Gulf Atlantic Legal Defense Insurance

Fax Number: 1-800-357-0652

Personal Counsel Plan Application

General Information

Name:

Address:

City: County: State: Zip:

Medical License No.: Home Phone No.: Email:

Date of Birth: / / Office Phone No.: Fax No.:

Policy Information

Insurance Company: Policy Effective Date: / /

Retroactive Date: / / Policy Limits: ☐ $250,000/$750,000 ☐ $1,00,000/$1,500,000 ☐ $5000,000/$1,500,000 ☐ Other ____________

(Attach copy of your current decleration page.)

Practice Information

Does the address provided above represent the only location/facility at which you provide professional service?
If NO, please provide the name, address and phone/fax number for each on a separate page. ☐ Yes ☐ No

Your Practice Specialty: Subspecialty:

Partnership / Corporation / Professional Association Information *(No charge for this coverage.)*

1. Are you: Employed By ☐ Under Contract to ☐ or share office space ☐ with another physician? If so, please answer below.

2. Do you practice as a ☐ Partnership ☐ Professional Association ☐ Solo PA ☐ Corporation ☐ Other (describe below)

Name of Entity:

Claim Information

Note: For purposes of this application and your Gulf Atlantic policy - "Claim" means notice to you of an actial, threatened, or possible demand for money for services arising out of your professional services. A claim includes any medical incident or other situation which you believe may result in a demand being made against you, including, but not limited to, a patient complaint, poor or unexpected results, an attorney's request for medical records or a lawsuit; **"Medical Incident"** means any act, error or omission in providing of or failure to provide professional services by you. This includes your repsonsibility for anyone acting under your directions or control.

3. ☐ Yes ☐ No Do you have any open claims being defended by your current or prior insurance carrier(s)? If YES, please attach a complete description of the Claims.

4. ☐ Yes ☐ No Have you ever reported any Medical Incidents to your current or prior insurance carrier(s)? If YES, please attach a complete description of the Medical Incidents and their status. (Use extra paper if necessary.)

5. ☐ Yes ☐ No Are you aware of any Claims, potential Claims or Medical Incidents that have not been reported to your current or prior insurance carrier(s)? If **YES**, please attach a description of these items and their status.

Supplemental Waiver / Release

Any person knowing and with intent to injure, defraud or deceive any insurer files any statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I hereby certify that the above statements, representations and repsonses are true, complete and correct, and I understand and agree that Gulf Atlantic will rely on such statements, representations and responses in making a decision as to whether to issue a policy to me. If the answers contained in the application or this certification materially change during any policy period, I agree to immediately notify you. If transmitted to Gulf Atlantic electronically, I agree that the electronic copy of this application received by Gulf Atlantic shall be, and shall have the same effect for all purposes, as the original.

Applicant Signature: **Date:** / /