ning a current PLICO policy, please the policy number:	If previously covered with PLICO, please enter the policy number:
	DLICO Inc
PHYSICIAN PROF	PLICO, Inc. ESSIONAL LIABILITY INSURANCE APPLICATION
ication Instructions	
f additional space is needed, please complete Section X. Supp	plemental Information with a reference to the question.
Additional documentation may be requested by the conndorsements, Declarations Page, etc.	Example 1 For example: A copy of your most recent professional liability policy, including all
lease print legibly. Please answer all questions; if a question	n is not applicable, state "N/A".
erage Desired	
MS-MADE COVERAGE NOTICE:	
retroactive date and expiration date of the policy. Plea ns-Made and Occurrence coverage or the additional e	injuries for which claims are first made during the policy period, for services rendered between ase contact your agent should you have any questions pertaining to the differences between expense associated with "extension contract" or "tail coverage".
erage Desired: Claims-Made coverage without Prior Acts coverage	Occurrence coverage
Claims-Made coverage with Prior Acts coverage	Occurrence coverage with Prior Acts coverage
realize that my failure to purchase such coverage from my	r) from my current insurer where I am insured under a Claims-Made policy. I y current insurer will result in an uninsured exposure for any claims which may arise
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage	v current insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured	y current insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage	y current insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name	y current insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage	recurrent insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying Initial Here
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name	y current insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full)	Initial Here Initial Here Male Female
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name	Initial Here Initial Here Male Female
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name	Tritial Here Initial Here Initial Here Suffix Date of Birth MM/DD/YYYY Ider Identifier Number Jack of Birth MM/DD/YYYY Jack of Birth MM/DD/YYY
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name Social Security Number (Optional) National Provide	Tritial Here Initial Here Suffix Date of Birth MM/DD/YYYY Ider Identifier Number - - - - - - - - - -
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name Social Security Number (Optional) Business Phone Business Fa Email address:	Tritial Here Initial Here Suffix Date of Birth MM/DD/YYYY Ider Identifier Number Residence/Cell Phone Residence/Cell Phone
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name Social Security Number (Optional) Business Phone Business Fhone Email address: f you have a web address, please provide the website	Tritial Here Initial Here Suffix Date of Birth MM/DD/YYYY Ider Identifier Number Residence/Cell Phone Residence/Cell Phone
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name Social Security Number (Optional) Business Phone Business Fa Email address:	Tritial Here Initial Here Suffix Date of Birth MM/DD/YYYY Ider Identifier Number Residence/Cell Phone Residence/Cell Phone
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name Social Security Number (Optional) Business Phone Business Fhone Email address: f you have a web address, please provide the website	Tritial Here Initial Here Suffix Date of Birth MM/DD/YYYY Ider Identifier Number Residence/Cell Phone Residence/Cell Phone
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name Social Security Number (Optional) Business Phone Email address: f you have a web address, please provide the website	vocurrent insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying Initial Here Suffix Date of Birth MM/DD/YYYY der Identifier Number
realize that my failure to purchase such coverage from my as a result of professional services rendered while insured with PLICO, if offered, will not provide Prior Acts coverage eneral Information Last Name First Name (Full) Middle Name Social Security Number (Optional) Business Phone Email address: f you have a web address, please provide the website	vocurrent insurer will result in an uninsured exposure for any claims which may arise by my current insurer's policy. I understand that the policy for which I am applying Initial Here Suffix Date of Birth MM/DD/YYYY der Identifier Number

D. Practice Locati			location first. Con	ibined perc	centage of practice for	all locations must total 10	00% and cannot be of equal values.)
1.	Office	☐ Hospital	Other		If other please explain:		
% of practice	Practice/Hos	nital Name					
				1111			
	Number & St	reet					
	Suite	City				Sta	te Zip Code
							Start Date:
	County						MM YYYY
2. % of practice	Office	Hospital	Other		If other please explain:		
	Practice/Hos	pital Name					
	Ni mali co a a						
	Number & St	reet 		1 1 1 1			
	Suite	City				Sta	te Zip Code
				1111			
	County						Start Date: / / YYYY
3.	Office	Hospital	Other		If other please explain:		
% of practice							
	Practice/Hos	pital Name					
	Number & St	reet					
							-
	Suite	City				Sta	te Zip Code
	Country						Start Date: / /
	County			_			MM YYYY
			e hospital locatio		ahamaaa.ild asiisa		Yes No
ir no, piease exp	iain your prot	осої то асітії ра	itients to a hospital i	r the circum	stance would arise.		
. Billing and Cor	respondenc	e Address:					
Location	# (from Oue	estion D above):		Residen	ice Other (Please	e enter below)	
				<u> </u>			
Number 8	k Street						Suite
City						Stat	e Zip Code
. Educational Ba	ckgrou <u>nd</u>						
. Medical Schoo					-		
Name of	School		11111				Degree
City					State Completed	from: / / YYYY	To: MM YYYY
Country:							
Country							

