PHYSICIANS AND SURGEONS
PROFESSIONAL LIABILITY INSURANCE APPLICATION

You are applying for coverage under *Conventus*' claims-made policy. If your application is accepted by *Conventus*, the insurance is limited to matters described in the policy which arise out of events described in the policy occurring on or after the retroactive date in the applicable policy declaration issued to you, AND are first reported by you to *Conventus* either prior to termination of this policy or within any policy period or additional reporting period applicable to you.

Conventus

Inter-Insurance Exchange

900 Route 9 North, Suite 503, Woodbridge, New Jersey 07095

Phone: (800) 446-7647 **Fax: (732) 634-2904**

www.conventusnj.com

PHYSICIANS AND SURGEONS
PROFESSIONAL LIABILITY INSURANCE APPLICATION

Section I – General Information (Please type or print clearly)

1. Name and Address of Applicant:
   ❒ MD ❒ DO
   ____
   ____
   ____
   ____
   ____
   ____

   Contact Person: ______________________
   Phone: ______________________
   Fax: ______________________
   E-Mail: ______________________

2. Name of Practice Group (if applicable):
   ____
   ____
   ____
   ____
   ____
   ____

   Total # of Physicians in Group: ______________________

   Website Address of Practice: ______________________

3. Birth Date: ______________________

4. NJ License Number: ______________________

5. Gender: Male ______ Female ______

6. Federal E. I. N.: ______________________

7. Type of practice (check all that apply):
   ❒ Employee
   ❒ Professional association
   ❒ Partnership
   ❒ Sole proprietor/unincorporated
   ❒ Independent contractor
   ❒ Limited liability corporation
   ❒ Solo corporation (Name) ______________________
   ❒ Principal in a professional corporation
   ❒ Other (describe) ______________________

Section II - Medical Education and Training

8. Primary Specialty (please list all that apply): ______________________ % of practice: ______________________

   Sub-specialty (please list all that apply): ______________________ % of practice: ______________________

9. Does your practice include (circle all that apply): Surgery Minor Surgery No Surgery

10. Do one or more boards of the American Board of Medical Specialties currently certify you?
    Please list: ______________________
    If not, are you Board eligible? ❒ Yes ❒ No

11. Have you ever been denied Board certification? ❒ Yes (provide details) ❒ No

12. Name(s) of medical school(s):

Medical School	City	State/Country	Graduation date
If a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates? ❒ Yes ❒ No			
If Yes, date certified:	If No, please explain:		

13. All internship/residency training undertaken and dates, whether completed or not:

Location	Specialty	Mo/Yr Completed
Served internship at:		
Served residency at:		
Served fellowship at:		

14. Have you participated in any risk management or professional liability claims prevention courses over the past 24 months?
❐ Yes ❐ No

If Yes, please specify topic and date:____

15. Has your staff participated in any risk management or professional liability claims prevention courses over the past 24 months?
❐ Yes ❐ No

If Yes, please specify topic and date:____

Section III - Insurance Coverage Information

16. Limits of Liability requested (check one)
❐ $1,000,000/$3,000,000 ❐ $2,000,000/$4,000,000
❐ Other, please specify limits desired____________________________

17. Is Prior Acts coverage requested? ❐ Yes ❐ No
(If Yes, please attach a copy of your current policy's declaration page and complete the Supplemental Prior Acts Application)

18. Requested effective date: ____

Requested retroactive date:____

Section IV – Insurance Information – Current and Previous

19. Name of present insurance carrier:__________________________ Expiration date:__________________

a. Type of present policy (attach copy of declarations page from present policy)

❐ Occurrence Plus (Modified Claims-made) ❐ Occurrence
❐ Claims-made Tail Purchased? ❐ Yes ❐ No

20. List all carriers that have previously provided insurance :

Company Name	Policy #	Coverage Dates		Occurrence/Occurrence Plus/Claims-Made	Retro Date
		Effective	Expire		

