

AMERICAN PHYSICIANS ASSURANCE CORPORATION

Headquarters: 1301 N. Hagadorn Road, P.O. Box 1471, East Lansing, MI 48826-1471, 1-800-748-0465
 New Mexico Office: 7770 Jefferson St., NE, Suite 410, Albuquerque, NM 87109-4368, 1-800-880-9485

Application for Physicians and Surgeons Professional Liability Insurance

American Physicians Policy No.: _____
 (Leave blank if you do not currently have your professional liability insurance with American Physicians.)

FOR AMERICAN PHYSICIANS USE ONLY	
CLIENT NO: _____	APP ID: _____
ACN NO: _____	

Agency Name: Morrissey Agency, Inc. **Agency Code:** _____

Address: 400 N. Executive Dr. S.302 * Brookfield, WI 53005

Agency Phone: (262) 784-7574 **Agent or Representative:** Joseph Jordan

Please type or legibly print your responses in full. Supplement this application with responses to questions requiring more room than contained in this form and submit copies of all documents requested on the last page of this application.

1. Name (First, Middle, Last): _____	2. <input type="checkbox"/> MD <input type="checkbox"/> DO
3. Social Security Number: _____	4. Date of Birth: _____
5a. Physician's E-mail Address: _____	5b. Website Address: _____

7a. Current Medical Specialty: _____
 Board Certified? Yes No Certification Date: _____ Board Eligible? Yes No

7b. Name of Certification Board: _____
If not Board Certified or Board Eligible please explain on a separate sheet and attach to this application.

8a. Medical Subspecialty: _____
 Board Certified? Yes No Certification Date: _____ Board Eligible? Yes No

8b. Name of Certification Board: _____
If not Board Certified or Board Eligible please explain on a separate sheet and attach to this application.

9a. **Mailing Address:**

Street: _____		
City/State/Zip: _____		
County: _____	Office Telephone: () _____	Office Fax: () _____
Business manager/contact person: _____		Telephone: () _____

9b. **Principal Office Address:** (If different than mailing address)

Street: _____		
City/State/Zip: _____		
County: _____	Office Telephone: () _____	Office Fax: () _____
Kentucky residents only: Is this address within city limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		

9c. **Residence Address:** (If different than mailing address)

Street: _____		
City/State/Zip: _____		
County: _____	Residence Telephone: () _____	Residence Fax: () _____

9d. **Additional Offices:** (Please attach a separate sheet for additional office locations.)

Street: _____		
City/State/Zip: _____		
County: _____	Office Telephone: () _____	Office Fax: () _____

10. Type of coverage requested: **TO AVOID ANY GAPS IN THIS IMPORTANT INSURANCE COVERAGE, PLEASE CONSULT YOUR AMERICAN PHYSICIANS AGENT OR OTHER REPRESENTATIVE ABOUT THE DIFFERENCES IN THESE INSURANCE FORMS.**

<input type="checkbox"/> Claims-made (Not available in all states) Covers incidents that take place and are reported during the policy period, which begins with the retroactive date.	<input type="checkbox"/> Occurrence (Not available in all states) Covers incidents that take place during the policy period regardless of when reported as a claim.
<input type="checkbox"/> TailGard® (Available in Michigan only) Claims-made coverage with a pre-paid reporting period extension.	

11. Requested limits of insurance: **NOT ALL OF THE LIMITS LISTED BELOW ARE AVAILABLE IN ALL STATES. PLEASE CONSULT YOUR AMERICAN PHYSICIANS AGENT OR OTHER REPRESENTATIVE FOR DETAILS.**

<input type="checkbox"/> \$100,000 per incident/\$300,000 policy aggregate	<input type="checkbox"/> \$500,000 per incident/\$1,000,000 policy aggregate
<input type="checkbox"/> \$200,000 per incident/\$600,000 policy aggregate	<input type="checkbox"/> \$500,000 per incident/\$1,500,000 policy aggregate
<input type="checkbox"/> \$250,000 per incident/\$750,000 policy aggregate	<input type="checkbox"/> \$1,000,000 per incident/\$3,000,000 policy aggregate
<input type="checkbox"/> \$300,000 per incident/\$900,000 policy aggregate	<input type="checkbox"/> Other: \$ _____ per incident \$ _____ policy aggregate

12. Requested effective date (12:01 a.m.): _____
 Requested retroactive date (12:01 a.m.): _____

A "retroactive date" is applicable for "Claims-made" coverage only. Claims-made coverage is limited to claims which are first made while the insurance is in force and which arise out of professional incidents that first occur on or after the retroactive date.