	If a fo	ational Backgroreign medica leted the Fifth please explain:	l school gi	aduate,	are yo	ou certi	fied by	the	Educ	catio	nal C	Comr	nissi	on f	or Fo	reign	Medi	ical	Grad	luate	es or	hav	e you	u			Yes	□ No
		ency: List all I			progr	ams.																						
	1.																П											
	1.	Name of Hospi	tal/Facility/	Program								_													_			
		City											Sta	te	Со	untry												
		Specialty Type	_												ı		ı		1 1		1 1		1	ı				
		Completed?	Yes	No		Still in tr	aining			Fi	om:		1M	/ [YYYY] 1	Го:	MM	/	YY	ΥΥ	Ш					
	2.											Ì																
	۷.	Name of Hospi	tal/Facility/	Program								_													_			ш
		City											Sta	te	Со	untry												
		Specialty Type										Ţ.																
		Completed?	Yes	☐ No		Still in tr	aining			F	om:			/] 1	Го:	Ш	/	Щ							
C.	Have	you participat	ted in any	addition	al trai	nina? (i.e. Fe	llows	shin.	etc.)		ľ	1M)	YYYY				MM		ΥΥ	ΥΥ				Г	Ye	s No
٠.						.			 		1 1						1 1		1 1							1 1]
	1.	Name of Heart	- I/E::- /	D																					\perp			
		Name of Hospi	tal/Facility/	Program	1.1	1 1	1 1		1 1	1	1 1				ı		1 1		1 1		1 1		1		ī	1 1		1.1
		City									Ш		Cto	to		l later (Ш		Ш			Ш	\perp	Ш		
		City	1 1 1		1.1	1.1	1 1		1 1	1	1 1	1	Sta	le 		untry	1 1		1 1		1 1		1		1	1 1		1.1
		Specialty Type																										Ш
			_			Skill in An				_				,				_										
		Completed?	Yes	No		Still in tr	aining			F	om:		1M	/ [YYYY			Го:	MM	/	YY	ΥΥ						
	2.																											
		Name of Hospi																										
		City											Sta	te	Co	untry												_
		Specialty Type													ı		ı		1 1		1 1		1	ı				
		Completed?	Yes	No	St	till in tra	iining			Fı	om:		1M	/ [YYYY		י ן	Го:	MM	/	YY	ΥΥ	Ш					
D.	Are y	ou entering pr	rivate prac	tice for	the fire	st time	?																				Ye	s No
	-	ı have particip	-					with	nin th	ne las	t thi	ree ((3) y	ears	, ind	icate t	the n	umb	er o	f Cat	tego	ry 1	cred	it ho	urs.	.		
F.	Have	you complete	d a risk m	anagem	ent edi	ucation	cours	e wi	thin 1	the la	st tv	welv	e (1)	2) m	nonth	ns?					_	-				Ĺ	Ye	s No
		, c cop.ccc							•				- (-	-,														
1111	. Prac	tice Informat	ion																									
	A. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your primary location, including, but not limited to, Telemedicine or Internet Medicine? (If this is covered by another professional liability insurance policy, complete Section IV., Question H.)																											
	-	which state(s):	İII													, 												
		s in which you			-				_ ′		_		_ ′ ˈ	F	, Please	check	the a	appro	opriat	e bo	x to i	ndica	ite th	e sta	_ ′ tus ເ	of you	ur lice	nse.
				(Exc	lude sta	ite abbr	eviation	fron	n licer	nse nu	ımbe	r.)				tive			activ				empo			Pend		
	1. Sta	ate	Licens	se#											[
	2. St	ate	Licens	se#					Ш						[
	3. Sta	ate	Licens	se#																						Г		
	4. Sta	ate	Licens	se#											[

