APPLICATION FOR PRIOR ACTS COVERAGE
(MUST BE RETURNED WITH THE PROFESSIONAL LIABILITY APPLICATION)

PLEASE PRINT OR TYPE

Item 1. Name of Applicant: ______________________________

Item 2. Earliest Date of Prior Acts Coverage Requested: ______________________________

At all times, from the date above, have you been continuously covered by a claims-made policy? __________

If "No", please explain: ______________________________

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Item 3. 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: ______________________________

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

II. Surgical Care	Yes	No
A. Unexpectedly returned to the operating room during the same admission?		
B. Sustained an acute MI or CVA during or within 72 hours of elective surgery or other major diagnostic or therapeutic procedure?		
C. Patient with post operative course that led to permanent injury?		

III. Obstetrical Care	Yes	No
A. Any result that led to injury of the mother?		
B. Any result that led to injury of the infant?		
C. Specifically:		
Cerebral palsy?		
Mental retardation?		
Fractures?		
Brachial plexus?		
DEATH(S)?		

IV. Other, please explain: ______________________________

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Item 4: Has your practice changed in any way since the date noted in Item 2 (classification or procedure changes)?

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If "yes", please specify: ______________________________

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

If the limits of liability under your prior claims-made policy was less than that for which you are applying for hereunder, the lower limits applies.

Please understand that there may be differences in coverage between that provided by your previous carrier(s) and the coverage applied for hereunder. Only those items covered under the Policy will be covered under a prior acts endorsement.

I declare that I know of no potential or actual claims, suits or incidents presently pending which have not been reported to my previous carrier(s). I understand that "Carrier" also means "Insurer".

I understand that this is only an application for Prior Acts Coverage and not a guarantee of coverage. **UNDER NO CONDITION WILL PRIOR ACTS BE COVERED WITHOUT THE RETURN OF THIS APPLICATION AND A PROPERLY EXECUTED ENDORSEMENT.**

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I UNDERSTAND THAT IF PRIOR ACTS COVERAGE IS OBTAINED BY FRAUD, MATERIAL MISREPRESENTATION OR OMISSION, IT IS VOID.

I FURTHER WARRANT THAT I HAVE LISTED ALL INCIDENTS, AND UNFAVORABLE OR ADVERSE RESULTS KNOWN TO ME, OR OF WHICH I SHOULD HAVE BEEN AWARE, WHICH WOULD ARISE FROM MY ACTS OR OMISSIONS WHICH HAVE OCCURRED WITHIN THE LAST TWENTY-FOUR (24) MONTHS, OR SINCE THE REQUESTED RETROACTIVE DATE, IF MORE THAN TWENTY-FOUR MONTHS. I FURTHER WARRANT THAT I HAVE NOT WITHHELD ANY INFORMATION THAT IS REASONABLY LIKELY TO INFLUENCE THE JUDGMENT OF THE COMPANY IN CONSIDERING MY REQUEST FOR PRIOR ACTS COVERAGE. I FULLY UNDERSTAND THAT ANY INCIDENTS, OR UNFAVORABLE OR ADVERSE RESULTS WHICH ARE OR SHOULD BE KNOWN TO ME AND WHICH CAN REASONABLY BE EXPECTED TO RESULT IN A CLAIM WILL NOT BE COVERED, WHETHER LISTED ON THIS FORM OR NOT.

DATE: ______________________ SIGNATURE: ______________________________