

## Important Notice to Applicants

### Important Information Concerning Claims Made Policies

With a claims-made policy, two dates matter most, the **effective date** (policy start date) and the **retroactive date** (the first date you had uninterrupted claims made coverage, unless otherwise stated).

Coverage applies only to incidents occurring **on or after the retroactive date** if the claim is **first made and reported in writing to Inspirien during the policy period**. No coverage applies to:

- Incidents before the retroactive date.
- Claims, suits, or proceedings first brought before the effective date.
- Incidents known (or that should have been known) prior to the effective date that could reasonably lead to a claim.
- Incidents or claims reported to another insurer before the effective date.

To avoid gaps, applicants should report all potential claims to their current carrier before their policy ends (or within the reporting period allowed). Another option is to purchase a **“tail” (reporting endorsement)** to extend reporting time. For details, contact your agent or Inspirien.

### Important Information Regarding Extended Reporting Periods (Tail)

Upon termination of your policy, either by you or by us you will have the right to purchase an endorsement providing an Extended Reporting Period, during which claims otherwise covered by this policy may be first made against you and reported to us.

Without this endorsement, you will not have coverage for any claim reported to us after your policy terminates. The endorsement would reinstate your policy limit once for all claims reported after the termination date.

To exercise your option to purchase this endorsement, you will need to contact your insurance agent within the number of days indicated in your policy after the policy terminates. You must also pay any outstanding premium balance that remains on your terminated Claims Made policy.

## Important Information Concerning Electronic Delivery of Policies

To receive electronic delivery of policy information you must have a valid email on file with us and have a device capable of receiving emails, viewing and downloading files, and a PDF reader. If a document requires proof of receipt, we will utilize an electronic method that provides such verification like a read receipt confirmation. If we receive a non-deliverable notification we will attempt to deliver via an alternative electronic method or revert to paper delivery.

Please acknowledge your desire of policy information delivery by checking the appropriate box:

I agree to receive all mailings and communication electronically; such electronic mailings or communications may even include cancellation or nonrenewal notices.

I do not consent to electronic delivery.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Email address for electronic delivery \_\_\_\_\_

## Alabama Applicants Only Arbitration Acknowledgement: Important Information Concerning Your Legal Rights

### **This Document Affects Your Legal Rights. Read the Following Information Carefully.**

- 1. The policy for which you have applied includes a binding arbitration agreement.**
- 2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.**
- 3. The results of the arbitration are final and binding on you and the insurance company.**
- 4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.**
- 5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.**
- 6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.**

## Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause - contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disagreements be resolved by binding arbitration.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_

This notice provides no coverage and should not be construed to replace any provisions of your policy. You should read your policy and your Declarations page for complete information about your coverage. If there is any conflict between the policy and this notice, the provisions of the policy will govern.



505 Cloverdale Road, Suite 104  
 Montgomery, AL 36106  
 Return to: notifications@inspirien.net

## Application for Professional Liability Insurance for Physicians and Dentists

### Section 1 - General Information

<b>Proposed Coverage Effective Date</b>		
<b>Full Name of Applicant</b>		___ MD ___ DO ___ DDS ___ DDM ___ Other _____
<b>Date of Birth</b>		
<b>Home Address</b>		
<b>Home Phone</b>		<b>Cell Phone</b>
<b>Organization Name</b>		<b>Tax ID #</b>
<b>Type of Practice</b>		
<input type="checkbox"/> Solo Unincorporated Provider <input type="checkbox"/> Individual (solo) Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Member of Multi-person Corporation <input type="checkbox"/> Employee of _____ <input type="checkbox"/> Independent Contractor of _____ <input type="checkbox"/> Other _____		
<b>Principle Business Address</b>		
<b>Email Address</b>		<b>Web Address</b>
<b>Billing Address (if different from principal business address)</b>		
<b>Administrator Contact at Business</b>		
<b>Name</b>	<b>Phone</b>	<b>Email</b>

### Section 2 - Provider Information

Answer each question. For all yes answers, please explain in space provided or by attachment.