	 Practice Information (continued) Do you have previous practice location(s)? If yes, list al 	l location(s) within the past 10 years. If your request	ed retroactive date is Yes No
	greater than 10 years, provide locations back to the ret	roactive date. Please list most recent location first.	
1.	Name of Practice		
	City	State Country	
	Specialty	From: / / /	/ /
2.			
	Name of Practice		
	City	State Country	
	City		
	Specialty	MM YYYY	MM YYYY
D.	Please explain the following gaps if they occurred in the	e last 10 years:	
	$\textbf{1.} \ \ Gaps \ greater \ than \ 1 \ year \ between \ your \ medical \ school, \ residual$	dency, other training or first time in practice.	
	2. Gaps greater than 6 months between practice locations.		
_	To which Modical Contains on Association of the	-2	
E.	To which Medical Societies or Associations do you belon	y:	
	Note: All percentages requested below for specialties, procedu	res and surgical activities are of your total practice.	_
	**Please enter complete name of specialty/sub-special	, .	
F	What is your present specialty?		% of total practice
•			<u> </u>
_	What is your sub-specialty?		% of total practice
G.	Are you permanently retired from the practice of clinical	Il medicine? Yes No	
Н.	American Board Certified? Yes No	Specialty Board	/ Date most recently certified
		Specialty воаги	
	_	Specialty Board	Date most recently certified
	If not American Board Certified, are you board eligible?	Yes No If yes, when do you plan on taking your b	
	. , , _		MM YYYY
	If not American Board Certified, have you ever taken a specialty	y board examination and failed to pass?	NO
	If yes, how many times?		
	If yes, please explain:		
I.	Indicate the estimated average weekly numbers, under	each of the following categories, for which you requi	re PLICO coverage.
	Hours per week Patients seen per week	None Unscheduled walk-in	None
J.	Please check any of the following procedures you will p	patients per week erform:	
	Abdominoplasty - Tummy Tuck	□ D & C	Pacemakers - Epicardial
H	Abortions- Elective% of total practice Abortions- Therapeutic % of total practice	Discectomy Open	Pacemakers - Endocardial
H	Acupuncture - Therapeutic/Local Anesthetic	Other Than Open	Pacemakers - Temporary
H	Anesthesia General/Spinal/Caudal	Electromagnetic Therapy	Peritoneoscopy
F	Angiography	Electroconvulsive/Shock Therapy	Phlebography
H	Angioplasty	Embolization	Pneumoencephalography
H	Arteriography	ERCP	Polypectomy
H	Arthroscopy	Face Lifts	Prenatal /Gynecological Practice
\vdash	Assisting in major surgery - own patients only	Face Lifts Mini (done with laser)% of total practice	Prenatal Practice - 1st & 2nd Trimester
\vdash	Assisting in major surgery - own patients only Assisting in major surgery - own & other than own patients	Gastrointestinal Endoscopy	Prenatal Practice - to term, no delivery
\vdash	Assisting in major surgery - own & other than own patients Bariatric Surgery - Laparoscopic	Gynecology - Major Surgery	Prenatal Practice - to term, and delivery
H		Hair Transplants - Follicular Unit Transplantations	Normal Deliveries - total per year
H	Bariatric Surgery - Non-Laparoscopic	Hair Transplants - Other	Cesarean Deliveries - total per year
F	Biopsy - Endoscopic Blepharopigmentation % of total practice	HVLA on the cervical spine on patients younger than 18 years of age	Prolotherapy
_	- 70 of total practice	younger than 20 years of age	Radial/Laser Keratotomy

