

# Professional Liability Insurance Company of America

## NAME CHANGE ENDORSEMENT

Any reference in this Policy to Professional Liability Insurance Company of America is hereby changed and amended to Medical Liability Insurance Company of America. In Texas, Professional Liability Insurance Company of America shall be doing business solely as Medical Liability Insurance Company of America.

BY: Howard B. Nathans  
Howard B. Nathans  
President/CEO

Date: December 1, 2004

# PROFESSIONAL LIABILITY INSURANCE COMPANY OF AMERICA

## Physician Professional Liability Insurance Application

### I. GENERAL INFORMATION

**A.** \_\_\_\_\_  
 LAST NAME FIRST NAME MIDDLE NAME DEGREE  
 DATE OF BIRTH (M/D/Y) \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

**B. OFFICE LOCATIONS WHERE YOU PRACTICE (List Principal Location First)**

1. \_\_\_\_\_  
 SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY %OF PRACTICE

2. \_\_\_\_\_  
 SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY %OF PRACTICE

3. \_\_\_\_\_  
 SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY %OF PRACTICE

**C. HOSPITALS WHERE YOU PRACTICE. LIST PRINCIPAL LOCATIONS FIRST**

1. \_\_\_\_\_  
 HOSPITAL CITY STATE COUNTRY TYPE OF PRIVILEGES % OF PRACTICE

2. \_\_\_\_\_  
 HOSPITAL CITY STATE COUNTRY TYPE OF PRIVILEGES % OF PRACTICE

3. \_\_\_\_\_  
 HOSPITAL CITY STATE COUNTRY TYPE OF PRIVILEGES % OF PRACTICE

4. \_\_\_\_\_  
 HOSPITAL CITY STATE COUNTRY TYPE OF PRIVILEGES % OF PRACTICE

**D. HOME ADDRESS**

\_\_\_\_\_  
 SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY

**E. PREFERRED MAILING ADDRESS:**  OFFICE# \_\_\_\_\_  HOME  OTHER(BELOW)  
FROM B ABOVE

OTHER ADDRESS: \_\_\_\_\_  
 ( ) STREET ADDRESS ( ) CITY STATE ZIP  
 BUSINESS PHONE BUSINESS FAX E-MAIL ADDRESS

### II. EDUCATIONAL BACKGROUND

**A. MEDICAL SCHOOL**

\_\_\_\_\_  
 NAME OF SCHOOL CITY STATE COUNTRY DEGREE MM/DD/YY COMPLETED

IF FOREIGN MEDICAL SCHOOL GRADUATE:

ARE YOU CERTIFIED BY THE EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES OR HAVE YOU COMPLETED THE FIFTH PATHWAY PROGRAM?  YES  NO

**B. RESIDENCY: LIST ALL RESIDENT TRAINING LOCATIONS.**

IF YOU ARE CURRENTLY IN A RESIDENCY OR FELLOWSHIP PROGRAM, PLEASE ENTER YOUR ANTICIPATED RESIDENCY/FELLOWSHIP ENDING DATE HERE:  
 Your PLICA policy may be issued for less than one year in order to have the policy expiration month and day equal the residency ending month and day.

1. \_\_\_\_\_  
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

2. \_\_\_\_\_  
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

3. \_\_\_\_\_  
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

ADDITIONAL TRAINING (FELLOWSHIPS, ETC)

4. \_\_\_\_\_  
 NAME OF HOSPITAL STATE COUNTRY FROM (MM/DD/YY) TO (MM/DD/YY) TYPE COMPLETED

- C. ARE YOU ENTERING PRIVATE PRACTICE FOR THE FIRST TIME?  YES  NO
- D. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS?  YES  NO

If "yes", how many category 1 credit hours? \_\_\_\_\_

- E. HAVE YOU COMPLETED A RISK MANAGEMENT EDUCATION COURSE WITHIN THE PAST TWELVE (12) MONTHS?  YES  NO

- F. IF YOU ANSWERED YES, DID THE COURSE PROVIDE ALL THE FOLLOWING?

