

II. GENERAL INFORMATION

If additional space is needed, please use supplemental form

If additional space is needed for an explanation(s), attach a separate page and reference the related question number with the answer.

A. DOES THE ENTITY USE A COLLECTION AGENCY THAT HAS THE AUTHORITY TO FILE COLLECTION SUITS WITHOUT YOUR KNOWLEDGE?

YES NO N/A

If yes, please explain:

B. DOES THE ENTITY OWN OR SHARE OWNERSHIP IN A HOSPITAL, NURSING HOME, CLINIC OR OTHER HEALTH CARE FACILITY?

YES NO

If yes, please explain:

C. HAS YOUR ORGANIZATION OR ANY OF YOUR EMPLOYEES:

1. Ever been the subject of disciplinary investigative proceedings or a reprimand by a Governmental Licensure Board or administrative agency, hospital or professional association?

YES NO

If yes, please explain and include dates and individuals involved:

Individual(s) From: MM YYYY To: MM YYYY Explanation

2. Ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, dental license, or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered?

YES NO

If yes, please explain and include dates and individuals involved:

Individual(s) From: MM YYYY To: MM YYYY Explanation

3. Ever had any professional liability insurance refused, declined, canceled or nonrenewed by the insurance company?

YES NO

If yes, please explain and include dates and individuals involved:

Individual(s) From: MM YYYY To: MM YYYY Explanation

D. DOES THE ENTITY OWN OR OPERATE ANY LABORATORY?

YES NO

1. Is the laboratory providing services solely for your patients?

YES NO

If no, please explain:

E. DOES THE ENTITY MAINTAIN CURRENT CERTIFICATES OF INSURANCE ON FILE FOR ALL DOCTORS AND ALLIED HEALTH CARE PROVIDERS EMPLOYED, CONTRACTED OR PRIVILEGED AT THIS FACILITY?

YES NO

If no, please explain:

F. WILL THE ENTITY BE PERFORMING ACTIVITIES THAT WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY?

YES NO

If yes, state practice name, location and carrier name:

Practice Name Location Carrier Name

G. HAS THE ENTITY PERFORMED ANY CONTRACT WORK FOR OR ENTERED INTO ANY CONTRACT OR AGREEMENT (WRITTEN OR ORAL) WITH ANY ENTITY/CITY/COUNTY/STATE/FEDERAL AGENCY/CLINIC INCLUDING PROVIDING CARE AT CORRECTIONAL FACILITIES, PRISONS, MENTAL HEALTH FACILITIES, VETERANS ADMINISTRATION, UNIVERSITY, MILITARY, INDIGENT CARE OR CHILDREN'S CLINICS, ETC.?

YES NO

If yes, please specify and explain:

H. IS THE ORGANIZATION INVOLVED OR HAS IT HAD ANY INVOLVEMENT IN THE DESIGN, MANUFACTURE OR DISTRIBUTION OF ANY DENTAL PRODUCT(S) OR WRITTEN AN INSTRUCTION MANUAL FOR PRODUCTS FOR USE BY OTHER DENTISTS?

YES NO N/A

If yes, please explain:

I. IF GENERAL ANESTHESIA IS ADMINISTERED OUTSIDE OF A HOSPITAL SETTING:

1. Is scheduled preventative maintenance performed on all biomedical equipment each year by a qualified biomedical technician?

YES NO

If no, please explain:

2. If general anesthesia is administered outside of a hospital setting and you provide outpatient surgical services:

a. Is the facility accredited by either JCAHO AAHC

YES NO

b. Does the entity have a dental services review committee?

YES NO

c. Does your recovery room provide full time observation by a qualified health care provider?