Describe the professional activities for which you are requesting coverage

Specialty \_\_\_\_\_

Sub-specialty \_\_\_\_\_

Have you ever:	Yes	No
a. Been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative or licensing agency, hospital, or professional association?	___	___
b. Been charged with or convicted of an act committed in violation of any law or ordinance other than traffic offenses?	___	___
c. Had any state professional license or license to prescribe or dispense narcotic refused, suspended, revoked, renewal refused, restricted or accepted only on special terms?	___	___
d. Has any insurance company canceled, declined, denied or refused to renew or placed conditions or restrictions on your professional liability insurance? (Missouri residents- do not answer)	___	___
e. Failed any medical licensing or specialty organization examination or not eligible for Boards?	___	___
f. Been named in a claim or suit for professional malpractice, or have any judgements been made against you or any out-of-court settlements made on your behalf? <i>If yes, please complete a Supplemental Claims Information Form at the end of the application.</i>	___	___
g. Been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management, or any other mental illness?	___	___
h. Do you have a medical condition, which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	___	___



Check the procedures performed by you.

- Abortion, elective
- Acupuncture
- Amniocentesis
- Anesthesia
  - Caudal
  - Conscious Sedation
  - General
  - Local
  - Regional Nerve Block
  - Spinal
  - Other \_\_\_\_\_
- Angiography
- Angioplasty
- Appendectomy
- Arteriography
- Arthroscopy
- Assist in Major Surgery
  - On own patients
  - On patients of others
- Bariatric Surgical Procedures
  - Gastric Banding
  - Gastric Bubble
  - Gastric Bypass
  - Gastric Stapling
- Blepharoplasty
  - Cosmetic
  - Reconstructive
- Breast Biopsy
- Breast Implants
- Breast Reduction
- Cardiac Surgery
- Cataract Surgery
- Caesarean Sections
- Chelation Therapy
- Chemonucleolysis
- Chemotherapy
- Cholecystectomy
- Circumcision
- Colonoscopy
- Colposcopy
- Cryosurgery, other than external lesions
- Catheterizations
  - Arterial
  - Cardiac
  - Swan-Ganz
  - Ureteral
  - Umbilical
- Dermatological or Aesthetic Procedures \_\_\_\_\_ %
  - Botox Injection
  - Chemical Peels
  - Chemabrasion
  - Collagen Injection/Derma Fillers
  - Dermabrasion
  - Fat Transfer
  - Hair Transplant
  - Laser Hair Removal
  - Laser Skin Resurfacing
  - Microdermabrasion
  - Silicone Injection
  - Spa
  - Other \_\_\_\_\_

- D & C
- Dermatopathology
- Dialysis Procedures
- Discography
- Echocardiography
- Endoscopic Laser Therapy
- Endoscopy
  - Cystoscopy
  - Bronchoscopy
  - EGD
  - Gastroscopy
  - Hysteroscopy
  - Proctoscopy
  - Sigmoidoscopy
  - Other \_\_\_\_\_
- Experimental Procedures or research or drug testing (include a copy or form used to obtain informed consent). Are procedures FDA approved? \_\_\_ Yes \_\_\_ No
- ERCP/ERC
- Exchange Transfusion
- Facial Plastic Surgery
  - Elective Cosmetic
  - Reconstructive
- Fluoroscopy
- Fracture Reduction
  - Closed
  - Open
- Hand Surgery
- Hemorrhoidectomy
- Hernia Repair
- Hip Nailing
- Hyperbaric Medicine
- Hysterectomy
- Injection of Radioisotopes
- Intensive Care for Newborns
- Intensive Care Medicine for Adults
- Infertility Treatment
  - Medical
  - In Vitro Fertilization
  - Other Surgical \_\_\_\_\_
- Laminectomy
- Laminectomy: Certified? \_\_\_\_\_
- Laser Surgery: Type \_\_\_\_\_
- Lasik
- Left Heart Catheterization
- Liposuction
  - Tumescant
  - Other
- Lithotripsy
- Mammography
- Medical Weight Loss Management \_\_\_\_\_ %
- Mesotherapy
- Myelography
- Myomectomy
- Neonatology
- Normal Deliveries

