

Professional Liability Decreased Limits Application

IMPORTANT – PLEASE READ: The lower limit of liability will apply to any claim reported after the effective date of this endorsement regardless of the date the medical incident occurred.

Named Insured: _____

Agency Name: _____ Policy Number: _____

1. Please check the limits you are requesting:

\$1,000,000/\$3,000,000
 \$2,000,000/\$4,000,000

Chiropractors Only

\$100,000/300,000
 \$200,000/600,000
 \$500,000/1,500,000

2. The requested effective date of change: _____
This change will reduce limits of liability back to the original retroactive date of this policy.

3. Please indicate your reason for requesting this decrease in limits: _____

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

If YES, please provide full details for each incident. Use a separate sheet if necessary. _____

5. I understand and agree that all claims reported on or after the effective date of this change will have the lower limits of liability. These lower limits will apply regardless of the occurrence date of the medical incident or any agreements made by you with other persons or organizations.

All of the information above is true to the best of my knowledge and belief.

Signature of Applicant: _____ Date: _____

All changes are subject to company approval.

All questions must be answered for change to be considered.