III. Practice Information (continued)		
Blepharoplasty - Cosmetic % of total practice	Intrathecal Pumps	Radiation/X-Ray Therapy
Blepharoplasty - Reconstruction % of total practice	Kyphoplasty	Rectal Ozone Therapy
Botox % of total practice	Laporoscopic Cholecystectomy	Rhinoplasty% of total practice
Brachioplasty	Laparoscopy	Sigmoidoscopy - 60 cm or less
	Laser Surgery	
Breast Implants - Cosmetic % of total practice	Laser Therapy (Endoscopic)	Sigmoidoscopy - greater than 60 cm
Breast Implants - Reconstruction % of total practice	Laser Therapy (Non-Endoscopic)	Silicone Injections % of total practice
Breast Reduction - Cosmetic	Lipoinjection% of total practice	Skin Flaps/Grafts
Bronchoscopy	Liposuction	Cosmetic% of total practice
Bronco-esophagology	Other Than Tumescent Technique	Reconstruction% of total practice
Buttock Implants	Tumescent Technique Only% of total practice	Spinal Cord Stimulators
Calf Implants	Lithotripsy	☐ Thigh Lift
Cataract Surgery	Lymphangiography	Tubal Ligations
Catheterization - Left Heart	Mammograms	Upper GI Endoscopy
Catheterization - Right Heart (other than CVP lines)/	Myelography	Vasectomies - own patients
Swan Ganz	Nerve Blocks	Vasectomies - own & other than your
Cheek/Chin/Lip Implants	Facet	own patients
Chelation Therapy	Lumbar Epidural Steroid	Weight Control Medication % of total practice
Chemical Peels - Superficial / Medium	Myofascial	Other Medical Techniques
Chemical Peels - Deep% of total practice	Cccipital	List Procedures (do not restate your specialty)
Cleft Lip Surgery - Reconstructive	☐ Paraspinal/Paravertebral	List Procedures (do not restate your specialty)
Cleft Palate Surgery - Reconstructive	Peripheral	
Colonoscopy	Sciatic	
Cryosurgery (Cervical)	Triggerpoint Injection	
Cryosurgery (non-external lesions)	Oxidation Therapy	
I/ Bloom in the transmission of countries and in the	Complete the College to a constant and the later	
K. Please indicate the percentage of your total practice pe	rforming the following surgical activities:	
% Cardiac	% Orthopedic (including back)	% Thoracic
% Gynecology	% Orthopedic (not including back)	% Traumatic
% Hand	% Otolaryngology	% Urology
% Neurosurgery	% Plastic (cosmetic enhancement only)	% Vascular
% Obstetrics	% Plastic (reconstruction only)	% Other (Describe)
% Ophthalmology		
L. In the last 10 years,		□v _{ee} □ v _e
Have you discontinued major surgical procedures, performa	ince of obstetrics, or any other medical activity?	Yes No
If yes, list procedures/activities, reason for discontinuing, ar	nd date discontinued.	Date:
, , , , , , , , , , , , , , , , , , , ,		MM YYYY
2. Have you performed weight control surgery or prescribed w	eight control medication?	Yes No
a. If yes, what percentage of your practice (% of patier	nt care) was devoted to prescribing anorectic drugs?	
<1% 1% - 10% 11%-50%	>50% Never prescribed weight control media	cation
	nt care) was devoted to performing weight control surgery?	
S. If yes, what percentage of your practice (% of patter) <1% 1% - 10% 11%-50%	>50% Never performed weight control surge	erv
M. Do you have ownership or financial interests in a weigh		Yes No
If yes, what is the name of the weight control clinic v	vith which you are affiliated?	
N. Do you work in an emergency room on a scheduled basi	s? (If yes, answer 1 and 2 below.)	Yes No
1. Indicate average number of hours per month devoted to in-	hospital emergency room care. (Do not include on-call hours	.) hrs
		1111
2. On average how many of the above hours are you working	in order to fulfill staff privilege requirements?	hrs
(If you have emergency room activities which are covered by	y another professional liability insurance policy, please comp	lete Section IV, Question H.)
O. Please use the space below for any comments you feel v	will help PLICO better understand any special circums	tances concerning your practice
or recase use the space below for any comments you feel t	neip r Lico better unuerstand any special direums	ances concerning your practice.

IV. Additi	onal Professional Information	
Please full	y explain any "yes" answer in Section X. Supplemental Information with a reference to the question.	
	estions A through G, please complete Section IV., Question H, if you are covered by other insurance for these activities.)	
A. Indicat	te the average hours per week devoted to treating or reviewing treatment of federal prison inmates.	rs None
B. Indicat	te the average hours per week devoted to treating non-federal prison inmates.	rs None
C. Indicat	te the percentage of your practice devoted to being a team physician for any professional or collegiate athletes.	6 None
D. Indicat	te the percentage of your practice devoted to working in a nursing home facility.	6 None
-	participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?	Yes No
	nclude a copy of the indemnification agreement provided by the pharmaceutical company. I practice as a medical director?	☐ Yes ☐ No
-	In practice as a medical director: Indicate as a medical director:	
If ves, v	what percentage of your practice is devoted to this activity?	6
	lescribe your responsibilities:	
G. Do you	devise or review plant/employer safety standards?	Yes No
What pr	roducts are manufactured by the company?	
Compar	ny Name:	
Location	n:	
H Will vo	u be performing activities which will be covered by another professional liability policy?	☐ Yes ☐ No
-		
ir yes, a	are you a(n): Employee Independent Contractor Resident/Fellow Faculty	
Practice	Name:	
Location	n:	
Name o	f Insurer:	
traffic suspen	ou ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, ided, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? Delease indicate the date(s) and explain: Date:	Yes No
	MM YYYY y professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever involuntary deductible or surcharge assessed against your policy?	Yes No
If yes, p	please indicate the date(s) and explain: Date:	
K. Have y	ou ever been accused of sexual misconduct of any kind?	Yes No
If yes, p	please indicate the date(s) and explain: Date:/	
	MM YYYY ou ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? nvulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.)	Yes No
	es, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, a tement from your physician attesting to your fitness to practice your specialty must accompany this application.	
Тур	pe(s) of illness:	
Dat	re(s) of treatment(s): From: MM / YYYY To: MM / YYYY Currently in treatment	
Nar	ne of treating physician(s):	
Add	lress(es):	

