



Atlantic Specialty Lines, Inc.

ALLIED MEDICAL PSYCHIATRIST SUPPLEMENTAL APPLICATION SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Name of Clinic/Center: _____

2. List the professional societies of which you are a member: _____

3. License Number(s) and State(s): _____

Are you board-certified in Psychiatry?

No Yes

If "No," are you eligible?

No Yes

4. Do you perform electro-convulsive therapy for the center named above (ECT)? No Yes

a. Where is this procedure performed? _____

b. Is Anesthesia always administered in a licensed Medical facility? No Yes

c. Who administers Anesthesia? Anesthesiologist CRNA Other: (explain) _____

5. Medical School Attended: _____ Country: _____

Year Graduated: _____ Degree: _____

6. Has any insurance company ever declined, failed to renew, conditionally renewed or No Yes cancelled a Professional Liability Policy for you?

If "Yes," please list company, date, and reason for the action by the company:

7. Have you ever been:

a. The subject of an investigatory or disciplinary proceeding or reprimand? No Yes

b. Convicted for an act committed in violation of any law or ordinance other than No Yes traffic offenses?

c. Treated for alcoholism or drug addiction? No Yes

8. a. Have you ever had a malpractice claim or suit filed against you? No Yes

If "Yes," how many? _____

b. Do you know of any incident that may result in a claim against you? No Yes

If "Yes," for each claim, suit, or incident, complete a separate claim activity form.

9. a. How many hours per week do you spend in active practice for Clinic/Center? _____
- b. How many weeks per year do you spend in active practice for Clinic/Center? _____
10. a. Apart from the insurance provided by your employer, do you carry your own professional liability insurance? No Yes
If "Yes," what is the name of your insurer? _____
- Policy Number:** _____
Policy Dates: _____ / _____ **Limits:** _____ / _____
- b. Occurrence or Claims Made Coverage? (Circle one)
If "Claims Made," what is retroactive date? _____
- c. Does this malpractice policy cover you for your acts at the center? No Yes

* 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 be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.
 * not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

 Applicant's Signature

 Sub-Producer

 Title/Date

 Producer

*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.