13. List all states where you are licensed (attach a sheet of paper if additional space is needed):

State	License Number	Average number of hours per week per state

14. Narcotics Drug Enforcement Agency Number: _____

15. List all hospitals and surgicenters where you have privileges and the percentage of your total hospital admissions (or surgeries) allocated to each. If none, please explain on a separate sheet of paper and attach it to this application.

Name	City	County	State	% of Admissions

16. List all medical societies, medical associations, or other related professional societies, to which you belong:

17. Name of medical school(s):

Medical School	City	State/Country	Graduation Date

If this is (these are) a foreign medical school(s), are you certified by the Educational Council for Foreign Medical Graduates?
 Yes – Date Certified: _____ No – Explain on a separate sheet.

18. List 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:		

19. Please indicate below your best estimate of the **NUMBER** of the following procedures you expect to perform, or in which you will participate, within the next year, beginning with the date of your requested coverage:

<input type="checkbox"/> Abortion – first trimester	<input type="checkbox"/> Discograms
<input type="checkbox"/> Abortion – after first trimester	<input type="checkbox"/> Electromyography
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Endoscopy (other than proctoscopy or sigmoidoscopy)
<input type="checkbox"/> “Alternative medicine” or “complementary medicine” procedures (as viewed by most physicians) Please describe: _____	<input type="checkbox"/> Please describe: _____
_____	<input type="checkbox"/> Endoscopic Retrograde Cholangiopancreatography-ERCP
_____	<input type="checkbox"/> Eyeliner pigmentation
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Fluoroscopy
<input type="checkbox"/> Anesthesia:	<input type="checkbox"/> Fracture reductions – closed
<input type="checkbox"/> General	<input type="checkbox"/> Fracture reductions – open
<input type="checkbox"/> Epidural	<input type="checkbox"/> Gastroscopy
<input type="checkbox"/> Spinal	<input type="checkbox"/> Hemorrhoidectomy:
<input type="checkbox"/> Other – Please describe: _____	<input type="checkbox"/> Internal Hemorrhoidectomy
_____	<input type="checkbox"/> External Hemorrhoidectomy
<input type="checkbox"/> Angiography/Angioplasty	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Arteriography	<input type="checkbox"/> Intravenous Pyelogram (IVP)
<input type="checkbox"/> Assisting in major surgery – own patients	<input type="checkbox"/> Laparoscopy- Please describe: _____
<input type="checkbox"/> Assisting in major surgery – other than own patients	_____
<input type="checkbox"/> Bariatric procedures:	<input type="checkbox"/> Laser surgery – Other – Please describe: _____
<input type="checkbox"/> Gastric banding	_____
<input type="checkbox"/> Gastric bypass	<input type="checkbox"/> Liposuction
<input type="checkbox"/> Gastric stapling	<input type="checkbox"/> Lumbar puncture
<input type="checkbox"/> Breast implants and/or reduction	<input type="checkbox"/> Mesotherapy
<input type="checkbox"/> Bronchoscopy	<input type="checkbox"/> Myelography
<input type="checkbox"/> Blepharoplasty	<input type="checkbox"/> Ophthalmology – Invasive procedures involving the eye
<input type="checkbox"/> Brachytherapy	<input type="checkbox"/> Pacemaker insertion
<input type="checkbox"/> Catheterization:	<input type="checkbox"/> Pain management:
<input type="checkbox"/> Cardiac <input type="checkbox"/> Right Heart <input type="checkbox"/> Left Heart	<input type="checkbox"/> Cordotomy
<input type="checkbox"/> Arterial	<input type="checkbox"/> Dorsal root gangliotomy