YES NO

Please explain all "no" answers for questions 1. 2. a, b, or c:

Blank lines for explanation

II. GENERAL INFORMATION (Continued)

If additional space is needed, please use supplemental form

J. DOES YOUR ORGANIZATION AND MEMBERS THEREOF, FOR WHICH THIS APPLICATION INCLUDES:

- 1. Adhere to Americans with Disabilities Act and treat patients with disabilities, including patients with HIV/AIDS? YES NO
- 2. Take precautions against blood-borne diseases in your practice:
 - a. Including but not limited to wearing masks and surgical gloves? YES NO
 - b. Autoclave/sterilize equipment after each patient? YES NO
 - c. Adhere to OSHA/CDC guidelines? YES NO

Please explain all "no" answers for questions J. 1. or I. 2. a, b, or c: _____

K. DOES YOUR ORGANIZATION HAVE A WRITTEN DOCUMENT THAT DEFINES THE SERVICES PROVIDED IN YOUR OFFICE?

YES NO

L. DOES YOUR ORGANIZATION HAVE AN ESTABLISHED PROCESS FOR FOLLOWING-UP ON PATIENT DIAGNOSTIC AND LAB TEST RESULTS?

YES NO N/A

If yes, please provide the implementation date: -
MM YYYY

If yes, does the process include:

- 1. Results reviewed by the doctor and documented? YES NO
 If no, please explain: _____
- 2. Decision on care documented? YES NO
 If no, please explain: _____
- 3. Patients notified promptly of test results and noted in file? YES NO
 If no, please explain: _____
 If no, are you willing to establish a process going forward? YES NO

M. HAVE YOU ADDED ANY NEW SERVICES, PROCEDURES OR TREATMENTS TO YOUR PRACTICE IN THE LAST TWELVE MONTHS?

YES NO

If yes, did your practice complete:

- 1. A risk/benefit analysis prior to implementing? YES NO
 If no, please explain: _____
- 2. Appropriate credentialing and training of all staff? YES NO
 If no, please explain: _____
- 3. A review of existing policies and procedures for necessary updates? YES NO
 If no, please explain: _____

N. DO YOU HAVE A COMPREHENSIVE SYSTEM FOR DOCUMENTING PATIENT CARE?

YES NO

If yes, does it include:

- 1. The clinical rationale for decisions? YES NO
 If no, please explain: _____
- 2. Patient education to help the patient make informed decisions about their health care? YES NO
 If no, please explain: _____
- 3. Documentation of patient telephone conversations and messages? YES NO
 If no, please explain: _____

O. DO YOU HAVE PROCEDURES THAT SCREEN AND TRACK THE RATIONALE FOR REQUESTING HEALTH CARE RECORDS TO ENSURE THAT ONLY THE PERSON LEGALLY AUTHORIZED TO REQUEST A COPY OF RECORDS, ACTUALLY OBTAINS ACCESS TO THEM?

YES NO

If no, are you willing to establish a process going forward? YES NO

P. DO YOU HAVE A POLICY AND PROCEDURE MANUAL IN YOUR OFFICE?

YES NO

If yes, please check the topics addressed in your manual:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Human Resources | <input type="checkbox"/> Office Operations | <input type="checkbox"/> Medication Management | <input type="checkbox"/> Other, (please explain): _____
_____ |
| <input type="checkbox"/> Patient Registration | <input type="checkbox"/> Patient Care | <input type="checkbox"/> Appointment Scheduling | |
| <input type="checkbox"/> Confidentiality | <input type="checkbox"/> Documentation | <input type="checkbox"/> Billing & Collections | |
| <input type="checkbox"/> Health Care Records | <input type="checkbox"/> Patient Complaints | <input type="checkbox"/> Disclosure of Adverse Events | |
| <input type="checkbox"/> Facility Management | <input type="checkbox"/> Terminating Patient Relationship | <input type="checkbox"/> Informed Consent/Refusal | |

If no, are you willing to create a manual going forward? YES NO

If yes, indicate estimated implementation date: -
MM YYYY

Which topics will be included:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Human Resources | <input type="checkbox"/> Office Operations | <input type="checkbox"/> Medication Management | <input type="checkbox"/> Other, (please explain): _____
_____ |
| <input type="checkbox"/> Patient Registration | <input type="checkbox"/> Patient Care | <input type="checkbox"/> Appointment Scheduling | |
| <input type="checkbox"/> Confidentiality | <input type="checkbox"/> Documentation | <input type="checkbox"/> Billing & Collections | |
| <input type="checkbox"/> Health Care Records | <input type="checkbox"/> Patient Complaints | <input type="checkbox"/> Disclosure of Adverse Events | |
| <input type="checkbox"/> Facility Management | <input type="checkbox"/> Terminating Patient Relationship | <input type="checkbox"/> Informed Consent/Refusal | |

