ADMIRAL INSURANCE COMPANY
1100 W. Louis Henna Blvd., Bldg. 1, Suite 200
Round Rock, TX 78681
Phone: 512-795-0766 — Fax: 512-795-0833
http://www.admiralins.com

PHYSICIANS PROFESSIONAL LIABILITY SHORT FORM APPLICATION

1. Full Name of Insured _____
2. Practice Address _____
4. Date of Birth: _____ Social Security #: _____
5. What is your medical or surgical specialty? _____ % of Total Practice: _____
6. What is your sub-specialty? _____ % of Total Practice: _____
7. Average number of hours worked per week: _____
8. American Board Certified? _____ Yes _____ No
   Medical Specialty: _____ Date Certified: _____
   Medical Specialty: _____ Date Certified: _____
8. Average Weekly Patient Load: _____ Total surgeries performed annually: _____
9. Are you performing any surgical procedures, whether minor or major? _____ Yes _____No
   If "yes," please provide details (you may also provide details in the space provided on page 2): _____

   _____
10. Please answer the following questions: (If "yes" to any questions, provide details in space provided on page 2):
    A) Have you been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? _____Yes _____No
    B) Have you had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or voluntarily surrendered? _____Yes _____No
    C) Have there been any allegations of sexual impropriety made against you? _____Yes _____No
    D) Have you had any serious health issues including mental health and/or substance abuse? _____Yes _____No
    E) Have you been investigated, charged or convicted of a misdemeanor (other than traffic violations) or felony or is any such matter pending? _____Yes _____No
11. Has any claim or suit for alleged malpractice been brought against you? _____Yes _____No. If YES, how many total claims or incidents: _____. Please complete the Supplemental Claim Information Form attached to this application for each and every claim. Also, please attach 10 years of currently valued company loss runs.
12. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? _____Yes _____No. If Yes, please complete the Supplemental Claim Information Form attached to this application for each and every claim.
13. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?_____Yes _____No. If Yes, please provide details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident.

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

_____ _____
Signature of Applicant **Date**

Please use this section to provide additional information or to answer any questions

Question #	

SUPPLEMENTAL CLAIM INFORMATION FORM

(Complete one form for each claim)

1. Name of applicant/named insured: _____

2. Name of other parties or defendants named in suit: _____

3. Data of alleged error or occurrence, or contact date: _____

4. Data claim was made: _____

5. Name of claimant: _____

6. Name of Insurance Company handling your claim: _____

7. Present status of claim or final disposition: _____

Circle One: **CLOSED** **OPEN**

8. Defense costs paid to date inclusive of any deductible: _____

9. If closed, total loss paid, inclusive of any deductible: _____

10. If claim is open or pending, what are the insurers reserves?

Defense: _____ Loss: _____

11. Description of case and events including allegations and assessment of liability: _____

12. Claimants last settlement demand: _____

13. Describe steps taken to avoid a similar incident: _____

_____ _____

Date **Signature**