address: _____

_____ _____ _____ _____
City County State Zip

Office Phone Number: _____ Office Fax Number: _____

Email Address: _____ Office Manager: _____

Secondary Office Locations (If any): _____

_____ _____ _____ _____
City County State Zip

## III. COVERAGE REQUEST

Requested Effective Date: _____ _____ _____ Retroactive Date: _____ _____ _____
MONTH DAY YEAR MONTH DAY YEAR

**If retroactive coverage is requested, please complete the attached No Known Loss Form.
**If you do not want retroactive coverage, please complete the attached Waiver of Prior Acts Form.

Please indicate your desired level of coverage in the appropriate box.

☐ $100,000/$300,000 ☐ $200,000/$600,000 ☐ $250,000/$750,000
☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000 ☐ $1,300,000/$3,900,000 (New York Only)

## IV. CLASSIFICATION, LICENSING AND BOARD CERTIFICATION INFORMATION

A. What is your present specialty? _____
B. What is your present sub-specialty? _____
C. What percentage of your practice is devoted to your specialty? _____ Sub-specialty? _____
D. Indicate the average number of: Patients seen per week: _____ Hours practiced per week: _____
If working 20 hours or less, reason for being part-time? _____
How long have you been part-time? _____

E. Licensing (List all states in which you are currently licensed.) _____

| State | Medical License Number | % of Practice | Federal DEA License Number & Status | Member of State Medical Association? |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |
| | | | | ☐ Yes ☐ No |

F. If you are a foreign graduate, are you certified by the Educational Commission for Foreign Medical Graduates? ☐ Yes ☐ No ☐ N/A

G. Are you American Board Certified? ☐ Yes ☐ No
   a. If "yes," list Specialty Board(s): _____ (Indicate allopathic or osteopathic)
   b. If "yes," list date of initial Board Certification: _____

H. Please indicate the number of Continuing Medical Education (CME) credit hours you have attained over the past 12 months: _____

## V. MEDICAL PROCEDURES INFORMATION

- ☐ Abortion, elective
- ☐ Acupuncture
- ☐ Anesthesia
  - ☐ Caudal
  - ☐ Local
  - ☐ Spinal
  - ☐ Other _____
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On own patients
  - ☐ On patients of others
- ☐ Bariatric Surgical procedures
  - ☐ Gastric banding
  - ☐ Gastric bubble
  - ☐ Gastric bypass
  - ☐ Gastric stapling
- ☐ Blepharoplasty
  - ☐ Cosmetic
  - ☐ Reconstructive
- ☐ Brazilian Butt Lift / Miami Thong Lift
- ☐ Breast Biopsy
- ☐ Breast Implants
- ☐ Breast Reduction
- ☐ Cardiac surgery
- ☐ Cataract surgery
- ☐ Chelation therapy
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Circumcision
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Cryosurgery, other than external lesions
- ☐ Dermatological procedures
  - ☐ Botox injection
  - ☐ Chemical peels
- ☐ D & C
- ☐ Dermatopathology
- ☐ Echocardiography
- ☐ Endoscopic laser therapy
- ☐ Endoscopy
  - ☐ Cystoscopy
  - ☐ Bronchoscopy
  - ☐ EGD
  - ☐ Gastroscopy
  - ☐ Hysteroscopy
  - ☐ Proctoscopy
  - ☐ Sigmoidoscopy
  - ☐ Other _____
- ☐ ERCP/ERC
- ☐ Exchange transfusion
- ☐ Facial plastic surgery
  - ☐ Elective cosmetic
  - ☐ Reconstructive
- ☐ Fluoroscopy
- ☐ Fracture Reduction
  - ☐ Closed
  - ☐ Open
- ☐ Hand surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip nailing
- ☐ Hospitalist
  Please complete the Hospitalist supplement.
- ☐ Hyperbaric medicine
- ☐ Hysterectomy
- ☐ Intensive care for newborns
- ☐ Intensive care medicine for adults
- ☐ Infertility treatment
  - ☐ Medical
  - ☐ In vitro fertilization
  - ☐ Other surgical
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ LASIK
- ☐ Left heart catheterization
- ☐ Liposuction
- ☐ Organ transplantation
- ☐ Orthopedic surgery
  - ☐ Including spinal surgery
  - ☐ Without spinal surgery
- ☐ Osteopathic manipulative medicine
- ☐ Pain management
  - ☐ Cordotomy
  - ☐ Dorsal root gangliotomy
  - ☐ Facet blocks
  - ☐ Medication only
  - ☐ Nerve root blocks
  - ☐ Pump implantation and removal
  - ☐ Rhizotomy
  - ☐ Sphenopalatine lesioning
  - ☐ Spinal injections
  - ☐ Thoracic sympathectomy
  - ☐ Trigeminal lesioning
  - ☐ Other _____
- ☐ Percutaneous vertebroplasty
- ☐ Pacemaker placement
- ☐ Polypectomy
- ☐ Prenatal care – 1st Trimester
- ☐ Prenatal care – 2nd Trimester
- ☐ Prenatal care – 3rd Trimester
- ☐ Prolotherapy
- ☐ Provertin retinal therapy
- ☐ Radiation therapy
- ☐ Radiopaque dye injection
- ☐ Roux-en-Y
- ☐ Sclerotherapy
- ☐ Spinal fusion
- ☐ Spinal surgery, other
- ☐ Thoracic surgery %_____
- ☐ Thyroidectomy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery/hormonal gender conversion
- ☐ Tubal ligation
- ☐ Vascular surgery %_____
- ☐ Vasectomy