II. GENERAL INFORMATION (Continued)

If additional space is needed, please use supplemental

Q. ARE ANY OF THE FOLLOWING TYPES OF PATIENT CARE SERVICES RENDERED WITHIN THE FACILITY?

(If yes, please put an "X", and explain on a separate sheet of paper).

- | | | |
|--|--|--|
| <input type="checkbox"/> Sargenti Root Canal Therapy | <input type="checkbox"/> Surgical Placement of TMJ Implant | <input type="checkbox"/> Experimental Surgery |
| <input type="checkbox"/> Services for Obesity/Weight Control | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Research/Experimental Drugs/Product Studies |
| <input type="checkbox"/> Implants | <input type="checkbox"/> Face Lifts | <input type="checkbox"/> Alternative (Holistic) Dentistry/Medicine |
| <input type="checkbox"/> Prosthesis (Abutment Only) | <input type="checkbox"/> Bleaching/Whitening Agents | Please Explain: _____ |
| <input type="checkbox"/> Surgical Anchor | <input type="checkbox"/> Permanent Eye/Lipliner/Tattooing | _____ |
| <input type="checkbox"/> Third Molar Extractions | <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Spa Services |
| <input type="checkbox"/> TMJ Surgery | <input type="checkbox"/> Skin Peels | Please Explain: _____ |
| | | _____ |

R. INDICATE THE PERCENTAGE OF THE PRACTICE DEVOTED TO THE FOLLOWING ACTIVITIES: (Does not have to equal 100%)

- % Dentures:
- We Accept Referrals Replacement Dentures
- Same Day or Economy Dentures Relines
- % Oral Surgery (extractions, removal of cysts, Invasive Surgical Procedures, etc.)
- We accept Oral Surgery Referrals
- % Elective facial cosmetic surgery/procedures (including Rhinoplasty, Face-Lifts, Skin Grafts, Botox, Collagen, Tattooing, etc.)
- % Reconstructive Cosmetic Procedures (i.e. Cancerous Lesion Facial Reconstruction, Cleft Lip/Palate, etc.)
- % Procedures performed outside of the Oral and Maxillofacial Region (except bone harvesting procedures).
- Please explain: _____
- _____
- % Other Dental Techniques that will help Medical Protective better understand any special circumstances concerning the practice.
- List Procedures: _____
- _____

S. HAS THE PRACTICE DISCONTINUED ANY PROCEDURES?

YES NO

Which procedure(s)? _____

When? - Why? _____

MM YYYY

T. PERCENTAGE OF FEES DERIVED FROM MEDICARE/MEDICAID REIMBURSEMENT? %

PERCENTAGE OF FEES DERIVED FROM CAPITATION REIMBURSEMENT? %

U. IS YOUR PRACTICE AFFILIATED WITH A GROUP DENTAL PRACTICE, ADMINISTRATIVE ENTITY OR PRACTICE MANAGEMENT ORGANIZATION?

YES NO

If yes, please complete questions 1 - 5.

1. Are all offices supervised by the dental practice owner? YES NO Number of Locations:

If no, please explain: _____

2. Are referral guidelines established by the organization? YES NO

3. Please indicate each of the following credentialing standards that are in place for the organization.

- Working Interview Background Check
- Verify Training References Other: _____

4. Is there a training program in place for new hires including new graduate dentists? YES NO

If yes, please describe: _____

(Please use supplemental page if more space is needed.)

5. If you are submitting a group of insureds, is this one buying decision? YES NO

If no, please explain: _____

III. BUSINESS PRACTICES

If additional space is needed, please use supplemental form

Please indicate with an "X" each of the procedures performed within the entity and "X" if informed consent is obtained for each of the procedures checked or referred outside your practice.