Section V - Scope and Nature of Practice or Employment

21. List all locations where you work. (Mail will be sent to address #1 below unless otherwise indicated)

Employer/Facility Name	Street	City	County	State	Zip	Phone
#1						
#2						
#3						

22. Do you have ownership in any medical facility other than your office practice such as a surgi-center, urgent care center, etc.?
❐ Yes ❐ No (If Yes, and it is not covered by this insurance, please provide evidence of insurance)

23. Please indicate (if applicable) total hours worked per week and month at each office location for the following activities:

		Location #1		Location #2		Location #3	
		WK	MO	WK	MO	WK	MO
A	Actual patient care, including record keeping and hospital rounds						
B	Administrative duties						
C	Surgeries and assists						
D	House calls and nursing home visits						
E	Utilization review						
F	Teaching						

________% of patients seen through managed care contracts ________% of patients fee for service or indemnity insurance

24. Please indicate the **percentage** of your surgical practice, if any, that involve the following types of major surgery:

%		%	
	Abdominal		Ophthalmological
	Bariatric		Orthopedic – including spinal surgery
	Cardiac		Orthopedic – without spinal surgery
	Colon/Rectal		Plastic – Cosmetic
	General		Plastic – Reconstructive
	Gynecologic		Thoracic
	Hand		Traumatic
	Head and neck		Urologic
	Neurosurgical		Vascular

25. Please indicate below your best estimate of the **number** of the following procedures you expect to perform, or in which you will participate, in the next 12 months, beginning with the date of your requested coverage (use additional sheet for description).

# of Procedures	**Procedure**
	Abortion – first trimester
	Hospital
	Clinic
	Office
	Abortion – after first trimester
	Hospital
	Clinic
	Office
	Acupuncture
	Adenoidectomy
	"Alternative medicine" or "complementary medicine" procedures (as viewed by most physicians) Please describe:
	Anesthesia – obstetrical
	General
	Spinal
	Epidural
	Anesthesia – non-obstetrical
	General
	Spinal
	Epidural
	Anesthesia (other) - Please describe:

# of Procedures	Procedure
	Angiography
	Angioplasty
	Arteriography
	Assisting in major surgery – own patients
	Assisting in major surgery – other than own patients
	Breast implants
	Breast reduction
	Catheterization
	Cardiac
	Arterial
	Other – Please describe:
	Chelation therapy
	Chemabrasion
	Chemical Peel
	Chemotherapy
	Colonoscopy
	Cosmetic implantation or injection of silicone or other materials – Please describe:
	Cryosurgery – Please describe:
	D & C's
	Deliveries
	Cesarean
	Vaginal after Cesarean
	Discograms
	Electromyography
	Endoscopy (other than proctoscopy or sigmoidoscopy) Please describe:
	Experimental or investigative procedures, (please attach protocol used and state whether or not you follow FDA guidelines in administering this)
	Eyeliner pigmentation
	Fracture reductions – closed
	Fracture reductions – open
	Hair transplants, or other hair growing or replacement techniques
	Hemorrhoidectomy:
	Internal
	External
	Herniorrhaphy
	Laparoscopy:
	Diagnostic – Please describe:
	Surgical – Please describe:
	Laser Surgery – Please indicate type of surgery:
	Liposuction
	Lumbar puncture
	Manipulation therapy
	Myelography
	Needle aspirations
	Needle biopsy

# of Procedures	Procedure
	Office surgery OTHER THAN superficial suturing of skin, incision and drainage, or removal of warts, moles and sebaceous cysts – Please indicate type of surgery:
	Pacemaker insertion
	Pre-natal care
	Radical keratotomy
	Radiation
	Diagnostic
	Therapeutic
	Sclerotheraphy
	Shock therapy
	Spinal surgery
	Tattoo removal
	Thoracentesis
	Tonsillectomy
	Total joint replacements
	Tubal ligations
	Vasectomy
	Venography
	Weight control by means other than diet or exercise – Please describe:
	Any other procedure you reasonably believe will be of interest to a medical professional liability insurer Please describe:
	I DO NONE OF THESE PROCEDURES (Please Initial)

26. Have you made any changes to your practice in the past 10 years, such as change in specialty or services offered, etc.?