A minimum of three category 1 continuing medical education (CME) hours;  
Provide the CME hours through an approved national/regional medical education sponsor; and  
Strictly adhere to risk management (loss prevention) curriculum?  YES  NO

Please attach your completion (attendance) certificate from the CME program.

### III PRACTICE INFORMATION

- A. DO YOU PERFORM CONSULTATIONS, READ X-RAYS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE?  YES  NO

IF YES, WHICH STATE(S) \_\_\_\_\_

- B. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE (Use supplemental sheet if necessary)

1.STATE \_\_\_\_\_ LICENSE# \_\_\_\_\_ 2.STATE \_\_\_\_\_ LICENSE# \_\_\_\_\_

- C. PREVIOUS LOCATIONS OF PRACTICE. LIST MOST RECENT LOCATION FIRST

CITY	STATE	SPECIALTY	FROM MONTH/YEAR TO MONTH/YEAR

- D. TO WHICH STATE/LOCAL MEDICAL SOCIETIES OR ASSOCIATIONS DO YOU BELONG?
- \_\_\_\_\_

### IV. RATING INFORMATION

- A. WHAT IS YOUR PRESENT SPECIALTY? \_\_\_\_\_ SUB-SPECIALTY? \_\_\_\_\_

What percentage of your practice is devoted to your specialty? \_\_\_\_\_ Subspecialty? \_\_\_\_\_

- B. AMERICAN BOARD CERTIFIED?  YES  NO \_\_\_\_\_  
SPECIALTY BOARD DATE CERTIFIED
- IF NO, ARE YOU BOARD ELIGIBLE  YES  NO

IF YES, WHEN DO YOU PLAN ON TAKING YOUR BOARDS? \_\_\_\_\_

- C. INDICATE THE AVERAGE WEEKLY NUMBERS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE PLICA COVERAGE. (If you practice in multiple state, please identify the following information for each state.)

PATIENTS SEEN PER WEEK \_\_\_\_\_ HOURS PER WEEK \_\_\_\_\_ WALK-IN PATIENTS PER WEEK \_\_\_\_\_

Check box appropriate to practice:

- No surgery-permits incision of boils and superficial abscesses, or suturing of skin or superficial fascia
  - Minor surgery- and/or assisting in major surgery on own patients-includes minor obstetrical procedures, D & C's vasectomies, or any minor operation done under local anesthesia
  - Major surgery- includes any operation done under general anesthesia, including tonsillectomies, adenoidectomies, caesarean sections, and assisting in major surgery patients other than your own (major surgery does not include D&C's)
- List the surgical procedures you perform in your office or non-hospital facility:

Are you permanently retired from the practice of clinical medicine?  YES  NO

**D. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU WILL PERFORM:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> ABORTIONS                                 | <input type="checkbox"/> LAPAROSCOPIC CHOLECYSTECTOMY | <input type="checkbox"/> BIOPSY (ENDOSCOPIC)                               |
| <input type="checkbox"/> ACUPUNCTURE                               | <input type="checkbox"/> LAPAROSCOPY                  | <input type="checkbox"/> PERITONEOSCOPY                                    |
| <input type="checkbox"/> THERAPEUTIC/LOCAL ANESTHETIC              | <input type="checkbox"/> LASER SURGERY                | <input type="checkbox"/> LASER THERAPY (ENDOSCOPIC)                        |
| <input type="checkbox"/> GENERAL ANESTHETIC                        | <input type="checkbox"/> LIPOSUCTION                  | <input type="checkbox"/> PACEMAKERS UNDER GENERAL ANESTHESIA               |
| <input type="checkbox"/> ANGIOGRAPHY                               | <input type="checkbox"/> LYMPHANGIOGRAPHY             | <input type="checkbox"/> SILICONE INJECTIONS                               |
| <input type="checkbox"/> ANGIOPLASTY                               | <input type="checkbox"/> LITHOTRIPSY                  | <input type="checkbox"/> SKIN FLAP/GRAFTS                                  |
| <input type="checkbox"/> ARTHROSCOPY                               | <input type="checkbox"/> MAJOR GYNECOLOGICAL SURGERY  | <input type="checkbox"/> COSMETIC _____ %OF PRACTICE                       |
| <input type="checkbox"/> ARTERIOGRAPHY                             | <input type="checkbox"/> MYELOGRAPHY                  | <input type="checkbox"/> RECONSTRUCTION _____ %OF PRACTICE                 |
| <input type="checkbox"/> ASSISTING IN MAJOR SURGERY                | <input type="checkbox"/> NEEDLE BIOPSY                | <input type="checkbox"/> SWAN-GANZ CATHETERIZATION                         |
| <input type="checkbox"/> OWN PATIENTS ONLY                         | <input type="checkbox"/> NERVE BLOCKS                 | <input type="checkbox"/> TUBAL LIGATIONS                                   |
| <input type="checkbox"/> OWN & OTHER THAN OWN PATIENTS             | <input type="checkbox"/> LUMBAR EPIDURAL STEROID      | <input type="checkbox"/> VASECTOMIES                                       |
| <input type="checkbox"/> BLEPHAROPIGMENTATION                      | <input type="checkbox"/> PARASPINAL                   | <input type="checkbox"/> ON OWN PATIENTS                                   |
| <input type="checkbox"/> BLEPHAROPLASTY-BROW LIFTS                 | <input type="checkbox"/> SCIATIC                      | <input type="checkbox"/> ON OTHER THAN OWN PATIENTS                        |
| <input type="checkbox"/> COSMETIC _____ % OF PRACTICE              | <input type="checkbox"/> FACET                        | <input type="checkbox"/> WEIGHT CONTROL THERAPY/SURGERY _____ %OF PRACTICE |
| <input type="checkbox"/> RECONSTRUCTION _____ % OF PRACTICE        | <input type="checkbox"/> PARAVERTEBRAL                | <input type="checkbox"/> MEDICATION-WEIGHT CONTROL                         |
| <input type="checkbox"/> BREAST IMPLANTS                           | <input type="checkbox"/> PERIPHERAL                   | <input type="checkbox"/> GASTRIC BUBBLE                                    |
| <input type="checkbox"/> COSMETIC _____ %OF PRACTICE               | <input type="checkbox"/> MYOFASCIAL                   | <input type="checkbox"/> GASTRIC STAPLING                                  |
| <input type="checkbox"/> RECONSTRUCTION _____ %OF PRACTICE         | <input type="checkbox"/> OCCIPITAL                    | <input type="checkbox"/> OTHER WEIGHT CONTROL PROCEDURES                   |
| <input type="checkbox"/> BRONCHOSCOPY                              | <input type="checkbox"/> TRIGGERPOINT INJECTION       | <input type="checkbox"/> PRENATAL PRACTICE                                 |
| <input type="checkbox"/> CATARACT SURGERY                          | <input type="checkbox"/> PHLEBOGRAPHY                 | <input type="checkbox"/> SEE PATIENTS DURING THE FIRST & SECOND TRIMESTER  |
| <input type="checkbox"/> CRYOSURGERY (OTHER THAN EXTERNAL LESIONS) | <input type="checkbox"/> PNEUMOENCEPHALOGRAPHY        | <input type="checkbox"/> SEE PATIENTS TO TERM BUT DO NOT PERFORM DELIVERY  |
| <input type="checkbox"/> ERCP                                      | <input type="checkbox"/> RADIAL/LASER KERATOTOMY      | <input type="checkbox"/> SEE PATIENTS TO TERM AND PERFORM DELIVERY         |
| <input type="checkbox"/> PHENOL FACIAL PEEL                        | <input type="checkbox"/> RADIATION/X-RAY THERAPY      | <input type="checkbox"/> NORMAL OBSTETRICAL DELIVERIES                     |
| <input type="checkbox"/> DIAGNOSTIC EMBOLIZATION                   | <input type="checkbox"/> RADIOPAQUE DYE               | <input type="checkbox"/> HOW MANY PER YEAR? _____                          |
| <input type="checkbox"/> GENERAL/SPINAL/CAUDAL ANESTHESIA          | <input type="checkbox"/> NON-TOXIC ONLY               | <input type="checkbox"/> CESAREAN SECTION                                  |
| <input type="checkbox"/> PULSE OXIMETRY                            | <input type="checkbox"/> SHOCK THERAPY                | <input type="checkbox"/> HOW MANY PER YEAR? _____                          |
| <input type="checkbox"/> END TIDAL CO <sup>2</sup> ANALYZER        | <input type="checkbox"/> SIGMOIDOSCOPY                | <input type="checkbox"/> OTHER MEDICAL TECHNIQUES                          |
| <input type="checkbox"/> HAIR TRANSPLANTS                          | <input type="checkbox"/> LESS THAN 60 CM              | LIST PROCEDURES _____  |
| <input type="checkbox"/> SCALP EXCISION/TRANSPLANTATIONS           | <input type="checkbox"/> GREATER THAN 60 CM           | _____  |
| <input type="checkbox"/> PLUG TECHNIQUE/MINIGRAPH                  | <input type="checkbox"/> COLONOSCOPY                  | _____  |
|  | <input type="checkbox"/> POLYPECTOMY                  | _____  |
|  | <input type="checkbox"/> GASTROINTESTINAL ENDOSCOPY   | _____  |