- Organ Transplantation
- Orthopedic Surgery
  - Including Spinal Surgery
  - Without Spinal Surgery
- Osteopathic Manipulative Medicine
- Pain Management
  - Cordotomy
  - Dorsal Root Ganglionectomy
  - Facet Blocks
  - Medication Only
  - Nerve Root Blocks
  - Pump Implantation and Removal
  - Rhizotomy
  - Sphenopalatine Lesioning
  - Spinal Injections
  - Thoracic Sympathectomy
  - Trigeminal Lesioning
  - Other \_\_\_\_\_
- Paracentesis
- Percutaneous Vertebroplasty
- Peripheral Nerve Surgery
- Pacemaker Placement
- Polypectomy
- Prenatal Care - 1<sup>st</sup> Trimester
- Prenatal Care - 2<sup>nd</sup> Trimester
- Prenatal Care - 3<sup>rd</sup> Trimester
- Prolotherapy
- Provertin Retinal Therapy
- Radiation Therapy
- Radiopaque Dye Injection
- Roux-en-Y
- Sclerotherapy
- Shock Therapy
- Spinal Fusion
- Spinal Surgery, Other \_\_\_\_\_ %
- Thoracic Surgery \_\_\_\_\_ %
- Thoracentesis
- Thyroidectomy
- Tonsillectomy/Adenoidectomy
- Transgender Surgery/Hormonal Gender Conversion
- Tubal Ligation
- Vascular Surgery \_\_\_\_\_ %
- Vasectomy
- X-Ray Procedures
  - Noninvasive
  - Invasive
- None of the above apply to my practice - Initial \_\_\_\_\_
- Other procedures not listed above (please list)

### Section 3 – Practices and Procedures

In what States are you requesting Inspirien to provide you coverage?

State _____	License Number _____	% of Practice _____
State _____	License Number _____	% of Practice _____
State _____	License Number _____	% of Practice _____

National Provider Identifier Number \_\_\_\_\_

Federal DEA License Number \_\_\_\_\_

Has your DEA License ever been restricted or revoked?  Yes  No

If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

Has there been any changes in your practice or specialty in the past 5 years?  Yes  No

If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

Do you perform procedures which are not included in your primary medical specialty?  Yes  No

If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

Do you normally staff an emergency department?  Yes  No How many hours per month? \_\_\_\_\_

Is this required for staff privileges at the hospital?  Yes  No

Do you work part-time outside of your regular full-time practice for which you are applying by this application (“moonlight”)?

Yes  No If yes, please explain.

\_\_\_\_\_  
\_\_\_\_\_

Is this activity insured by your part-time (“moonlighting”) employer?  Yes  No

If yes, name of insurance company \_\_\_\_\_

If no, how many hours do you work per month? \_\_\_\_\_

Do you desire this policy to cover this work?  Yes  No

I practice medicine  Full Time  Part Time (20 hours per week or less)

Are you in the employment of an individual firm or corporation other than the organization listed in Section 1?

Yes  No If yes, please explain, giving details of your responsibilities.

\_\_\_\_\_  
\_\_\_\_\_

Do you provide professional health care services to correctional institution inmates (i.e. federal or state prisons, county jails, or youth detention centers)?  Yes  No If yes, please describe your duties and hours worked?

\_\_\_\_\_  
\_\_\_\_\_

Do you provide health care services to nursing home, assisted living, or other convalescent homes?  Yes  No

If yes, name of facility \_\_\_\_\_

Do you have professional liability coverage for this exposure?  Yes  No Carrier \_\_\_\_\_

Do you or will you render medical professional services via telecommunications technology that involve patients who reside outside your primary state of practice that you are requesting Inspirien to provide you coverage?  Yes  No

If yes, please explain and list all states and type of professional services rendered.