❒ Yes ❒ No If Yes, please describe:________________

27. If you are employed by someone else, please answer the following:

a. Name of employer ________________

b. Name of employer's professional liability insurer ________________
(if your employer is to pay the premium for your coverage, please complete Appendix A)

28. List all facilities and hospitals where you have staff or courtesy privileges.

Facility Name and Location	Department	Type of Privileges	Dates From/To

29. List all locations where you have practiced since formal training. Please explain any period(s) of inactivity. Attach explanatory sheet if necessary. If available, please attach your CV.

Location (city and state)	Dates From/To

30. List all states in which you are licensed or have been licensed and information on that state license if applicable:

State	License #	DEA #	Active Y/N	% of Patients	% of Hospital Proc.	% of Income	% of Office Hours

31. Please indicate the number of people you employ by the following categories (if you have a Corporation, please skip this question and provide the information on Appendices B and C):

	Lab or X-Ray technicians		Nurse practitioners*
	Medical assistants		Physicians or surgeons**
	Nurses		Physician assistants*
	Nurse anesthetists*		Surgical assistants*
	Nurse midwives*		Other (Please specify)

* a Non-Physician Health Care Provider Application must be completed for each person in this category.
** a Health Care Professional Application must be completed for each person in this category.

32. How many employees have left your practice in the past 3 years?________________________________

33. Do you have a position for which no coverage is required, or for which you are insured with another carrier?
❒ Yes ❒ No
(If Yes, indicate activity, entity and location to be excluded and indicate hours worked at this position only)

____

____

____

Section VI – Practice and Procedures – General Questions

34. a. Do you perform surgery in your office? ❐ Yes ❐ No

If Yes, please list the specific procedures: ______________________________

b. Is general anesthesia administered for these (or any) office procedures? ❐ Yes ❐ No

If Yes, by whom, and with what training? ______________________________

35. What specific emergency equipment do you have available? ______________________________

36. How far is this location from the nearest hospital with emergency services? ______________________________

37. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office?
❐ Yes ❐ No

38. Do you work in an emergency room? ❐ Yes ❐ No

If Yes, how many hours on average per week _______________ and for what institution? ______________________________
If coverage is to be provided by a carrier other than *Conventus*, please provide evidence of that other coverage

39. If you perform cosmetic plastic surgery, please list on a separate sheet all of the procedures you perform. Also, please attach a copy of all advertising materials related to cosmetic plastic surgery.

40. Do you provide any services over the internet or through a telemedicine program? ❐ Yes ❐ No

41. Regarding collection procedures:
   a. Do you have written protocol for handling collection problems with your patients? ❐ Yes ❐ No

   b. If you utilize collection agencies, have you specified, in writing, the specific circumstances under which legal action may be taken against your patients? ❐ Yes ❐ No

   c. Are your patients clearly informed, in writing, of your billing procedures and collection policies and do they understand their rights if they choose to dispute a charge? ❐ Yes ❐ No

42. Have you introduced any new technology into your office practice during the past 3 years such as computerized medical records, voice data recording, computerized order entry technology, or any other automation surrounding patient care and record keeping?
❐ Yes ❐ No

43. Do you participate in any patient satisfaction surveys or studies conducted by any managed care provider or do it on your own?
❐ Yes ❐ No

Section VII – Professional History

44. Are you in military service or employed full-time by the federal government? ❐ Yes ❐ No

45. Do you work for a correctional facility (jail)? ❐ Yes ❐ No

46. Has any health care facility ever denied, restricted, suspended or revoked privileges or has probation been invoked? ❐ Yes ❐ No