**E. INDICATE THE PERCENTAGE OF YOUR SURGICAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES:**

_____ % PLASTIC (RECONSTRUCTION ONLY)	_____ % THORACIC	_____ % ORTHOPEDIC (INCLUDING BACK)
_____ % PLASTIC (COSMETIC ENHANCEMENT ONLY)	_____ % CARDIAC	_____ % ORTHOPEDIC (NOT INCLUDING BACK)
_____ % TRAUMATIC	_____ % OBSTETRIC	_____ % OTHER (DESCRIBE) _____

**F. IN THE LAST TEN (10) YEARS,**

1. Have you discontinued major surgical procedures?  YES  NO  
If yes, list procedures and date discontinued \_\_\_\_\_
2. Have you performed weight control surgery or prescribed weight control medication?  YES  NO
3. If Yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs  
 <1%     1%-10%     11%-50%     >50%
4. If Yes, what percentage of your practice (% of patient care) was devoted to performing weight control surgery?  
 <1%     1%-10%     11%-50%     >50%
5. Do you have ownership interests in a weight control clinic?  YES  NO
6. If Yes, what is the name of the weight control clinic with which you are affiliated: \_\_\_\_\_



J. PLEASE USE THE SPACE BELOW FOR ANY COMMENTS YOU FEEL WILL HELP THE PROFESSIONAL LIABILITY INSURANCE COMPANY OF AMERICA BETTER UNDERSTAND ANY SPECIAL CIRCUMSTANCES CONCERNING YOUR PRACTICE \_\_\_\_\_