\_\_\_\_\_  
\_\_\_\_\_

Do you supervise any individuals other than your own employees?  Yes  No

If yes, provide a detailed explanation of your responsibilities and your relationship to the entity which employs these individuals.

\_\_\_\_\_

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**Section 4 - Education and Training**

Indicate your education background or attach a copy of your Curriculum Vitae if such information is included.

Undergraduate School	<hr/>		Year Completed	<hr/>
Graduate School	<hr/>		Year Completed	<hr/>
Medical School	<hr/>	Location	Year Completed	<hr/>
Internship at	<hr/>	Location	Year Completed	<hr/>
Residency at	<hr/>	Location	Year Completed	<hr/>
Fellowship or Advanced Training	<hr/>		Year Completed	<hr/>

Please explain any gaps in above chronological sequence.

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Are you a U.S. Citizen?  Yes  No If no, indicate your status and date of entry into the USA.

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Are you a foreign medical school graduate?  Yes  No  
 If yes, are you certified by the Educational Council for Foreign Medical School Graduates?  Yes  No

Are you U.S. Board Certified?  Yes  No Specify 

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Organization Extending Certification 

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Are you in your first year of practice?  Yes  No

**Section 5 - Organization and Employee Information**  
 (only needs to be completed once for entire group practice)

Legal Name of Your Organization 

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Date Organization was formed? 

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Do you desire to purchase a separate limit for your organization listed above?  Yes  No

If yes, retroactive date of organization 

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\*must attach declarations page from current policy to evidence retroactive date

Do you desire to have shared limits at no extra cost?  Yes  No

If yes to separate limits, please list all physicians or dentists who are working for your organization, but are not applying for coverage with Inspirien.

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Provide a list on a separate sheet of paper with all owners and percentage owned of the corporation. If multiple entities, please provide for each entity.

**Employee Information**

Certain mid-levels present additional exposure to the practice. The types of mid-levels requiring a charge are Nurse Practitioners, Physicians Assistants, Midwives, Nurse Anesthetists, Podiatrists. There are two ways to cover them:

1. They can share in the physician's limit or
2. You can name them on your policy and provide separate limits to each of them.

Allied Provider Name	License Type (PA/NP, CRNA)	Hire Date	Shared or Separate Limits	Avg. Hours Worked/Week	Retroactive Date*

Please attach separate roster in excel if additional space is needed for listing of names.

\*Note: When separate limits are requested, proof of the current retroactive date from your declaration page and a reporting endorsement (tail) will need to be purchased when they depart your employment.

## Section 6 - Coverage

Per Claim / Annual Aggregate Limits Requested:

1 Million/3 Million     2 Million/4 Million     3 Million/5 Million     Other: \_\_\_\_\_

Do you want a deductible to apply?  Yes     No

If yes, check the deductible amount     \$5,000 per claim     \$10,000 per claim     Other: \_\_\_\_\_

### Current/Prior Coverage Information

Company	Policy Number	Policy Limits	Policy Type		Policy Period
			Claims Made	Occurrence	
			Claims Made	Occurrence	
			Claims Made	Occurrence	
			Claims Made	Occurrence	
			Claims Made	Occurrence	

Were you at any time without insurance?  Yes     No

If yes, please indicate on a separate sheet of paper when and the reason.

Are you requesting prior acts coverage?  Yes     No

If no, you may skip the section next **Prior Acts Questions** section.

Retroactive date requested \_\_\_\_\_

\*This date should match the retroactive date on your current professional liability policy

Prior acts coverage is not automatic and is subject to underwriting approval. Because you are requesting coverage on a claims-made basis you will either need to purchase a reporting endorsement from your prior claims-made insurance carrier or request we provide you with prior acts with the same retroactive date that is on your expiring policy. If you do not purchase a reporting endorsement or request prior acts coverage, professional healthcare incidents that occurred prior to the date you are applying to this coverage will no longer be covered. The ability to purchase a reporting endorsement is time sensitive and typically needs to be done within 30 days of your policy cancellation date.