<input type="checkbox"/> Urinary	<input type="checkbox"/> Facet blocks
<input type="checkbox"/> Other – Please describe: _____	<input type="checkbox"/> Medication only
_____	<input type="checkbox"/> Nerve root blocks
<input type="checkbox"/> Chelation therapy	<input type="checkbox"/> Pump implantation
<input type="checkbox"/> Cholangiogram	<input type="checkbox"/> Sphenopalatine lesioning
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> Spinal injections
<input type="checkbox"/> Circumcision	<input type="checkbox"/> Thoracic sympathectomy
<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> Trigeminal lesioning
<input type="checkbox"/> Cryosurgery – Please describe: _____	<input type="checkbox"/> Penile implants
_____	<input type="checkbox"/> Polyp removal
<input type="checkbox"/> Cystoscopy	<input type="checkbox"/> Pre-natal care:
<input type="checkbox"/> D & Cs	<input type="checkbox"/> 1 st Trimester <input type="checkbox"/> 2 nd Trimester <input type="checkbox"/> 3 rd Trimester
<input type="checkbox"/> Deliveries: Home _____ Hospital _____	<input type="checkbox"/> Prolotherapy
<input type="checkbox"/> Deliveries - Vaginal	<input type="checkbox"/> Radial keratotomy (Lasik Surgery)
<input type="checkbox"/> Deliveries - Cesarean	<input type="checkbox"/> Radiation oncology
<input type="checkbox"/> Deliveries - Vaginal Birth after Cesarean (VBAC)	<input type="checkbox"/> Sclerotherapy: <input type="checkbox"/> Surface veins <input type="checkbox"/> Deep veins
<input type="checkbox"/> Dermatological procedures	<input type="checkbox"/> Shock therapy (ECT)
<input type="checkbox"/> Botox injection	<input type="checkbox"/> Thoracentesis
<input type="checkbox"/> Chemical peels	<input type="checkbox"/> Threadlifts
<input type="checkbox"/> Chemabrasion	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> MOHS surgery	<input type="checkbox"/> Total joint replacement
<input type="checkbox"/> Dermabrasion	<input type="checkbox"/> Tubal ligations
<input type="checkbox"/> Fat transfer	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Hair transplant	<input type="checkbox"/> Venography
<input type="checkbox"/> Laser hair removal	<input type="checkbox"/> Weight control by means other than diet or exercise
<input type="checkbox"/> Laser skin resurfacing	<input type="checkbox"/> Please describe: _____
<input type="checkbox"/> Microdermabrasion	
<input type="checkbox"/> Silicone injection	<input type="checkbox"/> I DO NOT PERFORM ANY OF THESE PROCEDURES
<input type="checkbox"/> Tattoo removal	

20. Please indicate the **percentage** of your surgical practice, if any, that involves the following types of surgery:

_____ Abdominal	_____ Neurosurgical
_____ Bariatric	_____ Obstetrical
_____ Cardiac	_____ Ophthalmological
_____ Cardiovascular disease	_____ Orthopedic – including spinal surgery
_____ Colon/rectal	_____ Orthopedic – without spinal surgery
_____ Emergency Medicine	_____ Otolaryngological
_____ Gastroenterology	_____ Plastic – cosmetic
_____ General	_____ Plastic – reconstructive
_____ Gynecologic	_____ Thoracic
_____ Hand	_____ Traumatic
_____ Head and Neck	_____ Urologic
_____ Neonatology / Pediatrics	_____ Vascular

21. Please describe and provide dates for any major changes in your practice in the last ten years (such as changes of specialty or significant procedures initiated or no longer performed):

22a. List all practice locations within the ten years prior to this application, with the current or most recent first:

Name	City/State	Dates at Location	Type of Practice

22b. Do you practice as a hospitalist? Yes No

If yes, please explain: _____

In responding to questions 23 through 44c, please explain any “yes” response and/or provide any required explanation or details on supplementary pages and attach to this application.