| | | |
|---|---|---|
| ☐ Chemobrasion<br>☐ Collagen injection<br>☐ Dermabrasion<br>☐ Fat transfer<br>☐ Hair transplant<br>☐ Laser hair removal<br>☐ Laser skin resurfacing<br>☐ Microdermabrasion<br>☐ Silicone injection<br>☐ Other _____ | ☐ Tumescent<br>☐ Other _____<br>☐ Lithotripsy<br>☐ Mammography<br>☐ Mesotherapy<br>☐ Myelography<br>☐ Myomectomy %_____<br>☐ Neonatology | None of the above apply to my practice<br>(Initial) _____<br><br>Other procedures not listed above<br>(Please list)<br>_____<br>_____<br>_____ |

A. If applying for Obstetrical coverage, indicate:
   a. Average number of deliveries per year _____
      Percentage of high-risk deliveries _____
   b. Average number of VBAC deliveries per year _____
      What induction agents do you use on VBAC patients? _____
   c. Do you have privileges to perform C-sections at each hospital staff? ☐ Yes ☐ No
   d. If you employ a Nurse Midwife, how many deliveries does that individual perform annually? _____ ☐ N/A

B. Do you or will you staff an emergency room?
   a. If "yes," how many hours per week? _____
   b. If "yes," in what facilities or for what staffing company? _____
   c. Is this emergency room practice required solely to maintain hospital staff privileges? ☐ Yes ☐ No

## VI. ADDITIONAL PROFESSIONAL INFORMATION - If you answer "yes" to any of these questions please provide details.

A. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ☐ Yes ☐ No

B. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? ☐ Yes ☐ No

C. Have you ever been refused hospital privileges? ☐ Yes ☐ No

D. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? ☐ Yes ☐ No

E. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committees? ☐ Yes ☐ No

F. Have you ever been convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? ☐ Yes ☐ No

G. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? ☐ Yes ☐ No

H. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? ☐ Yes ☐ No
If yes, state conditions(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application.

Type(s) of Illness: _____

Date(s) of treatment(s): _____

Name of treating physician(s): _____

I. Have you ever been accused of sexual misconduct of any kind? ☐ Yes ☐ No

J. Have you or your practice been the subject of any billing or reimbursement inquiry Or investigation by any governmental agency, private health insurance payors or public Health insurance payors, including, but not limited to, Medicare or Medicaid? ☐ Yes ☐ No

K. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years? ☐ Yes ☐ No
If YES, please provide details: _____

L. Do you anticipate any changes in your specialty or practice activities (including the addition of new procedures) in the next year? ☐ Yes ☐ No
If YES, please provide details: _____

M. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty? ☐ Yes ☐ No

N. Do you provide medical services within the confines of any state, local or federal correctional facility, jail or prison? ☐ Yes ☐ No

