

Prior Acts Coverage Supplemental Questionnaire & Warranty Statement

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

Applicant Name:

Expiring Policy Number (if applicable):

1. Have any of the following occurred in your practice during the past 5 years?
If you answer "Yes" to any, please complete a Claims Information Form for each such instance.
- a) Any unexpected death (including stillbirth)? Yes No
 - b) Any unexpected neurological or functional impairment? Yes No
 - c) Any injury to a fetus or a child during birth? Yes No
 - d) Any unexpected organ failure or removal? Yes No
 - e) Any unanticipated removal of any body part during or after any invasive procedure? Yes No
 - f) Any tear, perforation or unplanned cutting of any organ or body part? Yes No
 - g) Any suspicious or positive x-ray, Pap smear or mammogram where the patient was not contacted? Yes No
 - h) Emergency surgery, myocardial infarction or cerebral vascular incident within 96 hours of your previous treatment or surgery? Yes No
 - i) Complications arising from improper medication, contraindicated medication and/or improper medication dosage? Yes No
 - j) If you answer "Yes" to any of the above, have all such instances been reported to and has coverage been confirmed by a prior insurance carrier? Yes No

2. Does your current professional liability insurer allow you to report adverse outcomes, medical incidents and/or medical records requests? Yes No
 If "Yes," will your current insurer provide coverage from any future claims or suits that may arise from such adverse outcomes, medical incidents and/or medical records requests? Yes No

3. Are you, or any individual or entity proposed for this insurance coverage aware of any claim that may fall within the scope of the policy, or aware of any fact, situation, transaction, event, act, failure to act, error, omission, circumstance or attorney contact which could result in a claim or suit being made against you? Yes No
 If "Yes," have all such claims and circumstances been reported to and accepted by a prior carrier? Yes No
If "Yes," please complete a Claims Information Form for each such instance.
Without prejudice to any other rights or remedies of the Underwriter, it is agreed that any claim required to be disclosed in response above is excluded from the proposed insurance, whether or not it is disclosed above. Similarly, any claim arising or resulting from any fact, situation, transaction, event, act, failure to act, error, omission, circumstance or attorney contact required to be disclosed in response above is excluded from the proposed insurance, whether or not it is disclosed above.

4. Has any professional liability insurer refused to accept your notice or report of a medical incident, threat of claim, letter of intent to commence legal action, attorney contact, adverse outcome, notice of claim, records request, or any circumstance or occurrence which could reasonably be expected to result in a claim or suit being made against you? Yes No

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of and for all individuals and entities proposed for this insurance, warrants that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this supplement are true and complete, and understands that the information submitted herein becomes a part of the Application and that such information is material and is used to influence the judgment of the Underwriter in determining whether to offer coverage. The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	