23. Have you ever had your membership in any professional society or association refused, suspended or revoked, or have you ever received any criticism or reprimand from any professional society? Yes No

24a. Has any licensing authority ever refused you a license to practice medicine? Yes No

24b. Has any licensing authority ever restricted, suspended or revoked your license to practice medicine? Yes No

24c. Have you ever voluntarily surrendered a license to practice medicine? Yes No

24d. Has any licensing authority ever placed you on probation or restricted your practice? Yes No

24e. To your knowledge, is your license to practice currently under investigation? Yes No

25. Has any hospital or health care institution ever denied, restricted, reduced, or suspended your privileges or invoked probation? Yes No

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

27. Are you now being, or have you ever been, treated for or suffered from, alcoholism, chemical dependency or a mental disorder or mental illness? Yes No

28. 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

29. Have you ever been convicted of, or are you currently under investigation for, a crime other than a routine civil traffic offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
30. Have you ever been refused board certification?	<input type="checkbox"/> Yes <input type="checkbox"/> No
31a. Have you ever had medical professional liability insurance declined, canceled, issued with reduced limits or a deductible, issued with a special surcharge or any other special terms, or has renewal been refused or not offered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
31b. To your knowledge has any medical professional liability insurer ever considered such an action against you or is any such action against you currently being considered?	<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Do you intend to carry or do you currently carry any other medical professional liability insurance from any other insurer while this insurance is in effect?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please attach proof of coverage from the other insurer and explain.	
33a. Do you own, operate or supervise any hospital or sanitarium or maintain any overnight facilities in your office? If yes, attach explanation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
33b. Are you a medical director of any nursing home, health care facility or business enterprise providing medical services? If so, indicate name: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
33c. Do you treat nursing home patients?	<input type="checkbox"/> Yes <input type="checkbox"/> No
33d. Do you treat other than your own patients at the nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
33e. How many nursing home patients, on average, do you treat per month? _____	
34. Are you an employee of, or do you perform contract work for, any government agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No
35. Are you a sports team physician for any college, university or professional team?	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. Do you participate in any pharmaceutical testing programs? If yes, is it (are they) FDA-approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
37. Do you treat or review treatment for jail or prison inmates? If yes, provide details on a separate sheet as to where and how often inmates are treated. If coverage is currently provided by another carrier, please provide evidence of that coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
38. Do you engage in any "moonlighting" activity apart from your practice? If yes, explain on a separate sheet of paper and attach to this application.	<input type="checkbox"/> Yes <input type="checkbox"/> No
39. Do you work in an emergency room? If yes, how many hours on average per week: _____ If yes, for what institution? _____ If yes, are you covered by other insurance for the emergency room work?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
If coverage is currently provided by another carrier, please provide evidence of that coverage.	
40. If you are not a radiologist: a. Do you take and/or interpret your own X-rays or perform other imaging procedures? b. If yes, estimated number per year: _____ c. Does a radiologist over-read your X-rays?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
41a. Do you perform surgery in your office? (Surgery other than incision of boils and superficial abscesses or suturing of skin or superficial fascia.) If yes, please list the specific procedures: _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
41b. Is general anesthesia administered for these (or any) office procedures (i.e. MRI, etc.)? If yes, by whom: _____ With what training/qualifications? _____ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

41c. What specific emergency equipment do you have available in your office? _____

41d. How far is this office location from the nearest hospital with emergency services? _____

41e. Do you have privileges at the nearest hospital with emergency services? Yes No

42a. Do you perform invasive pain management procedures? Yes No

If yes, please list the procedures you perform:

In your office: _____

In a hospital: _____

42b. If you are not an anesthesiologist, attach evidence of training, seminars and/or continuing education on those procedures you perform.

43. Do you practice medicine in any internet or telemedicine program? Yes No

If yes, for what state(s)? _____

Do you hold a current medical license for each state? Yes No

Attach a copy of your license for each state.

