



CORPORATION APPLICATION ADDENDUM

If you own a corporation, partnership, LLC or other legal entity and you would like PPIC to provide the entity with a separate limit of liability, please provide the following.

I. GENERAL INFORMATION

1. Name of Entity: _____

a) Other Name(s) under which the entity practices (e.g. DBAs):

b) Is the above a holding company: Yes No

If yes, are these subsidiaries such as (mark each type that is applicable):

_____ Surgery Center	_____ Emergency Service Center
_____ Urgent Care Center	_____ Any Type of Out-Patient Facility
_____ MRI Facility	_____ Physical Therapy Facility
_____ Lab Facility	_____ Other (please explain)

2. Legal Address:

Street			
City	County	State	Zip

3. Billing Address:
(If different than above)

Street			
City	County	State	Zip

4. Contact Person for Entity: _____ Title: _____

5. Contact Email: _____ 6. Contact Phone: _____

7. Website: _____ 8. Fax #: _____

II. COVERAGE REQUESTED

9. Limits of Liability Desired (per claim/aggregate) **Note:** Some limits are not available in certain states.

\$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000 \$500,000/\$1,500,000

\$1,000,000/\$1,000,000 \$1,000,000/\$3,000,000 \$2,000,000/\$4,000,000 Other \$ _____

10. Prior Acts

a) If your expiring policy is on a Claims-made basis, are you exercising the option of purchasing extended reporting period coverage?..... Yes No

If no, do you want us to provide coverage for prior acts?..... Yes No

Indicate the retroactive date you would like: _____

b) Please attach a copy of your most recent declarations page

c) Indicate reason for termination of latest policy: _____

Prior Acts Coverage is not granted automatically; therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase extended reporting coverage from your present carrier.

III. PRACTICE INFORMATION

11. The entity is:

- "Solo" Medical Corporation
- Multi-Physician Shareholder Medical Corporation
- Medical Partnership with Formal Written Agreement
- Other _____

12. Contracts or Agreements

- a) Does the entity have a written contract or agreement with a Medical Practice Foundation, Management Services Organization or similar entity? Yes No
If Yes, please attach a copy to this application
- b) Does the entity render services under any other written contract or agreement? Yes No
If Yes, please attach a copy to this application

IV. PRIOR ACTS PERIOD

13. Practice History

Has the Corporation's podiatrist roster changed, up or down, by more than 10% in the last five years? Yes No
If Yes, please explain: _____

14. Professional Employees

Please list all professional employees that are CRNA's, Physician Assistants, Surgical Assistants, Nurse Midwives, Chiropractors or Dentists that have been employed by the entity in the last five years. Attach additional pages if necessary.

Name	Job Title/Specialty

15. Insurance History

Complete the following chart to reflect the entity's entire professional liability insurance history during the Prior Acts coverage period. Begin with the entity's current professional liability insurance carrier.

Note: To assist in answering this question, you may attach copies of all previous declaration pages and list all endorsements.

16. Insurance

Has any professional liability insurer canceled, declined, rescinded or modified coverage, or refused renewal, excluding insurance company withdrawal?

(e.g. reduced limits, assigned a deductible, restricted coverage, surcharged rates) Yes No
If Yes, please attach an additional page with full details.

17. Claims or Suits

- a) Has the entity or any employee (other than a podiatrist) ever been notified of its involvement in a malpractice claim, suit, or "incident" either directly or indirectly? Yes No
- b) As of this date, are you aware of any claims or suits made against the entity or of any conduct, circumstances, incidents or accidents that are likely to give rise to a claim that have not been reported to the entity's current and/or prior insurer(s)? Yes No

Please submit current claims history for all requested coverages for the past ten (10) years, if available. In the summary, include the date of the event.

V. FRAUD STATEMENTS / WARNINGS

NOTICE TO ALABAMA APPLICANTS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines, or confinement in prison, or any combination thereof.

NOTICE TO ARKANSAS, LOUISIANA, MARYLAND, RHODE ISLAND & WEST VIRGINIA APPLICANTS

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

*Applies in Maryland only

NOTICE TO 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 for the purpose of defrauding or attempting to defraud the 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 Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA and OKLAHOMA 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)*. *Applies in Florida only

NOTICE TO KANSAS APPLICANTS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

NOTICE TO KENTUCKY and NEW YORK 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, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in New York only

NOTICE TO MAINE, TENNESSEE, VIRGINIA & 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 (may)* include imprisonment, fines and denial of insurance benefits. *Applies in Maine only

NOTICE TO NEW MEXICO 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 civil fines and criminal penalties.

NOTICE TO NEW JERSEY APPLICANTS

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO 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.

NOTICE TO 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 thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO ALL OTHER 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 information for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DECLARATION AND CERTIFICATION:

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

Signature of Applicant

Signature of Broker/Agent

Title

Date

Date

Signed by Licensed Resident Agent

(Where Required By Law)

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES A POLICY WILL BE ISSUED.