Lancet Indemnity

APPLICATION FOR CORPORATION PARTNERSHIP OR OTHER LEGAL ENTITY PROFESSIONAL LIABILITY INSURANCE

Agency Name: _____

Address: _____

Phone: _____

Please legibly print all responses in full. If more room is required than is provided here, please respond at the end of this application or supplement it with additional pages, along with any and all other requested documents.

1. Full Legal Name of Entity: _____

2. Federal Tax ID Number: _____ 3. Date of Incorporation: _____

4. Mailing Address: _____

5. Contact Person: _____ Phone: _____

Email: _____

6. Requested Limits of Insurance: (Circle One)

$100,000 per incident/$300,000 policy aggregate
$200,000 per incident/$600,000 policy aggregate
$250,000 per incident/$750,000 policy aggregate
$500,000 per incident/$1,500,000 policy aggregate
$1,000,000 per incident/$3,000,000 policy aggregate
Other: $_____ per incident

$_____ policy aggregate

Is this an application for limits of insurance that are to be shared with the member physicians?
Or, is this an application for an additional and separate limit of insurance?

7. Requested/Desired Effective Date: _____ Requested/Desired Retroactive Date: _____
(Coverage is limited to claims, which are first made while the insurance is in forced and which arise out of professional incidents that first occur on or after the retroactive date.)

8. All Practice Locations: (Please use additional sheets as required to list all information for all locations)

a. Address:_____

Description of Healthcare Provided at this location: _____

_____ # of Patients per Week at this location: _____

b. Address:_____

Description of Healthcare Provided at this location: _____

_____ # of Patients per Week at this location: _____

c. Address:_____

Description of Healthcare Provided at this location: _____

_____ # of Patients per Week at this location: _____

d. Address:_____

Description of Healthcare provided at this location: _____

_____ # of Patients per Week at this location: _____

e. Address:_____

Description of Healthcare provided at this location: _____

_____ # of Patients per Week at this location: _____

9. Ownership (Please use an additional sheet as required to list all information for all locations)

Name	Medical Specialty/Professional Designation	Percentage Ownership

a._____

b._____

c._____

d._____

e._____

f. _____

(Coverage will not be provided on behalf of any of the above without completed separate individual applications)

10. Professional Employees (Please use an additional sheet as required to list all information for all professional employees. Includes all persons engaged in healthcare in a capacity requiring a professional license, e.g. physicians, burses, registered nurses, physicians assistance.)

Name	Medical Specialty/Professional Designation

a._____

b._____

c._____

d._____

e._____

f. _____

(Coverage will not be provided on behalf of any of the above without completed separate individual applications)

11. Please include as a supplement to this application copies of current professional licenses of all professionals listed in item 9 and 10 above.
12. Please include as a supplement to this application a copy of the license of any professional license applicable to this entity.
13. Please include as a supplement to this application copies of any applicable certification on behalf of the applicant entity.
14. Please include as a supplement to this application a copy of the expiring declaration page with the former insurer, if any. If none, please explain.
15. Has a claim or other action based on any alleged professional negligence ever been brought against the applicant entity? If yes, please provide complete details of each claim against this applicant entity on separate Claim Information form.

FRAUD WARNING

ANY PERSON WHI KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY OR OTHER PERSON, SUBMITS AND APPLICATION OR FILES A CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION OF A MATERIAL NATURE, MAY BE SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

APPLICANTS REPRESENTATIONS, WARRENTIES AND AUTHORIZATIONS

I understand that no coverage will be bound until after Lancet Indemnity RRG has reviewed this completed application and formally bound the requested coverage.

I understand that no insurance will be provided for: 1) any claim known to the applicant prior to the effective date of this insurance, whether or not reported to any prior insurer; or 2) any claim that may arise out of any incident known to the applicant prior to the effective date of this insurance, whether or not reported to any prior insurer.

I specifically represent and warrant to Lancet Indemnity RRG 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 risk described to the underwriter in this application. I further agree that any false or misleading statement in this application shall be ground for the insurer to cancelled and void coverage at its sole and absolute discretion. I understand that a photocopy or facsimile of this application will serve as if it were the original.

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 insures, all professional societies or associations, any state licensing authority, or any hospitals or healthcare institutions, to Lancet Indemnity RRG, and it subsidiaries or agents.

I agree to cooperate with the risk manage department of Lancet Indemnity RRG, and it subsidiaries or agents, and to supports its efforts to enhance the quality of patient care.

_____ _____

Signature Title Date

Please Attach:

Copy of current/most relevant license(s)
Copy of current declarations page
Supplemental claim form for each claim, regardless of outcome
Copy of letterhead or sample billing statement