These procedures are not performed

- Full Mouth Banding Orthodontics
- Dental Implants (Anchor portion only)
- Partial Impacted Third Molar Extractions (D7210, D7220, D7230)
- Fully Impacted Third Molar Extractions (D7240, D7241, D7250)
- Conscious Sedation (D09240, D09242)
- General Anesthesia Sedation (D09220)
- Facial Cosmetic Surgery
- Other (Please Explain): _____

Do you obtain informed consent?

- YES NO
- YES NO
- YES NO
- YES NO
- YES NO
- YES NO
- YES NO
- YES NO

Check here if these procedures are referred outside of your practice to residency trained licenced specialist.

-
-
-
-
-
-
-
-

IV. ANESTHESIA INFORMATION

If additional space is needed, please use supplemental form

A. AS DEFINED BELOW, PLEASE "X" IF YOU, A SHAREHOLDER, EMPLOYEE OR INDEPENDENT CONTRACTOR TREAT PATIENTS UNDER:

- Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar Non-Scheduled Drug) or nitrous oxide only. Please continue to Section V.
- CONSCIOUS SEDATION UTILIZING ADA CODE D09241 and D09242- (Excluding Nitrous Oxide)** A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.
 - Oral IM/IV
- GENERAL ANESTHESIA UTILIZING ADA CODE D09220- (To include deep sedation)** A controlled state of depressed consciousness or unconsciousness, accompanied by partial or complete loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

B. PLEASE INDICATE WHO ADMINISTERS CONSCIOUS SEDATION:

- Dentist RN/LPN
- Oral Surgeon Dentist Anesthesiologist
- Nurse Anesthetist/CRNA MD/DO Anesthesiologist
- Other (specify): _____

WHERE IS CONSCIOUS SEDATION PERFORMED? (Check all that apply)

- In office Licensed Surgical Center
- Hospital Other (specify): _____

FOR:

- Own Patients
- Other Than Own Patients

C. PLEASE INDICATE WHO ADMINISTERS GENERAL ANESTHESIA:

- Dentist RN/LPN
- Oral Surgeon Dentist Anesthesiologist
- Nurse Anesthetist/CRNA MD/DO Anesthesiologist
- Other (specify): _____

WHERE IS GENERAL ANESTHESIA PERFORMED? (Check all that apply)

- In office Licensed Surgical Center
- Hospital Other (specify): _____

FOR:

- Own Patients
- Other Than Own Patients

D. HOW OFTEN DOES YOUR PRACTICE UPDATE HEALTH HISTORIES?

- Every _____ Month(s)
- Every Patient Visit
- Anytime invasive procedures are performed
- Other (please explain): _____

E. ARE THE OFFICES CERTIFIED FOR GENERAL ANESTHESIA BY A STATE ORGANIZATION? YES NO

F. IF CONSCIOUS OR GENERAL ANESTHESIA SEDATION IS PERFORMED OUTSIDE OF A HOSPITAL, HOW OFTEN DOES YOUR STAFF PARTICIPATE IN SIMULATED EMERGENCY TRAINING?

Every: 3 months 6 months 12 months Other:

G. HAS THE ORGANIZATION CONFIRMED THAT ALL ANESTHESIA PROVIDERS ALLOWED INTO YOUR OFFICE HAVE A MINIMUM TWO YEAR ANESTHESIA RESIDENCY AND PROFESSIONAL LIABILITY LIMITS EQUAL TO OR GREATER THAN YOUR LIMITS?

If no, please explain: _____

H. IF A CRNA IS UTILIZED, ARE THEY SUPERVISED ON SITE BY A DOCTOR WITH A MINIMUM OF TWO YEARS ANESTHESIA RESIDENCY OR GREATER? YES NO

If no, please explain: _____

I. IS THE ANESTHESIA PROVIDER CURRENTLY LICENSED IN YOUR STATE? YES NO

If no, please explain: _____

J. ARE INDIVIDUALS ADMINISTERING THE SEDATION CERTIFIED IN ONE OR MORE OF THE FOLLOWING? YES NO

If yes, please "x" the boxes that apply: CPR ACLS ATLS PALS

If no, please explain: _____

K. IS THE FOLLOWING EQUIPMENT UTILIZED? YES NO

If yes, please "x" equipment used.

