



Application for Additional Insureds

All information below must be completed and all questions answered "Yes" or "No". Please provide any extra explanations on a separate page. Submit this form with a copy of state license, CV and signed No Known Loss.

Effective Date	Additional Insured Name	Date of Birth
Professional Degree	School of Professional Degree	Year of Graduation
Social Security Number	License Number	Phone Number
		Email Address

Primary Insured

Additional Insured Questions: (Please explain all "Yes" answers on separate page)

- In the past 10 years, have you been named a suit or subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No
- Have you ever had any insurance canceled, declined or refused to renew? Yes No
- Have you ever been convicted of a felony? Yes No
- Have you ever sought treatment for drug or alcohol addiction? Yes No
- Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any other named insured? Yes No
- Do you administer any anesthesia? Yes No
- Do you perform or assist in any surgical procedures? (List All) Yes No
- Years at my current company? _____
- Years of professional experience? _____
- Number of hours worked per week? _____
- Number of patients seen per week? _____
- Do you work at any other company or location other than the one applying for this coverage? Yes No

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I FURTHER ACKNOWLEDGE ANY MISREPRESENTATION OR LACK OF NOTIFYING THE CARRIER OF CHANGES IN MY PRACTICE MAY RESULT IN COVERAGE BEING VOIDED.

Authorized Representative Signature

Date

Printed Name

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