**V. ADDITIONAL PROFESSIONAL INFORMATION**

**A. PLEASE FULLY EXPLAIN ANY "YES" ANSWER ON THE SUPPLEMENTAL FORM:**

- 1. Do you perform surgery on professional athletes?  YES  NO  
If Yes, what percentage of your professional athletes? \_\_\_\_\_ %
- 2. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?  YES  NO  
If Yes, include a copy of the indemnification agreement provided by the pharmaceutical company. (if you are covered by other insurance for this activity, please complete Section IV I)
- 3. Do you treat or review treatment of Federal prison inmates?  YES  NO
- 4. Do you treat non-federal prison inmates?  YES  NO  
If Yes, what percentage of your practice is devoted to treating non-federal inmates? \_\_\_\_\_ %
- 5. Do you use a collection agency which has the authority to file collection suits without your knowledge?  YES  NO
- 6. Do you practice as a Medical Director at a blood bank?  YES  NO
- 7. Do you devise or review plant/employer safety standards?  YES  NO  
(1) What products are manufactured by the company? \_\_\_\_\_  
(2) Company Name \_\_\_\_\_ Location \_\_\_\_\_
- 8. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license, or Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?  YES  NO  
If Yes, please indicate the date(s): \_\_\_\_\_
- 9. Have you incurred or become aware of having a condition that impairs your ability to practice your medical specialty?  YES  NO  
(e.g. convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, addiction of alcohol, narcotics or other controlled substances, etc.)  
If Yes, state condition, date(s) and identify your treating physician in the space below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your speciality must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type	Duration	Treating Physician (Name & Address)
10. Have you had a State medical license or Federal narcotics license revoked, restricted, limited, denied, suspended, subject to probationary conditions, voluntarily relinquished or otherwise sanctioned?		<input type="checkbox"/> YES <input type="checkbox"/> NO
11. Have you had a complaint filed against you by any State Board of Medicine?		<input type="checkbox"/> YES <input type="checkbox"/> NO

**B. PRACTICE ORGANIZATION:**

Please check the boxes that best describes your practice affiliation(s): ("X" applicable boxes under B1 and B2).

**B1. Employment status:**

- Employee
- Shareholder/Partner
- Independent Contractor
- Solo Unincorporated/Sole Proprietor
- Other: \_\_\_\_\_

**B2. Entity Type:**

- Multi-Shareholder Corporation, Partnership, Limited Liability Company
- Solo Incorporated-No employed or contracted physicians
- Hospital
- Government
- Industrial
- Other- Please explain: \_\_\_\_\_

**C. NAME OF YOUR PARTNERSHIP, PROFESSIONAL CORPORATION OR ASSOCIATION:**

**D. IS THIS ENTITY OR EMPLOYER CURRENTLY INSURED BY ANOTHER MEDICAL PROFESSIONAL LIABILITY COMPANY?**  YES  NO

If Yes, please provide a copy of the Policy Declarations Page.

**E. IF THE BUSINESS PURPOSE OF THE ENTITY IS OTHER THAN A MEDICAL OFFICE PRACTICE, PLEASE EXPLAIN:**

- F. DO YOU DESIRE COVERAGE FOR THIS ENTITY?  YES  NO  
 Indicate below whether you want to share your policy limits with this entity, or desire separate limits for the entity.  
 Separate limits only available if entity is not a Solo Corporation.  
 separate limits  shared limits

**VI. LOSS INFORMATION (IMPORTANT ! COMPLETE FULLY)**  
 COMPLETE AND ATTACH A CLAIM FORM FOR EACH SUCH CLAIM, POTENTIAL CLAIM OR SUIT

- A. Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services?  YES  NO  
 If "Yes", how many? \_\_\_\_\_  
 If "Yes", have these been reported to your insurer?  YES  NO
- B. Do you have knowledge of any incident, claim, circumstance, unexpected result, potential claim or suit in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to claim?  YES  NO  
 If "Yes", how many? \_\_\_\_\_  
 If "Yes", have these been reported to your insurer?  YES  NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE A COPY OF THE REPORT(S).

**VII. CLAIM/SUIT INFORMATION FORM (Please make copies if additional forms are needed)**

If making additional copies, please enter applicants name here:

NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED BY THE UNDERWRITING DEPARTMENT.