V. Loss Information (Important! Please fully complete.)									
Please complete the Loss Information Supplement for each written request, incident, claim or suit (A, B or C) below that has NOT been covered by a PLICO policy.									
Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.									
For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.									
A. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services?									
If yes , how many? None None									
B. Are you aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit against you? This includes, but is not limited to, the following:									
► Amputation ► Death ► Loss of major organ function ► Loss of vision ► Permanent neurological injury									
If yes , how many? None									
C. In the last 12 months, have you or anyone from your practice received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit against you?									
If yes , how many? None None									
VI. Practice Organization Information									
Please provide the number of practice organizations of which you are an employee, shareholder/partner or independent contractor: Please provide details below for your primary practice organization. If you indicated more than one organization above, please complete a Practice Organization Supplement for									
each one.									
A. Type of Legal Entity: (Check only one box)									
Solo Unincorporated/Sole Proprietor Solo Incorporated Multi-Shareholder Corporation, Partnership, Limited Liability Company Other-please explain:									
Unite-please explain.									
B. Employment status: Employee									
MM DD YYYY									
C. Type of Organization:									
☐ Standard Medical Practice ☐ Hospital									
State Licensed Medical Surgery Center									
For use by other physicians									
Your patients onlyOther-please explain:									
D. Entity Name: (As stated in the Articles of Incorporation and all formal entity/clinic names.)									
E. If the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.)									
F. Is this entity or employer currently insured with PLICO? If yes, please provide the PLICO corporation or partnership policy or group number, if known.									
Policy #: Sub-group #: Sub-group #:									
G. Do you desire coverage for this entity?									
If yes, please select the type of entity coverage desired: Shared Policy Limits Separate Policy Limits									
(To request Separate Limit Entity coverage, please contact your agent or PLICO Service Representative to complete an application for consideration.)									
H. If the purpose of the entity noted above is other than a medical office practice, please explain:									
The property of the second decision and the second second processor, processo									

VΙ	. Practice Organizati	on Information (continued)				
I.	Indicate the number	r of each of the following who	provide services in your office	(please exclude yourself):	1.1.1.1
	Physicians		Nurse Midwives		Physician Assistants	
	Dentists		Nurse Midwife Assistants		Physician Surgical Assistants	
	Aestheticians		Nurse Practitioners		Podiatrists	
	Case Managers		Nurse Surgical Assistants		Psychologists	
	CRNAs/RNAs		Occupational Therapists		Respiratory Therapists	
	Chiropractors		Perfusionists			
J.	Do you or any member contract for services	ber of your group currently sup s?	ervise any of the specialists li	sted above with whom yo	ou do not either employ or	Yes No
		to do so within 12 months of your rovide an explanation:	requested effective date?			Yes No
	II yes, please pl	Tovide an explanation.				
VI	I. Coverage Informa	tion				
		and/or policy types may not b	e available in all states.			
A.	Requested Coverage Annual policy term will	e Period (12:01 am): begin and end on the same month	From: and day.	: MM DD / YYYY	To: / DD	/ YYYY
В.		e shown on your current Claims for Occurrence with Prior Acts or Cla		MM DD YYY	<u> </u>	
_		er Occurrence/Per Claim Filed		Annual Aggregate		
	List all previous prof	fessional liability insurers with ir requested retroactive date.	in the past 10 years. If your re		is greater than 10 years, pro	vide previous
	1. Current Insurer:					
	Occurrence	Claims-Made	From: MM DD / YY	To:	/ DD / YYYY	
	2. Previous Insurer:					
	Occurrence	Claims-Made	From: MM / DD / YY	To: MM	/ DD / YYYY	
	3. Previous Insurer:					
	Occurrence	Claims-Made	From: MM DD / YY	To: MM	/ DD / YYYY	
Ε.		gaps in coverage within the pase	et 10 years. If your requested	retroactive date is greate	r than 10 years, please explai	n any

