

POSITIVE PHYSICIANS INSURANCE EXCHANGE

SUPPLEMENTAL APPLICATION – CLAIMS MADE PRIOR ACTS COVERAGE

Name of Applicant

Requested Retroactive Effective Date: ___/___/___

ATTACH A COPY OF THE CURRENT DECLARATION PAGE SHOWING THE RETROACTIVE DATE

I hereby represent that I am requesting Claims Made coverage. Except as indicated below, I have no knowledge of any professional liability claims, circumstances, occurrence, incidents or conduct which has been or likely to be asserted against me or any corporation association or partnership for which I am making application, which occurred on or after the requested Retroactive Effective Date.

Report below any such incidents involving serious injury including, but not limited to: brain injury, unexpected death, blindness (in one or both eyes), significant burns (including overexposure to radiation), significantly diminished life expectancy, injury to the spinal cord, significant sensory and motor loss, or loss of a significant portion of an arm or leg. Please give a brief description of each such claim, occurrence, incident or circumstance.

Incident #1

Name of Patient/Claimant: _____ Age: _____ Sex: _____

Date(s) of Incident resulting in injury/demand: _____

Location of Incident: _____

Summary of Incident: _____

Current Status:

_____ Claim/Suite Made. Date ___/___/___ Open _____ Closed _____ No Claim/Suit Made _____

Amount of Reserve _____ Amount of settlement of Judgement _____

Amount paid on applicant's behalf: _____ If no payment, was claim/suit withdrawn? _____

Name of Insurer: _____

Additional Defendants or Medical Professionals Involved: _____

Incident #2

Name of Patient/Claimant: _____ Age: _____ Sex: _____

Date(s) of Incident resulting in injury/demand: _____

Location of Incident: _____

Summary of Incident: _____

Current Status:

_____ Claim/Suite Made. Date ___/___/___ Open _____ Closed _____ No Claim/Suit Made _____

Amount of Reserve _____ Amount of settlement of Judgement _____

Amount paid on applicant's behalf: _____ If no payment, was claim/suit withdrawn? _____

Name of Insurer: _____

Additional Defendants or Medical Professionals Involved: _____

Please note that no coverage will be provided under the applied-for policy, for any such claim, occurrence, incident or circumstance permitted to be reported to your current insurance provider*. (*Insurance Provider includes any self-insurance, or any other financial mechanism, whether public or private, established for the purpose of paying awards, judgments or settlements for loss or damages against insured entitled to participate in such mechanism).

The above is true to the best of my knowledge, information and belief. I understand that misrepresentations, omissions, concealment of facts, or incorrect statements in this application which are fraudulent, or material either to acceptance of the risk or to any hazard assumed by PPIX. may result in denial of coverage under the applied for insurance for any claims(s) arising there from. This application will become part of the policy.

Date _____ Applicant Signature _____