



**APPLICANT’S AUTHORIZATION AND CERTIFICATION**

I authorize the release of all information to **CARE Risk Retention Group** (hereafter “**CARE**”) from any medical school or hospital where I have received training; any person(s) who has information concerning my fitness to practice, including persons with whom I received training; any hospital at which I have applied for privileges, whether those privileges were granted or not; past and present medical associations, societies, specialty boards and any regulatory body granting me a license to practice medicine in any state, any insurance company to which I have applied for medical malpractice coverage, whether such coverage was granted or not; and any employer for whom I performed medical services, whether as an employee or an independent contractor.

I understand that information requested by **CARE** may include, but not necessarily be limited to, any occurrence, incident, claim or suit in which I may be or may have been involved; any denial, suspension, revocation, or disciplinary investigation, recommendation or action relating to staff privileges at a hospital, clinic, employer or any other person connected with my providing medical services; any disciplinary action taken by any medical licensing authority; or any action of a civil or criminal nature taken against me that resulted from or was alleged to have been a part of my professional activities. I understand that the information will be used in addition to my application in determining whether **CARE** will issue insurance to me.

I agree that the persons providing the information and their agents, directors, employees, shall not incur any liability as a result of any information released in good faith pursuant to this authorization including any errors, omissions or mistakes contained in such information.

I understand that this is an application for insurance, and shall not bind **CARE** to the issuance, nor shall it bind me to the acceptance of a policy.

Any person, who intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files for an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony in the third degree.

**I HEREBY CERTIFY THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT: (1) IF THE POLICY IS ISSUED, THIS IS DONE BY CARE IN RELIANCE UPON THESE REPRESENTATIONS, AND (2) ANY POLICY OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION IS VOID.**

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SIGNATURE OF APPLICANT

\_\_\_\_\_  
DATE OF SIGNATURE

\_\_\_\_\_  
PLEASE PRINT FULL NAME

\_\_\_\_\_  
SOCIAL SECURITY NUMBER