VIII. Notices and Agreements 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. I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with PLICO, Inc. (the "Company"). I agree to notify the Company if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association. I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued. I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score. I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank. I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying. I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct

any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which

If application is being signed by the applicant's agent: By my signature, I hereby represent that the applicant has granted me full authority to execute this application on his or her behalf. I also represent that I have reviewed the responses contained in this application with the applicant, and we are in agreement they are full and complete to the best of our combined knowledge and belief. In addition, I represent that I have discussed the representations provided throughout this application with the applicant and that applicant understands and agrees that such representations are binding upon him or her, even though I am executing this application on the applicant's behalf. I further acknowledge that any material misrepresentation or omission made on this application may form the basis for the company to terminate my

Applicant's Signature

Print Name

Agent's Signature

Print Name

the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

agency agreement with cause.

IX. Supplemental Information

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		PLICO, Inc.							
	Assignment (of Right to Cancel Coverage Supplement							
olicant's Name:									
		y the right to cancel your coverage and receive any prer	mium refunds? Yes No						
es, please complete the	e following statement:								
initialing. I assign to th	ne following employer or named third p	party (include name and address), both the right to cancel my	y policy						
to receive any unearn	ed premium. However, I do request tha	at copies of all correspondence, formal notices, etc., be sent to	me at						
ne last address of record. This assignment may be revoked by me at any future time by faxing a written notice to (405) 815-4901 or ending written notice to PLICO, Inc., P.O. Box 1838, Oklahoma City, Oklahoma 73101-1838.									
Name:									
Street:									
State:	Zip Code:	Phone Number:							
		efund will automatically be assigned to a third party fina							
mium on your behal	f.								

PLICO, Inc. **Loss Information Supplement** Please make copies if additional forms are needed. Applicant's Name: Note: Additional documentation may be requested at PLICO's discretion. A \square B \square C \square from the Loss Information section? (Check only one) A. Current or prior claim. B. Complication, incident, or adverse outcome. C. Written request for records. **B. Patient/Claimant Information:** Last Name C. Date of treatment and/or surgery which led, or could lead, to allegations against you. D. Date of notice received, if applicable. E. Has this matter been reported to your current or former insurer? Yes No If yes, date reported to your current or former insurer: Current or former insurer name: If no, please explain: F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. Open Closed G. Current status: If open, indicate dollar value established by insurer: If closed: 1. Date of closing: Yes No 2. Was a payment made? Yes No a. If yes, did you consent to the settlement? \$ _____ b. Total amount of settlement or award: c. Total amount of settlement or award paid on your behalf: H. Nature of allegations or potential allegations: Condition Treated: Treatment Provided: Alleged Negligence: I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

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	PLIC	CO, Inc.		
	Practice Organization	Information Supplem	ent	
A. Type of Legal Entity: (Check only one box) Solo Unincorporated/Sole Proprietor Multi-Shareholder Corporation, Partnership, Lin		Solo Incorporated Other-please explain:		
B. Employment status:				
Employee Shareholder/Partner	Independent Contra	ctor Other	Date joined: / MM DD	/
C. Type of Organization: Standard Medical Practice Hospital State Licensed Medical Surgery Center For use by other physicians Your patients only Other-please explain:				
D. Entity Name: (As stated in the Articles of Incorp	ooration and all formal entity/clinic	names.)		
E. If the above entity does business under any	other name, please list all add	itional entity/clinic names (e.g. DBA, fictitious name, etc.)	
F. Is this entity or employer currently insured v	vith PLICO?			Yes No
If yes, please provide PLICO corporation or partner	ship policy or group number, if kn	own.		
Policy #: Group #:		Sub-group #:		
(To request Separate Limit Entity coverage, please I. If the purpose of the entity noted above is of			an application for consideration.)	
Physicians Dentists Aestheticians Case Managers	who provide services in your Nurse Midwives Nurse Midwife Assistant Nurse Practitioners Nurse Surgical Assistant	s	Physician Assistants Physician Surgical Assistants Podiatrists Psychologists	
CRNAs/RNAs	Occupational Therapists		Respiratory Therapists	
Chiropractors	Perfusionists			
J. Do you or any member of your group current contract for services? If no, do you plan to do so within 12 months of If yes, please provide an explanation:		ists listed above with whon	n you do not either employ or	Yes No

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