47. a. Has any state ever refused you a license to practice medicine? ❐ Yes ❐ No
b. Has any state ever restricted, suspended or revoked your license to practice medicine? ❐ Yes ❐ No
c. Have you ever voluntarily surrendered a license to practice medicine? ❐ Yes ❐ No
d. Has any state ever placed you on probation or restricted your practice? ❐ Yes ❐ No
e. To your knowledge, is your license to practice currently under investigation? ❐ Yes ❐ No

48. Has your license to prescribe or dispense narcotics ever been surrendered, refused, suspended or revoked, voluntarily or otherwise? ❐ Yes ❐ No

49. Have you ever incurred or become aware of any illness, or physical or emotional condition that impairs, or could impair, your ability to practice medicine? ❐ Yes ❐ No

50. Are you currently or have you ever been treated for a psychiatric condition, alcoholism or substance abuse?
❒ Yes ❒ No

51. Have you ever been charged with a criminal offense or are you currently under investigation for a criminal act? ❒ Yes ❒ No

52. Has your professional liability coverage ever been cancelled, restricted, non renewed, or have you withdrawn an application for insurance to avoid declination? ❒ Yes ❒ No

53. Have you ever practiced without insurance? ❒ Yes ❒ No

54. Has coverage for professional liability ever been refused or accepted under special terms? ❒ Yes ❒ No

55. Has a complaint against you ever been submitted to the Board of Medical Examiners or are you currently under investigation by any regulatory authority? ❒ Yes ❒ No

56. Have you ever served as an expert witness in any professional liability lawsuit? ❒ Yes ❒ No

If you answered Yes to any of questions 44 through 56, please explain on a separate sheet, and provide full documentation from any agency involved.

Section VIII - Claims

57. a. Has anyone ever filed a claim against you regardless of whether the claim was dismissed or a judgment was rendered?
❒ Yes ❒ No (If Yes, please complete a supplemental claims application for each claim.)

If Yes, has such incident(s) been reported to a prior professional liability insurer with the agreement of that insurer to provide coverage? ❒ Yes ❒ No

b. Do you know of any circumstance, act error, or omission that could possibly result in a professional liability claim against you?
❒ Yes ❒ No

If Yes, has this incident(s) been reported to a prior insurer? ❒ Yes ❒ No

Please provide completed details for each incident on the Supplemental Claims Information Form and attach to this application. The name of the patient, date of incident, details of what happened and why, insurer of the incident, and disposition including claims amount or current status must be included.

Section IX – Signature

I understand that no coverage will be bound until after *Conventus* Inter-Insurance Exchange has reviewed the completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression of *Conventus'* intent to provide coverage. If coverage is declined by *Conventus*, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage by *Conventus*, no insurance will be provided for any claim (or incident that the insured has reason to believe might result in a claim) known to the insured at the effective date that has, or has not, been reported to another insurance carrier prior to the effective date.

The information provided in this application is true, complete and accurate to the best of my knowledge. I know of no other relevant facts that might affect the underwriter's judgment when considering this application or that might be material to the underwriter's risk.

I authorize the release of any underwriting, credentialing and/or claim information from (and release from any and all liability for the provision of information) all prior and current insurers, all professional societies or associations, any state licensing authority, any hospitals, or any credentialing agency to *Conventus* and its subsidiaries, or agents, or Attorney-in-Fact.

Signature of Applicant ____ Date ________________________________

Conventus reserves the right to reject any application that does not meet its underwriting standards.

NOTICE TO NEW JERSEY APPLICANTS

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 PENALITIES.

