LANCET INDEMNITY
"THE INSURANCE COMPANY PHYSICIANS TRUST"

# STATEMENT OF NO KNOWN CLAIMS / LOSSES

(This statement must be completed, signed and returned with the completed application)

My signature below confirms that:

1. I have no known losses or claims that have not been reported to my prior insurance carrier.

2. I have no knowledge or information relating to a MEDICAL INCIDENT which could reasonably result in a claim that has NOT been reported to a prior insurance carrier.

3. I have no knowledge of ANY REQUEST FOR MEDICAL RECORDS which might result in a claim.

4. I have no knowledge or information relating to service or service on a board which might result in claim.

5. I have no known "potential" or "anticipated" losses.

6. No prior professional liability carrier has REFUSED coverage for or DECLINED to accept a report of a medical incident, threat of a claim, letter of intent, an adverse result notice or attorney contract.

Signature _____ Date _____

Printed _____

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