44a. Does your practice have:

• A formal procedure of contacting patients if they are “no shows” or cancellations? Yes No

• A system to track that patients are informed of test results? Yes No

• A system for monitoring patient compliance/non-compliance? Yes No

• A system to ensure patient follow-up with consultations and referrals to other health care practitioners? Yes No

• A written policy delineating necessary documentation for dispensing sample medication? Yes No

• A policy to ensure that clinical advice is given **only** by physicians, nurse practitioners and/or physician assistants? Yes No

• A policy to document all telephone calls in the medical record? Yes No

44b. Is (are) the physician(s) involved in the informed consent discussion with patients regarding the risks and benefits of procedures and treatment options? Yes No

If yes, are consent discussions documented in the medical record? Yes No

44c. Are after-hours calls documented in the medical record? Yes No

45. Average number of patients per week:

46. Average number of hours practiced per week:
(Including on call, charting, teaching,
phone consultations, etc.)

47a. Please advise your relationship with a Medical Corporation / Professional Organization as one of the following:

Solo Practitioner (Incorporated) Employee Other _____

Solo Practitioner (**NOT** Incorporated) Independent Contractor

47b. Please give COMPLETE CORPORATION / PROFESSIONAL ORGANIZATION NAME and **attach a copy of the Articles of Incorporation and Office Letterhead.**

Name: _____ Federal ID Number: _____

47c. Number of physicians working at this Corporation / Professional Organization: _____

47d. List all physicians at the Corporation / Professional Organization: _____

47e. Does this Corporation / Professional Organization currently carry separate medical professional liability insurance? Yes No

If yes, please attach a copy of the current declarations page.

If no, a professional organization application is required. **Please consult your American Physicians agent or other representative for details.**

47f. Do you as an individual, or your solo professional organization or medical corporation, practice under any other name, such as an "assumed name" (AKA) or "Doing Business As" (DBA)? Attach a sheet of paper if additional space is needed. Yes No

Dates Used	Name

48a. Indicate number of the following healthcare providers that you employ (include independent contractors): None

Specialty

- | | | |
|---|---|--|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Perfusionist | <input type="checkbox"/> Podiatrist – No Surgery |
| <input type="checkbox"/> Nurse Anesthetist | <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Nurse Midwife | <input type="checkbox"/> Podiatrist – Including Surgery | <input type="checkbox"/> Surgical Assistant |
| <input type="checkbox"/> Nurse Practitioner | | |

48b. Do you want to share your limit of liability with the healthcare providers listed in 48a above? Yes No

If yes, an additional shared limits charge will be made. **Shared limits are not available in IN, NM, or WI.**

If no, an additional vicarious charge will be made. Please attach a copy of the healthcare providers' separate insurance declarations sheet. If proof of current coverage is not provided a shared limits charge will be made.

48c. Do any of the healthcare providers above want a separate limit of liability? Yes No

If yes, a separate Healthcare Providers application must be submitted.

49. Indicate number of the following healthcare providers that you employ (include independent contractors): None

Specialty

- | | | |
|---|--|---|
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Ophthalmology Assistant | <input type="checkbox"/> Physical Therapist |
| <input type="checkbox"/> EMT - Paramedic | <input type="checkbox"/> Optician | <input type="checkbox"/> Physical Therapist Assistant |
| <input type="checkbox"/> Nurse | <input type="checkbox"/> Optometrist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Operating Room Assistant | <input type="checkbox"/> Pathology Assistant | <input type="checkbox"/> X-Ray Technician |
| <input type="checkbox"/> Other – Please describe: _____ | | |

PLEASE NOTE: Separate limits are ONLY available in IN and MI for healthcare providers listed in question 49 above. A separate Healthcare Providers application must be submitted in IN and MI for Healthcare Providers wanting a separate limit of liability. The healthcare provider must have the same coverage form and the limit of liability must be the same or higher than the professional organization.

50. Do you supervise any healthcare providers other than those employed at your practice? Yes No

If yes, please list facility, specialty and number supervised: _____

51. Do you supervise any residents or interns in your office? Yes No

If yes, please describe: _____

52. Beginning with your most recent or current insurer, please list **ALL** current and prior medical professional liability insurers. Please explain any gaps in the continuity of your professional liability coverage. Attach a sheet of paper if additional space is needed.