O. Do you treat patients in a nursing home or similar facility? ☐ Yes ☐ No
If YES, how many patients do you treat there per month, on average? _____

Are you contracted with a facility or are these your own private practice patients? _____

P. Do you serve as a medical director of a hospital, nursing home, or other facility? ☐ Yes ☐ No
If YES, please complete a medical directorship supplement. _____
Do you wish to have coverage for this exposure? ☐ Yes ☐ No
If yes, please complete a Medical Director Supplement.
If yes, does the entity have coverage? ☐ Yes ☐ No

Q. Do you render care or perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as a medium for rendering medical services (i.e. teleradiology, telemedicine or internet medicine)? ☐ Yes ☐ No
If YES, please complete the telemedicine supplement form.

R. Do you treat patients in an addiction facility, sober living facility or similar facility? ☐ Yes ☐ No

S. Do you treat patients for Addiction Medicine - Outpatient Only? If yes, please complete Addiction Medicine supplement ☐ Yes ☐ No

T. Do you provide IV ketamine treatment to patients? ☐ Yes ☐ No

U. Do you provide Esketamine treatment to patients? ☐ Yes ☐ No
If yes, are these services provided in a healthcare setting and are patients monitored for at least two hours prior to being discharged? ☐ Yes ☐ No

V. Do you prescribe ketamine lozenges? ☐ Yes ☐ No
If yes, are ketamine lozenges prescribed via Telemedicine? ☐ Yes ☐ No

## VII. EDUCATIONAL INFORMATION (Complete Below or Attach CV)

### MEDICAL SCHOOLS

| NAME OF MEDICAL SCHOOL(S) ATTENDED | LOCATION OF SCHOOL(S) ATTENDED | DEGREE | DATE GRADUATED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING

| INSTITUTION | LOCATION | SPECIALTY OR DEPARTMENT | DATES (MONTH/YEAR) | | WAS THE TRAINING FULLY COMPLETED? |
|---|---|---|---|---|---|
| | | | START | END | |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

## VIII. PRACTICE LOCATIONS HISTORY

### PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY

| LOCATIONS | DATES (MONTH/YEAR) | |
|---|---|---|
| | START | END |
| | | |
| | | |
| | | |
| | | |

## IX. ENTITY COVERAGE

☐ If a Solo Practice: Name of your Corporate entity and/or DBA name: _____
Do you want coverage for the above entity? _____
What is the retroactive date for this current coverage?_____
When was the entity formed? _____
☐ If a Member of a partnership or multi-shareholder corporation / Partnership/Group Name: _____
_____
☐ Work as an Employee or Independent Contractor for Other - please explain and provide name of Entity/Practice you are working for: _____

## X. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS

A. List below any Ancillary or Allied Health Care Professionals associated with your practice:

| | Name | Specialty | Status | Shared Limits Coverage | Additional Information |
|---|---|---|---|---|---|
| 1 | | | ☐ Employee<br>☐ Contractor | ☐ Yes<br>☐ No | DOB _____<br>Year of Graduation _____<br>Years at Current Company _____<br>Years of Professional Experience _____<br>Hours Worked Per Week _____<br>Number of Patients seen Per Week _____ |
| 2 | | | ☐ Employee<br>☐ Contractor | ☐ Yes<br>☐ No | DOB _____<br>Year of Graduation _____<br>Years at Current Company _____<br>Years of Professional Experience _____<br>Hours Worked Per Week _____<br>Number of Patients seen Per Week _____ |
| 3 | | | ☐ Employee<br>☐ Contractor | ☐ Yes<br>☐ No | DOB _____<br>Year of Graduation _____<br>Years at Current Company _____<br>Years of Professional Experience _____<br>Hours Worked Per Week _____<br>Number of Patients seen Per Week _____ |
| 4 | | | ☐ Employee<br>☐ Contractor | ☐ Yes<br>☐ No | DOB _____<br>Year of Graduation _____<br>Years at Current Company _____<br>Years of Professional Experience _____<br>Hours Worked Per Week _____<br>Number of Patients seen Per Week _____ |
| 5 | | | ☐ Employee<br>☐ Contractor | ☐ Yes<br>☐ No | DOB _____<br>Year of Graduation _____<br>Years at Current Company _____<br>Years of Professional Experience _____<br>Hours Worked Per Week _____<br>Number of Patients seen Per Week _____ |