APPENDIX A
ASSIGNMENT OF UNEARNED PREMIUM

1. If the premium payer is any party other than the named insured, is this insurance assigned to the payer? ☐ Yes ☐ No

2. ______________________________, hereinafter referred to as The Corporation and

   ______________________________, referred to as the Medical Care Practitioner(MCP), hereby enter into this agreement.

   a. Whereas The Corporation has agreed with the MCP to pay the cost of professional liability coverage for the MCP during the policy term beginning ______________, and

   b. Whereas the premiums for professional liability insurance coverage for the MCP may be due and payable in advance for the policy period

Now, therefore, the parties hereto agree to the following:

In consideration for The Corporation paying the premium for said insurance, the MCP hereby:

3. Assigns and gives a security interest to The Corporation for any and all unearned premiums which may become payable from the professional liability policies paid for by The Corporation.

4. Irrevocably appoints The Corporation as the MCP's Attorney-in-Fact with full authority to cancel the MCP's professional liability policies purchased by The Corporation, receive all sums assigned to The Corporation or in which the MCP has granted The Corporation a security interest in furtherance of this agreement.

5. All legal rights given to The Corporation shall benefit The Corporation's successors and assigns.

6. The MCP agrees not to further assign any interest in said professional liability policies without The Corporation's written consent.

Date ______________________________

____
Medical Care Practitioner

____
Witness to Medical Care Practitioner's signature

Date ______________________________

____
Corporation

____
Officer

____
Address of Corporation

APPENDIX B
EMPLOYED STAFF SUPPLEMENTAL APPLICATION

1. List the following non-physician health care providers in your practice: nurse anesthetists, nurse midwives, nurse practitioners, physician assistants, surgical assistants and/or any other personnel who must be licensed or certified. (use and attach additional sheet, if necessary)

Name*	License Number	Specialty or Position	Date of Hire	Employee	Status: Independent or Contractor	Avg. # hours per wk

* A Non-Physician Health Care Professional Liability Application must be completed and submitted for each person named here. *If coverage is not desired for independent contractors, attach certificates of insurance for all individuals or a copy of their professional liability policy(ies).*

Managed Care Supplemental Application

2. List name and address of all managed care groups with whom you are affiliated:

Group Name	Street	City	State	Zip

3. Do you authorize a certificate of insurance to be sent to these groups?
   ❒ Yes ❒ No

4. Does the contract require you to participate in arbitration?
   ❒ Yes ❒ No

I authorize the group(s) listed in #1 above to provide a copy of the managed care contract to *Conventus* upon request.

Signature ____ Date________________________________

We strongly recommend that your personal legal counsel review your managed care contract to insure that your interests are protected.

APPENDIX C
GROUP PRACTICE APPLICATION

1. Name of Organization____

   Tax ID # ______________________ Retroactive Date ______________________

2. Description of operations performed____

3. Please indicate the number of people you employ by the following categories.

	Lab or X-Ray technicians		Nurse practitioners*
	Medical assistants		Physicians or surgeons**
	Nurses		Physician assistants*
	Nurse anesthetists*		Surgical assistants*
	Nurse midwives*		Other (Please specify)

* a Non-Physician Health Care Provider Application must be completed for each person in this category.
** a Health Care Professional Application must be completed for each person in this category.

4. Are overnight facilities available? ❒ Yes ❒ No

5. Hours of operation ____

6. Describe the type of organization and ownership. (Check all that apply)

   ______ Professional Association
   ______ Corporation
   ______ Joint Venture
   ______ For Profit
   ______ Partnership
   ______ Community Clinic (non-profit)
   ______ Partnership, Limited
   ______ Not for Profit
   ______ Other, please describe ____

7. List all physicians including members, partners and shareholders (use and attach additional sheet, if necessary)

Name	License Number	Specialty or Position	Date of Hire	Employee	Status: Independent or Contractor	Avg. # hours per wk

If coverage is not desired for independent contractors, attach certificates of insurance for all individuals or a copy of their professional liability policy(ies).