### Prior Acts Questions:

If you are applying for prior acts answer the following questions regarding adverse patient outcomes which may have occurred in your practice in the last **two years which you have not already reported to your current professional liability insurance company**. Any yes answer must be reported to your current insurance carrier and proof provided to us prior to coverage being offered.

	Yes	No
1. Any change in your practice or coverage from what you are applying (different limits, different states, different procedures)?	___	___
2. Any fetal distress during labor and delivery, newborn Apgar score less than six at either one or five minutes, or evidence of neurological or physical compromise of an infant?	___	___
3. Any unexpected death (including stillbirths), organ failure (heart, liver, lung, kidney), or any significant neurological or functional deficit, or intractable pain, following surgery which were not present upon admission, which are not explained by the medical condition and/or general health of the patient?	___	___
4. Any alleged failure or delay to diagnose a condition resulting in death or serious permanent disability, or any delayed communications of positive diagnostic imaging or pathology reports?	___	___
5. Any contact by an attorney either requesting records of a patient or notifying you that a malpractice action is being investigated or contemplated?	___	___
6. Any acute myocardial infarction, arrest, embolism, aneurysm, or cerebral vascular accident during or within 48 hours of surgery or 72 hours of an office visit?	___	___
7. Any admission or return to the ER/OPD within 5 days of treatment due to complications from surgery resulting in serious temporary or permanent injury or death?	___	___

### THE FOLLOWING IS REQUIRED WITH THE APPLICATION

- a. Your expiring insurance policy Declarations Page showing Retroactive Date
- b. Current CV (curriculum vitae - also known as a resume)
- c. Current dated Loss Run report from all prior insurance companies over the last 5 years or length of practice if less than 5 years.

## State Disclosure Addendum

### Read Carefully Before Signing

The statements in this application, together with any supplemental applications, attachments and any other information submitted to the company in connection with this application will be referred to as the “policy application.”

### Representations as to accuracy of application, the authority of person signing, and applicant’s obligation to supplement information

By signing below, I represent and certify: (i) that the information contained in the policy application is true and accurate; (ii) that I have made all reasonable efforts to investigate the accuracy of the information provided in the policy application and to obtain such information from all persons and entities to be insured by the requested policy as is necessary to provide true and accurate information in the policy application; and (iii) that I am duly authorized to sign this policy application on behalf of all persons and entities to be insured by the requested insurance and that I have carefully read this policy application.

I acknowledge that obtaining the requested insurance, including any renewals of the requested insurance, is conditioned upon providing true and accurate information in this policy application, and any such insurance that may be issued will be based upon the company’s reliance on the information provided in the policy application. I also agree and understand that this policy application shall be the basis of the contract should a policy be issued, and that this policy application will be deemed to be attached to and part of such policy and any renewals of such policy, if issued. Further, if any information in this policy application is misleading, incomplete or false, the company may void the insurance issued pursuant to this policy application to the extent permitted by applicable law.

I agree that I will immediately notify the company in writing of any material change in the information provided in this policy application that may occur before the effective date of the requested insurance or before any renewal of the requested insurance. I understand that if I fail to provide such notice, the company may void the insurance issued pursuant to this policy application or any renewal of the requested insurance. I understand that, to the extent permitted by applicable law (and except as may be prohibited under Montana and/or Oregon law), the company may in its sole discretion modify or withdraw any quotation or agreement to bind insurance in the event of any material change in the information provided in this policy application.

### No Obligation to Issue or Purchase Insurance

I understand that the policy application is not a binder of insurance. Accepting the policy application does not bind the company to issue, or me to purchase, the requested insurance regardless of whether I have made payment, in whole or in part, for the requested insurance or whether the company has deposited such payment. I understand that the requested insurance shall not be effective until I have paid a deposit to the company in the amount invoiced by the company, regardless of whether or not a policy or any renewals of such policy have been issued.