B. Do any of your employees practice at a location geographically separate from yours? ☐ Yes ☐ No
If "yes", please explain. _____

| **Had any of the above Allied Health Care Professional:** | | |
|---|---|---|
| 1 | Named in a suit or subject of disciplinary or investigatory proceeding or reprimand by an administrative or governmental agency? | ☐ |
| 2 | Had their insurance canceled, declined or refused to renew? | ☐ |
| 3 | Have been convicted of a felony? | ☐ |
| 4 | Have sought treatment for drug or alcohol addiction? | ☐ |
| 5 | Are aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any other named insured? | ☐ |
| 6 | Administer any anesthesia? | ☐ |
| 7 | Perform or assist in any surgical procedure? | ☐ |
| 8 | Work at any other company or location other than the one applying for this coverage? | ☐ |

## XI. HOSPITAL AFFILIATIONS AND PRIVILEGES

### HOSPITALS WHERE YOU HAVE, OR HAD, ACTIVE PRIVILEGES OR WHERE YOU HAVE APPLIED

| HOSPITAL DATA | | DATES (MONTH/YEAR) | | % OF YOUR PATIENTS ADMITTED TO THIS FACILITY | ISSUE CERTIFICATE OF INSURANCE |
|---|---|---|---|---|---|
| NAME | MAILING ADDRESS | START | END | | |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

## XII. PROFESSIONAL LIABILITY INSURANCE & CLAIMS HISTORY

| INSURANCE COMPANY NAME | # OF CLOSED CLAIMS | # OF PENDING CLAIMS | POLICY DATES | | RETROACTIVE DATE | TALL COVERAGE PURCHASED? |
|---|---|---|---|---|---|---|
| | | | FROM | TO | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

A. Has any insurance company ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? ☐ Yes ☐ No

B. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? (THIS INCLUDES ANY WHICH HAVE BEEN CLOSED or DISMISSED) ☐ Yes ☐ No
If "yes," how many? _____

C. Other than the claims/suits indicated in 12B, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit? If you respond YES to any of the below questions, then you must provide additional information.

| | | |
|---|---|---|
| i. A request for records from a patient and/or attorney related to an adverse outcome? | ☐ Yes | ☐ No |
| ii. A letter from an attorney regarding your medical treatment of a patient? | ☐ Yes | ☐ No |
| iii. Intra-operative or post-operative complications or any other type complications resulting in death, paralysis, other significant disability or the need for follow-up surgery? | ☐ Yes | ☐ No |
| iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? | ☐ Yes | ☐ No |
| v. Any other incidents or circumstances that might reasonably lead to a claim or suit? | ☐ Yes | ☐ No |

D. HAVE ALL INCIDENTS & CIRCUMSTANCES THAT MIGHT REASONABLY LEAD TO A CLAIM OR SUIT (even if you believe the possible claim or suit would be without merit) BEEN REPORTED TO YOUR CURRENT OR PREVIOUS PROFESSIONAL LIABILITY INSURANCE CARRIER? ☐ N/A ☐ Yes ☐ No

**IMPORTANT!!! Please note that a NO answer to question D indicates that you are aware of a potential CLAIM OR SUIT but have not yet reported it to your current insurance company. Using a separate page, please provide the name of the patient you are referring to along with a detailed narrative as to what transpired and the date that the incident in question took place.**

**I HEREBY REPRESENT THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT MY ANSWERS AND STATEMENTS WILL BE THE BASIS FOR DETERMINING MY INSURABILITY AND PREMIUM FOR THE PROFESSIONAL LIABILITY INSURANCE BEING APPLIED FOR. I FURTHER UNDERSTAND THAT THE COMPLETION AND SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE COMPANY TO COMPLETE THIS INSURANCE.**

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

**ACKNOWLEDGED AND AGREED:**

| Applicant Name (Printed) | Applicant Signature (Required) | Date Signed |
|---|---|---|