APPENDIX C
GROUP PRACTICE APPLICATION
Continued

8. How long has the organization been in business? ______ Years ______ Months

9. Does the organization have a written Quality Assurance/Risk Management Program? ❒ Yes ❒ No

10. Has the organization ever been sued regardless of whether the claim was dismissed or a judgment rendered? ❒ Yes ❒ No
(If Yes, please complete Supplemental Claims Information sheet)

11. Name of current professional liability insurance carrier: ____

(Please attach a copy of the declarations page showing: retro date, limits of liability, policy period and any restrictive endorsements)

12. Has your professional liability insurance ever been cancelled, refused or non-renewed? ❒ Yes ❒ No

13. Are procedures in place for patient transfer to another facility in the event of an emergency? ❒ Yes ❒ No
(If Yes, please describe) ____

14. Are medications administered? ❒ Yes ❒ No
(If Yes, by whom?) ____

15. Are there subsidiaries that are to be included in this coverage? ❒ Yes ❒ No
(If Yes, please list name of subsidiary and provide a current organizational chart)

____

Please complete an application for each organization named.

EMERGENCY MEDICINE SUPPLEMENTAL APPLICATION

Dear Doctor:

You have applied for professional liability coverage to include the performance as an emergency physician of Emergency Medicine. *Conventus'* underwriting screening rules require applicants to answer several additional questions for review by the Underwriting Committee:

1. I have an unrestricted license to practice medicine in ________________________________ (name state)

2. Please indicate the extent of your formal residency or fellowship training in these procedures, including any specific additional training you have taken since the completion of your residency or fellowship in the areas of Emergency Medicine.

   ____

   ____

3. Are you currently enrolled in a program of continuing medical education? How many hours have you accumulated in Category I during the last 12 months? How many hours of Category I CME credits were in Emergency Medicine or Emergency Medicine related risk management?

   ____

   ____

4. I am insured as an emergency physician, not performing major surgery, and I have unrestricted clinical privileges in emergency medicine at the following healthcare facility(ies):

   ____

   ____

5. Have your hospital privileges as respects the performance of Emergency Medicine ever been reduced, proctored, suspended, restricted or modified? If so, please provide full details, including the names of hospitals and the dates this occurred.

   ____

   ____

6. I am familiar with each of the guidelines developed by MACEP for high risk conditions, and I agree to follow those guidelines in treating all emergency department cases for which I am the attending emergency physician. In addition, I agree to provide appropriate written discharge instructions to each patient to whom the guidelines of high risk conditions apply, as described in the MACEP guidelines.

   ____

   ____

Please attach your replies to these additional questions to your professional liability insurance application.

Signature of Applicant ____

Date____

SUPPLEMENTAL CLAIMS INFORMATION

(If more than four (4) claims, please photocopy additional pages as needed to describe all prior claims)

Please complete in chronological order for any closed, pending or potential claim.

1. Claimant's/plaintiff's name ___________________________

Date care rendered ______________ Date claim reported ______________

Status: ❐ Open ❐ Closed Date closed ______________

If closed, was any indemnity payment or award made? ❐ Yes ❐ No If Yes, amount ________

If open, what is the amount of loss reserve or damages sought? ______________

Name of insurance company defending you: ______________

Are you the primary target of the complaint? ❐ Yes ❐ No If No, who is? ______________

Allegation: ______________

Description of claim (include type of treatment, result of treatment, your involvement)

____

____

____

____

____

____

---

2. Claimant's/plaintiff's name ___________________________

Date care rendered ______________ Date claim reported ______________

Status: ❐ Open ❐ Closed Date closed ______________

If closed, was any indemnity payment or award made? ❐ Yes ❐ No If Yes, amount ________

If open, what is the amount of loss reserve or damages sought? ______________

Name of insurance company defending you: ______________

Are you the primary target of the complaint? ❐ Yes ❐ No If No, who is? ______________

Allegation: ______________

Description of claim (include type of treatment, result of treatment, your involvement)