*Verify that the practice will insure that all Anesthesiologists allowed in your practice will supply the following equipment

(Checking the box indicates this equipment will be available during all anesthesia procedures performed outside a hospital setting)

- | | | |
|--|--|---|
| <input type="checkbox"/> Fail safe mechanisms on anesthesia machines | <input type="checkbox"/> Sphygmomanometer/Stethoscope | <input type="checkbox"/> Portable Suction |
| <input type="checkbox"/> Basic Airway Equipment | <input type="checkbox"/> Electrocardiographic Monitoring Equipment | <input type="checkbox"/> Capnography |
| <input type="checkbox"/> Full Face Mask Resuscitator | <input type="checkbox"/> Pulse Oximeter | <input type="checkbox"/> Auxiliary Lighting |
| <input type="checkbox"/> Oral and Nasopharyngeal Airways | <input type="checkbox"/> CO2 Monitor | <input type="checkbox"/> Emergency Pharmaceutical Kit |
| <input type="checkbox"/> Endotracheal Tubes (Adult/Child size) | <input type="checkbox"/> Internal/External Temperature Monitor | <input type="checkbox"/> Direct Current Defibrillator |
| <input type="checkbox"/> Laryngoscope | <input type="checkbox"/> Tracheostomy/Coniotomy Equipment | |

If no, please explain: _____

L. DOES THE PRACTICE PRESCRIBE BENZODIAZEPINE DRUG CLASS ORAL SEDATION AGENTS (HALCION, TRIAZOLAM, ATIVAN, VALIUM OR SIMILAR ANESTHETIC AGENT) FOR USE PRIOR TO AND/OR DURING THE PATIENTS SCHEDULED APPOINTMENT? YES NO

1. If yes, do you prescribe to:

- Adults
- Children

2. If yes, do you prescribe: (Please check all that apply)

- One single dose the day of appointment
- Multiple doses: Prior to the scheduled appointment During the appointment

V. ROSTER OF STAFFING

If additional space is needed, please use supplemental form

PLEASE IDENTIFY ALL OWNERS, EMPLOYED AND CONTRACTED INDIVIDUALS WITHIN YOUR ORGANIZATION AND PROVIDE INFORMATION CONCERNING EACH MEMBER IN EACH CATEGORY LISTED BELOW.

Use the following Key for Individual Status (column 6).

- A.** Previous Medical Protective insured requesting Medical Protective Coverage
- B.** Current Medical Protective insured
- C.** Requesting Medical Protective Coverage
- D.** Applying for coverage elsewhere or covered elsewhere
- E.** Other-Including OHCP (Allied Staff) or Office Manager, etc. (requesting to share limits with the Entity)

**** Note Include all applicant(s), all health care providers and non-health care owners.**

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds as defined by a Shared Limit Additional Insured Endorsement.

1. <i>Last name first, then first and middle initials (i.e. Smith, J. G.)</i>	2. <i>Degree</i>	3. <i>(S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor</i>	4. <i>Percentage of ownership (if shareholder or partner) Enter as a Decimal</i>	5. <i>Specialty (Refer to list on next page)</i>	6. <i>Individual Status- A, B, C, D or E (See Key Above)</i>	7. <i>Medical Protective Policy#</i>
1.			□□□□.□□			
2.			□□□□.□□			
3.			□□□□.□□			
4.			□□□□.□□			
5.			□□□□.□□			
6.			□□□□.□□			
7.			□□□□.□□			
8.			□□□□.□□			
9.			□□□□.□□			
10.			□□□□.□□			
11.			□□□□.□□			
12.			□□□□.□□			
13.			□□□□.□□			
14.			□□□□.□□			
15.			□□□□.□□			

Key: enter specialty per the following: (Please use the number referenced 1-16 in lieu of writing out the specialty).