### Authorization to Obtain Information

The company is hereby authorized to obtain full information from any liability insurer, healthcare insurer, hospital, healthcare provider, medical association or society, board of medical examiners, governmental agency, attorney or other person or entity concerning: (i) any medical malpractice claim, suit, licensing board proceeding, credentialing proceeding, disciplinary action or any other civil or criminal action asserted against or relating to the professional conduct of any person or entity to be covered by the requested insurance; (ii) the qualifications of any person or entity to be covered by the requested insurance to perform professional healthcare services; and (iii) such other information which, in the sole judgment of the company, may have a bearing on whether to issue the requested insurance. I agree to hold harmless any person or entity providing such information to the company and the company, its directors, officers, employees, and agents from any liability arising out of the disclosure of such information, including any liability arising out of errors and omissions in the information disclosed.

### Alabama, Arkansas, Indiana, Kentucky, Minnesota, New Mexico, New York, Rhode Island, Tennessee, Texas, West Virginia

**Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to criminal and civil penalties which may include voiding of the policy if allowed by state law.

**California Applicants:** For your protection California law requires the following to appear on this form: any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado Applicants:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulated Agencies.

**District of Columbia Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Florida Applicants:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Louisiana Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine Applicants:** Per 24-A M.R.S.A. 2186(3), it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

**New Jersey Applicants:** Any person who includes false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Ohio Applicants:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Applicants:** WARNING: any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person 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 may have committed a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. For an insurer to deny a claim on the basis of misstatements, misrepresentations, omissions or concealments on the part of the insured, the insurer must show that the misinformation is material to the insurance policy, that the insurer relied on the misinformation and that the misinformation was provided fraudulently.

**Pennsylvania Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person 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 there to commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Virginia Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**Washington Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

_____ Signature of Applicant	_____ Title
_____ Printed Name of Applicant	_____ Date
_____ Signature of Producer (signature is required for N.H. producers only)	_____ Date
_____ Printed Name of Producers	

# Supplemental Claim Information

## Instructions to Applicant

- a. This form should be completed by the applicant whose signature appears on the Inspirien or any related entity Professional Liability Insurance Application.
- b. One of these forms should be completed for each claim or incident in which the applicant has been involved. If additional forms are needed, applicant may photocopy this form for use in reporting other claims.
- c. If space is insufficient to fully provide answers to the questions below, use reverse of this form or separate sheet.
- d. Answer all questions completely. Complete information is necessary for the equitable and careful evaluation of your application.

Full Name of Applicant \_\_\_\_\_

Full Name of the Individual(s) of your firm involved in this claim \_\_\_\_\_

Full Name of Claimant \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_

Indicate whether this was a \_\_\_ Claim \_\_\_ Incident \_\_\_ Suit

Date of Alleged Error \_\_\_\_\_ Date of Claim \_\_\_\_\_

Additional Defendants

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the name of the insurer involved in this claim? \_\_\_\_\_

What is the insurer's claim number assigned to this claim (if known)? \_\_\_\_\_

Description of the claim (please provide enough information to allow for evaluation and a separate sheet of paper if necessary)  
Alleged act, error, or omission upon which the claimant bases claim

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Description of the type and extent of injury or damage allegedly sustained

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If claim is closed, answer the following questions:

What was the total loss paid including a deductible that may have been applied? \_\_\_\_\_

Was this amount paid subsequent to a \_\_\_ Court Judgement \_\_\_ Out of Court Settlement

If claim is pending (open), answer the following questions:

What is claimant's settlement demand? \$ \_\_\_\_\_

What is defendant's settlement offer? \$ \_\_\_\_\_

What is insurer's loss reserve? \$ \_\_\_\_\_

What deductible (if any) applies? \$ \_\_\_\_\_

Is this claim in suit? \_\_\_ Yes \_\_\_ No

If claim is in suit, what amount (if any) was asked for in summons? \$ \_\_\_\_\_

Who is defense counsel (please include address and phone number if known or available)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby understand that information submitted herein becomes a part of and is incorporated with my Professional Liability Application and is subject to the same conditions.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name