____

____

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____

3. Claimant's/plaintiff's name ____________________

Date care rendered ____________ Date claim reported____________

Status: ❒ Open ❒ Closed Date closed ____________

If closed, was any indemnity payment or award made? ❒ Yes ❒ No If Yes, amount ________

If open, what is the amount of loss reserve or damages sought? ____________

Name of insurance company defending you: ____________

Are you the primary target of the complaint? ❒ Yes ❒ No If No, who is? ____________

Allegation: ____________

Description of claim (include type of treatment, result of treatment, your involvement)

____

____

____

____

____

____

4. Claimant's/plaintiff's name ____________________

Date care rendered ____________ Date claim reported ____________

Status: ❒ Open ❒ Closed Date closed ____________

If closed, was any indemnity payment or award made? ❒ Yes ❒ No If Yes, amount ________

If open, what is the amount of loss reserve or damages sought? ____________

Name of insurance company defending you ____________

Are you the primary target of the complaint? ❒ Yes ❒ No If No, who is? ____________

Allegation: ____________

Description of claim (include type of treatment, result of treatment, your involvement)

____

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____

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SUPPLEMENTAL PRIOR ACTS
APPLICATION FOR PROFESSIONAL LIABILITY

IMPORTANT: *Please read all of the following information carefully. Should you have any questions, please contact Conventus or your agent prior to completing any information on this page.*

- It is not the intent of *Conventus* Inter-Insurance Exchange to cover any incident, circumstance, act, error or omission of which you are currently aware which may reasonably be expected to result in a claim or suit.
- This information must be completed in its entirety before you can be considered for Prior Acts Coverage.
- A complete copy of all professional liability Declaration Pages and Endorsements for professional liability policies you maintained during the period for which you are requesting Prior Acts Coverage must accompany your application for coverage.
- In addition, you are eligible for Prior Acts Coverage only if you maintained continuous Claims Made Professional Liability Insurance, with your own limits of liability, during the entire requested Prior Acts Coverage Period.
- Prior Acts Coverage is optional and subject to separate underwriting approval. For your own protection, unless you are specifically notified by *Conventus* that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Reporting Endorsement Coverage ("tail" coverage) from your current carrier. Your agent is not authorized to bind prior acts coverage.

1. Name of Applicant:______________________________

2. Agent: ______________________________

3. Name of Prior Carrier: ______________________________

4. Retroactive date used by your prior carrier: ______________________________

5. Did any previous policy(ies) carry any kind of deductible or self insurance retention? ❒ Yes ❒ No
   If Yes, please describe and indicate amounts: ______________________________

   ____

6. List all states where you have practiced or taught and the years associated with these states since your earliest retroactive date (use separate sheet if necessary): ______________________________

   ____

7. Please check all types of practices that applied during the period for which you are requesting prior acts:
   ❒ Sole Proprietor/unincorporated ❒ Partnership ❒ Employed Physician
   ❒ Professional Association/Corporation ❒ Independent Contractor ❒ Limited Liability Corp.

   a. Professional Association/Professional Corporation Prior Acts coverage desired? ❒ Yes ❒ No
   b. If so, was your PA/PC insured during the period you had prior acts? ❒ Yes ❒ No

8. In what specialties have you practiced during the period that you have requested prior acts?
   ____

9. Have you changed, added or deleted any aspects of your practice after your requested retroactive date?
   ❒ Yes ❒ No If Yes, please describe and indicate date(s):
   ____

   ____

10. Has coverage been continuously in force since the retroactive date you are requesting? ❒ Yes ❒ No

11. Any incident, circumstance, act, error, or omission, including a request for records, of which you are aware, must be reported to your current carrier.

All of the above information is true and correct to the best of my knowledge and belief. Any and all acts, incidents, and/or circumstances of which I am aware, and which might reasonably be expected to result in a claim, have been disclosed on this application.

NAME OF APPLICANT: ______________________________

SIGNATURE OF APPLICANT: ______________________________