Name of Insurer	Coverage Type (Claims-made or Occurrence)	Policy Number	Policy Period

53. If your current (immediately prior to the insurance for which this application is being completed) insurance policy is on a claims-made basis, will a reporting period extension (“tail” coverage) be purchased from your current insurer? Yes No

Please provide a copy of the declarations page of your current coverage and any reporting period extension (“tail”).

54. Have you ever been accused of professional negligence, or has a claim or other action based on any alleged professional negligence ever been brought against you, your employees or any professional association, corporation, or partnership to which you currently belong or have belonged to in the past? Yes No

If yes, has such incident(s) been reported to a prior professional liability insurer and has that insurer acknowledged coverage for the incident(s)? Yes No

Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application. The name, age, and sex 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.

55. Do you have knowledge of any claims, potential claims, or suits in which you, your employees, or persons for whom you are responsible, or any professional association, corporation, or partnership to which you currently belong or have belonged to in the past, may become involved, including knowledge of any alleged injury arising out of the rendering of or failure to render professional services which may give rise to a claim? Yes No

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

Please provide complete details for each incident on a separate page (or you may choose to use the enclosed Supplemental Claim Information Form) and attach it to this application.

FRAUD WARNING

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION OF A MATERIAL NATURE, IS GUILTY OF A CRIME AND MAY BE SUBJECT TO IMPRISONMENT, FINES, AND DENIAL OF INSURANCE.

APPLICANT’S REPRESENTATIONS, WARRANTIES AND AUTHORIZATION

I understand that no coverage will be bound until after American Physicians Assurance Corporation has reviewed this completed application and formally bound the requested coverage. Acceptance of payment is not an expression of American Physicians Assurance Corporation’s intent to provide coverage. If coverage is declined by American Physicians Assurance Corporation, any advance payment will be promptly returned.

I understand that, if granted prior acts coverage or retroactive coverage on my professional liability policy, such coverage will apply only to liability arising out of an occurrence which happened prior to the effective date of the policy and subsequent to the retroactive date of the policy for which I am applying.

It is agreed that no insurance will be provided for:

1. any claim which has been reported to another insurance carrier prior to the effective date;
2. any claim known to the insured at the effective date which has not been reported to a prior carrier;
3. any claim that may arise out of an incident which has been reported to another insurance carrier prior to the effective date;
4. any incident which the insured has reason to believe might result in a claim but which has not been reported to an insurer.

I specifically represent and warrant to the insurer that 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 acceptance of the risks described to the underwriter in this application. I understand and acknowledge that this completed application shall be considered an integral part of any insurance policy issued to me by the insurer. I further agree that any false or misleading statement(s) in this application shall be grounds for the insurer to cancel and void coverage at its sole and absolute discretion.

I authorize the release of any underwriting and/or claim information (and release from any and all liability for the provision of information) from all prior and current insurers, all professional societies or associations, any state licensing authority, or any hospitals or health care institutions, to American Physicians Assurance Corporation and its subsidiaries or agents.

I agree to cooperate with the Risk Management Department of American Physicians Assurance Corporation, and its subsidiaries or agents, and to support their efforts to enhance quality of patient care.

Signature

Title

Date

ASSIGNMENT OF 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. However, I do request that copies of all correspondence, formal notices, etc. be sent to me at the last address of record.

This may be revoked by me at any future time by sending written notice to: American Physicians Assurance Corporation
Initial Here:

Please attach:

- | | |
|--|--|
| <input type="checkbox"/> Copy of current/most relevant medical license(s) | <input type="checkbox"/> Copy of letterhead or sample billing statement |
| <input type="checkbox"/> Copy of board certification | <input type="checkbox"/> Current loss runs from previous carrier(s) |
| <input type="checkbox"/> Curriculum vitae | <input type="checkbox"/> Communication Skills Assessment, if applicable |
| <input type="checkbox"/> Copy of current declarations page | <input type="checkbox"/> Articles of Incorporation |
| <input type="checkbox"/> Supplemental Claim Information Form for each claim, regardless of outcome | <input type="checkbox"/> Radiological Supplement, if applicable |
| | <input type="checkbox"/> Supplemental Information Form for VBAC's, if applicable |