- 1. General Dentist
- 2. Oral Maxillofacial Surgeon
- 3. Orthodontist
- 4. Pediatric Dentist
- 5. Periodontist
- 6. Prosthodontist
- 7. Endodontist
- 8. Dental Anesthesiologist
- 9. Oral Pathologist
- 10. Pain Management
- 11. Dental Assistant
- 12. Dental Hygienist
- 13. Office Manager
- 14. Dental Lab Technician
- 15. Nurse Anesthetist/CRNA
- 16. RN/LPN
- 17. X-Ray Technician
- 18. Other (Specify job desc. below)*

V. ROSTER OF STAFFING (Continued)

If additional space is needed, please use supplemental form

Please provide a brief job description and explanation for why coverage is not requested for any individuals where Individual Status is *D* on Roster or Specialty is #18-Other

<i>Number from Roster</i>	<i>Job Description</i>	<i>Explanation</i>

VI. LOSS INFORMATION (IMPORTANT, COMPLETE FULLY)

If additional space is needed, please use supplemental form

Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

A. Has your organization or any of your employees/contractors been involved now or in the past, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization? YES NO

If yes, how many? _____

If yes, have these been reported to your insurer? YES NO

B. Does your organization or any of your employees/contractors have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization which may give rise to a claim? YES NO

If yes, how many? _____

If yes, have these been reported to your insurer? YES NO

IF REPORTED TO YOUR INSURER, PLEASE PROVIDE COPIES OF THE REPORT(S).

VIII. COVERAGE INFORMATION

If additional space is needed, please use supplemental form

A. LIST ALL PREVIOUS PROFESSIONAL LIABILITY INSURERS FOR THE ENTITY BEGINNING WITH THE MOST RECENT.

1. _____ Claims Made Occurrence MM - DD - YYYY to MM - DD - YYYY
 Current Insurer for the Entity
2. _____ Claims Made Occurrence MM - DD - YYYY to MM - DD - YYYY
 Insurer for the Entity
3. _____ Claims Made Occurrence MM - DD - YYYY to MM - DD - YYYY
 Insurer for the Entity

B. COVERAGE DESIRED

1. Occurrence
 2. Claims-Made Coverage without Prior Acts Coverage
 3. Claims-Made Coverage with Prior Acts Coverage
 4. Convertible Claims-Made

(A copy of current declaration page showing current retroactive date must be attached for options 3 and 4)

If 1 or 2 are selected from the above and the most recent prior coverage was issued on a Claims Made basis, please select one of the following:

- An extended reporting endorsement (tail coverage) has been purchased (copy of tail is attached)
 An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a claims-made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying for from The Medical Protective Company, if offered will not provide prior acts coverage.

 Initial Here

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between claims-made and occurrence coverage or the additional expense associated with an "extension contract" or "tail coverage."

C. REQUESTED ENTITY COVERAGE EFFECTIVE DATE 12:01 A.M.

This date cannot be earlier than the expiration date of your current policy.

From: MM - DD - YYYY 12:01 a.m.

To: MM - DD - YYYY 12:01 a.m.

Annual policy terms will begin and end on the same month and day.

D. THE RETROACTIVE DATE SHOWN ON MY CURRENT CLAIMS-MADE POLICY IS:

(NOT REQUIRED FOR OCCURRENCE POLICIES OR CLAIMS-MADE WITHOUT PRIOR ACTS)

MM - DD - YYYY 12:01 a.m.

E. Limits Desired: _____, _____, _____ *per occurrence/per claims-filed*

_____, _____, _____ *annual aggregate*

(Requested limits may not be available from this company)

F. The EPLI Retroactive Date shown on my current Claims Made policy is:

This date cannot be greater than the retroactive date shown on your current policy

MM - DD - YYYY 12:01 a.m.

IX. STATE STATUTORY REQUIREMENT

NOTE: All applicants must read and initial the following:

Any person who knowingly files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and also punishable by criminal and/or civil penalties in certain jurisdictions.

 Initial Here

