



APPLICATION FOR PRIOR ACTS COVERAGE

(Must Be Returned With the Professional Liability Application)

Name of Applicant: _____

Earliest Date of Prior Acts Coverage Requested: _____

At all time, from the date above, have you been continually covered by a claim-made policy? YES NO

If No, please explain: _____

In the last 24 months (or if retroactive date is more than 24 months), do you have knowledge of any unsatisfactory outcome or event?

If so, please complete one form for EACH unsatisfactory outcome or event

Patient's Name: _____

Date(s) of Treatment in question: _____

Outcome / Result: _____

I. Medical Care (Please Circle)

- A. Any patient(s) who had a significant injury resulting from your treatment? YES NO
- B. Any patient(s) who had any unexpected compromise to airway or neurovascular bundle that led to injury? YES NO
- C. Any patient(s) who had a poor result that was not expected and became angry at you? YES NO
- D. Any patient(s) who died unexpectedly while under your care? YES NO
- E. Any patient(s) who died unexpected respiratory or cardiac arrest? YES NO
- F. Any patient(s) who sustain a major organ failure (heart, lung, or kidney) not present at time of treatment was rendered? YES NO
- G. Any case(s) where a foreign body was retained? YES NO
- H. Any written or verbal contact from patient, family, attorney or other representative with a demand for money or service or other indication of an intent to file a claim, lawsuit or other complaint against you? YES NO

II. Surgical Care (Please Circle)

- A. Unexpectedly returned to the operating room during the same admission? YES NO
- B. Sustained an acute MI or CVA during or within 72 hours of elective surgery or other major diagnostic or therapeutic procedure? YES NO
- C. Patient with post operative care that led to permanent injury? YES NO

III. Obstetrical Care

- A. Any result that led to injury of the mother? YES NO
- B. Any result that led to injury of the infant? YES NO

C. Specially:

Cerebral palsy?	YES	NO
Mental Retardation?	YES	NO
Fracture?	YES	NO
Brachial Plexus?	YES	NO
DEATH(s)?	YES	NO

IV. Other, please explain: _____

Item 4

Has your practice changed in any way since the date noted in Item 2 (classification or procedure changed?)

Item 5

ATTACH A COPY OF THE MOST RECENT CLAIMS-MADE POLICY ISSUED TO YOU. This must contain the retroactive date noted in Item 2 above. If it does not, attach all policies pertaining to the continuous claims-made coverage which you have had back to the date stated in Item 2.

Item 6

If you require coverage for "Additional Insured" that were on prior policies, you must include any endorsements showing the type and name of those Additional Insured. This includes group coverage. Each proposed Additional Insured is subject to a separate underwriting decision.

Signature:

Date