1. Patient/Claimant Information-Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender \_\_\_\_\_  Male  Female
2. Date of treatment and/or surgery, which led to the allegations against you: \_\_\_\_\_
3. Date claim/incident notice received (MM/YY): \_\_\_\_\_
4. Date claim reported to prior insurer (MM/YY): \_\_\_\_\_
5. Name of other doctor(s), hospital(s), or health care provider(s), if any, involved in the claim or suit: \_\_\_\_\_
6. Disposition or current status of claim or suit:  Open  CLOSED Date of Closing/Settlement or award (MM/YY): \_\_\_\_\_
7. Indicate case value established by carrier, if known (in\$): \_\_\_\_\_
8. Defending Insurance carrier name: \_\_\_\_\_
9. Claim file number, if known: \_\_\_\_\_
10. Was this matter closed with your consent?  YES  NO  
 Was a suit filed?  YES  NO  
 Was a payment made?  YES  NO  
 If no, was claim or suit withdrawn?  YES  NO  
 If Yes, indicate total amount of settlement or award (in\$) : \_\_\_\_\_  
 Amount paid on your behalf (in\$) : \_\_\_\_\_
11. Nature of allegations in the claim or suit:  
 Conditions treated: \_\_\_\_\_  
 Treatment provided: \_\_\_\_\_  
 Alleged Negligence: \_\_\_\_\_  
 Alleged injury: \_\_\_\_\_
12. Please provide a narrative description of the medical facts: (must include, but not limited to the type of treatment and/or surgery; your involvement) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**VIII. COVERAGE INFORMATION**

**A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS. LIST CURRENT INSURER FIRST. (Use a supplemental sheet if needed).**

1. \_\_\_\_\_  OCCURRENCE / / TO / /  
 INSURER  CLAIMS-MADE

2. \_\_\_\_\_  OCCURRENCE / / TO / /  
 INSURER  CLAIMS-MADE

3. \_\_\_\_\_  OCCURRENCE / / TO / /  
 INSURER  CLAIMS-MADE

**B. COVERAGE DESIRED**

Claims-made Coverage with Prior Acts Coverage.  
 (A copy of current declaration page showing current retroactive date must be attached).

Claims-Made Coverage without Prior Acts Coverage.

An extended reporting period endorsement (tail coverage) has been purchased (copy of tail is attached).

An extended reporting period endorsement has not and will not be purchased.

I will not purchase tail coverage (reporting period endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise in the future as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am purchasing from Professional Liability Insurance Company of America will not provide prior acts coverage. Initial Here:

Claims-made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between claim-made and occurrence coverage or the additional expense associated with an "extension contract or "tail coverage".

**C. REQUESTED COVERAGE EFFECTIVE DATE** From: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 12:01a.m.  
 This date cannot be earlier than the expiration date of your current policy. MONTH DAY YEAR

Annual policy terms will begin and end on the same month and day. To: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 12:01a.m.  
 MONTH DAY YEAR

**D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 12:01 a.m.  
 MONTH DAY YEAR

**E. IF YOU PRACTICE IN THE FUND STATES OF INDIANA, KANSAS LOUISIANA, NEBRASKA, NEW MEXICO, PENNSYLVANIA OR WISCONSIN, PLEASE INDICATE YOUR CURRENT FUND RETROACTIVE DATE IF DIFFERENT THAN THE RETROACTIVE DATE STATED ABOVE:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 12:01a.m.  
 MONTH DAY YEAR

Are you aware of any gaps in your Fund coverage?  YES  NO  
 If Yes, please provide the exact date and written explanation:

**F. LIMITS DESIRED** \_\_\_\_\_ per claim  
 \_\_\_\_\_ annual aggregate

**IX. ASSIGNMENT OR RIGHT TO CANCEL COVERAGE**

I assign to my employer both the right to cancel my policy and the return of any unearned premium due to policy changes for which my employer has paid the premium (e.g.termination of coverage, limit decrease, etc). However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last known address of record.

This may be revoked by me at any future time by sending written notice to the Professional Liability Insurance Company of America's Home Office, 10 S. Brentwood, St. Louis, MO 63105, Suite # 500.

Initial Here



