POSITIVE PHYSICIANS INSURANCE EXCHANGE

850 Cassatt Road 100 Berwyn Park Suite 220 Berwyn, PA 19312
Phone: 888-335-5335 Fax: 610-644-5265

Supplemental Application
Partnership, Professional Associations & Corporations Coverage

Please print responses in ink, and answer all questions in full. If a questions does not apply to your practice, state "none" or "N/A" (Not Applicable). Please indicate any additional responses on an additional paper. This application consists of A) application(s) for insurance, including any additional pages and Claim information form. The complete application, together with any supplementary information, must be signed in ink and dated by the applicant in all spaces indicated. Failure to provide complete information will delay the processing of the application.

I GENERAL INFORMATION

Formal Name/Title of Partnership, Association, Corporation (as filed with the PA Corporation Bureau. Attach copy of Articles of Incorporation.)

_____
_____

Has name/title changed from the last filing? Yes_____ No_____
If yes, state old name/title_____
(Attach copies of amendments to Articles of Incorporation)

List any other names the above entity is doing business as:_____
_____
.

What is your practice structure? Solo practitioner with Corporation____ Corporation_____
Partnership_____ Multi-Shareholder Corporation_____ Joint Venture_____
Space sharing_____ Other (describe)_____

Corporation License # (if known): MC_____

Primary Address/Location

Street _____ Building/Suite _____

City _____ State _____ Zip Code _____

County _____ Number of years at this location_____ % of practice _____

Primary Practice Office Phone	Fax
( )	( )

Practice Web Site Address: _____

E-mail Address: _____

List other Practice Addresses: (attach letterhead or separate sheet if necessary)

Street _____ Building/Suite _____

City _____ State _____ Zip Code _____

County _____ Number of years at this location_____ % of practice _____

Billing Address Other than Primary Practice

If you require that your premium billing be sent to an address other than your primary practice address, please indicate.

Street _____ Suite/Bldg._____

City _____ State _____ Zip code_____

II CORPORATE COVERAGE

Requested effective date of coverage:_____/_____/_____

If you currently have claims-made coverage will you purchase an extended reporting endorsement (tail coverage) from your current carrier?
Yes _____ No _____

If no, do you wish to purchase retroactive coverage from Positive Physicians Insurance Exchange?
Yes _____ No _____

Desired Retroactive Date (date policy converted from occurrence to claims made:____/____/___
(you must attach a copy of the most recent Declarations Page from your present carrier indicating the original effective date of coverage.)

Are you, as of this date, aware of any conduct, circumstances, or incidents that occurred during the period of claims made coverage that could reasonable be expected to result in a claim, and that has not been reported to your present or prior insurer(s)? Yes _____ No _____

STAFFING OF PARTNERSHIP, ASSOCIATION OR CORPORATION

Please identify all employed and contracted individuals and provided information requested.

STATUS*: Shareholder (S), Partner (P), Employee (E), Independent Contractor (IC)

NAME & DEGREE	SPECIALTY	*STATUS	%OF OWNERSHIP

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

Use a separate sheet for additional staffing

Has an application for individual coverage been completed for each of the physicians listed? _____

III LOSS INFORMATION

List current and previous professional liability insurers with dates for the past 10 years.

Insurer	policy term
Insurer	policy term
Insurer	policy term
Insurer	policy term

Has the entity been involved in a malpractice claim/suit/ incident in the **past 10 years?**
Yes _____ No _____

If yes, how many _____ *(If you answer yes, provide complete details of all open and closed claims/suits/incidents, including those closed with no payments, on the attached Claim Information Form. Copy and complete a separate form for each.)*

IV AUTHORIZATION

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. I hereby acknowledge that I have completed the required reporting of claims and incidents to my current carrier. Erroneous information and/or material misrepresentation will cause immediate rescission of my insurance coverage.
AGREEMENT: I understand that the policy being applied for does not cover the liability of others that I may have assumed under any contract or agreement.
(Note: Your being approved for coverage by the company does not imply acceptance by the company of any contract or agreement or any liability assumed there under.)
AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning my professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, inter-indemnity arrangement, underwriter, and insurance agent to furnish any information concerning me or my medical practice that the company may request.
AGREEMENT: Since I understand that the free exchange of information is essential, I agree that any person or organization furnishing information to the company pursuant to this consent and direction, together with the agent, employees, or officers of such person or organization, will not be liable to me in any way for the furnishing such information.
AGREEMENT: I agree that in order to maintain insurance coverage I will comply with the Company's established risk management programs and requirements.
Upon acceptance by Positive Physicians Insurance Exchange, this Application will be made a part of any policy issued.

Applicant (print):
_____

Authorized Signature | Date