**PLEASE PROVIDE THE FOLLOWING WITH THE APPLICATION or AS SOON AS POSSIBLE AS THEY ARE ITEMS REQUIRED BY UNDERWRITERS IF WE ARE TO PROVIDE YOU WITH PROMPT SERVICE AND FASTER TURN AROUND TIME ON QUOTING – THANKS!**

**If you have the need to provide additional info or to elaborate on previous YES responses please do so in the space provided below:**

DOCTORS professional liability

## Supplemental Claims Information

1. Patient's name: _____
2. Date reported to insurance company: _____
3. Name of Insurance Company: _____
4. Date of incident and your treatment: _____
5. Allegations: _____

   _____

   _____
6. What is the present condition of the patient? _____

   _____
7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ Yes ☐ No
8. Status of claim (check applicable answer):

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgment in your favor

Court outcome in your favor:
☐ Jury verdict
☐ Directed verdict

Unresolved/Open Claim:
☐ Awaiting mediation
☐ Awaiting court action

☐ Suit settled out of court
a. Date claim paid:_____
b. Amount paid: _____
c. Did you want to settle this claim?
☐ Yes ☐ No

Court outcome in favor of plaintiff:
Jury verdict
Directed verdict
Amt. of loss payment:
_____

Reserve Amount:
_____

9. Name and address of the attorney assigned to your case: _____

   _____
10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ☐ Yes ☐ No
    If "yes", amount was _____
11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____

    _____

    _____

    _____

Signature: _____ Date: _____

Name(Printed): _____

23276 S. Pointe Dr. Suite 204 Laguna Hills , California 92653 * P 888-959-9456 * F 888-600-6280 * W www.DPLRRG.com

## Statement of No Claims / Losses

*(This statement must be completed, signed and returned with the completed application)*

My signature below confirms that:

1. The Insured has reviewed, or has had an opportunity to review, the proposed insurance Policy from the Company. All capitalized terms referenced herein shall have the same meaning afforded to them in the Policy.

2. The Insured has conducted a diligent search and investigation as part of completing this Statement of No Claims/Losses and represents and warrants to the Company the following:
    a. No Claims, Occurrences, facts, circumstances, or situations exist that have not been previously reported to the Insured's prior insurance carrier;
    b. No requests for medical records have been made to any Insured, which refer to a potential lawsuit, medical malpractice action, or pre-suit proceedings;
    c. No requests for medical records have been made to any Insured about which any Insured knew (or should have known) and could have reasonably foreseen that such request might be expected to be the basis of a Claim; and
    d. No prior insurance carrier has refused or denied coverage for any Claims made against any Insured for the previous five (5) years.

3. To the extent ANY of the above statements or representations contained in Section 2 are untrue or inaccurate, the Insured acknowledges and agrees that the Company may seek to rescind or cancel the Policy and/or that the Policy may not afford coverage for any Claim, Occurrence, fact, circumstance, or situation based on, arising out of, or in any way involving such untrue statements or representations, whether or not any Insured knew that the Application contained an untruthful or inaccurate disclosure.

4. The person signing this Statement of No Claims/Losses further represents and warrants to the Company the following:
    a. He / She is an authorized agent of the entity(ies) and/or individual(s) seeking insurance from the Company; and
    b. He / She is authorized to complete this Statement of No Claims/Losses on behalf of the entity (ies) and/or individual(s) seeking insurance from the Company.

_____ _____

Signature Date

_____

Name

## Waiver of Prior Acts Coverage, DPLRRG

This form must be completed ONLY if you are requesting 1st year/no prior acts coverage.

I acknowledge the need to purchase tail coverage (reporting endorsement) from my previous carrier where I was insured under a claims-made policy. I realize that my failure to purchase such coverage from my previous carrier will result in an uninsured exposure while insured by my previous carrier's policy. I understand that the policy which I am purchasing from Doctors Professional Liability, RRG will not provide prior acts coverage.

_____ _____

Signature Date

_____

Printed Name

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. Have you ever been named in 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 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 at 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 _____

23276 S. Pointe Dr. Suite 204 Laguna Hills , California 92653 * P 888-959-9456 * F 888-600-6280 * W www.DPLRRG.com