MEDICAL PROFESSIONAL LIABILITY INSURANCE APPLICATION

DATE (MM/DD/YYYY)

IMPORTANT - If CLAIMS MADE is checked in the COVERAGE / LIMITS section below, this is an application for a claims - made policy.

AGENCY NAME: TMK RISK MANAGEMENT INC	CARRIER / NAIC CODE
AGENCY ADDRESS: DBA KALLMAN INSURANCE PO BOX 266736 WESTON FL 33326	APPLICANT (First Named Insured)
CONTACT NAME:	SOCIAL SECURITY # / DEA # (IF APPLICABLE)
PHONE (A/C, No, Ext): 954-389-5897	US CITIZEN? YES NO / DATE OF BIRTH
FAX (A/C, No): 954-389-6661	PRIMARY BUSINESS ADDRESS / PHONE (A/C, No, Ext):
E-MAIL ADDRESS: AKALLMAN@TMKRISK.COM	
CODE: / SUBCODE:	
AGENCY CUSTOMER ID:	MAILING ADDRESS

COVERAGE / LIMITS

CLAIMS MADE   OCCURRENCE

$ AGGREGATE

$ EACH OCCURRENCE

$ OTHER

PROPOSED EFFECTIVE DATE | PROPOSED RETROACTIVE DATE

PROFESSION

PHYSICIAN - PRIMARY PRACTICE: SECONDARY PRACTICE:

SURGEON - SPECIALTY: OTHER:

PHYSICIAN'S ASSISTANT | PERFUSIONIST | NURSE PRACTITIONER

NURSE ANESTHETIST | REGISTERED NURSE | COUNSELOR

SURGEON'S ASSISTANT | LICENSED PRACTICAL NURSE | OTHER (SPECIFY):

PSYCHOLOGIST | OPTOMETRIST

NURSE MIDWIFE | EMERGENCY MEDICAL TECHNICIAN

PERSONAL INFORMATION

TYPE OF CERTIFICATION CURRENTLY HELD

STATES IN WHICH YOU ACTIVELY PRACTICE

STATE	LICENSE #

EDUCATION (LIST MOST RECENT ATTENDANCE FIRST)

INSTITUTION	DATES OF ATTENDANCE MM/YYYY	MM/YYYY	DATE GRADUATED (MM/YYYY)	CERTIFICATION OR DEGREE RECEIVED

LIST CONTINUING EDUCATION COURSES AND CREDITS RECEIVED WITHIN THE LAST TWO (2) YEARS (OR ATTACH COPIES OF CERTIFICATES AND/OR CREDITS RECEIVED)

HAS YOUR CERTIFICATION / LICENSE IN ANY STATE EVER BEEN (VOLUNTARILY OR OTHERWISE) SUSPENDED, DENIED, REVOKED, RESTRICTED OR LIMITED IN ANY WAY? IF YES, EXPLAIN.

YES   NO

CURRENT PRACTICE (DESCRIBE GENERAL DUTIES AND EXTENT OF SUPERVISION (IF ANY)

LIST ANY ASSOCIATION / SOCIETY / MEMBERSHIPS RELATED TO YOUR PROFESSION

PRESENT EMPLOYEES AND POSITIONS

LOSS HISTORY

ENTER ALL CLAIMS (REGARDLESS OF FAULT) OR OCCURRENCES THAT MAY GIVE RISE TO CLAIMS FOR THE PRIOR 5 YEARS (3 YEARS IN KS & NY)   CHK HERE IF NONE   SEE ATTACHED LOSS SUMMARY

DATE OF OCCURRENCE	TYPE/DESCRIPTION OF OCCURRENCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID	AMOUNT RESERVED	CLAIM STATUS
					OPEN / CLOSED
					OPEN / CLOSED
					OPEN / CLOSED

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PRIOR CARRIER INFORMATION

CATEGORY																
CARRIER																
POLICY NUMBER																
POLICY TYPE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE		CLAIMS MADE		OCCURRENCE
RETRO DATE																
EFF-EXP DATE	TO:		FROM:		TO:		FROM:		TO:		FROM:		TO:		FROM:	
GENERAL AGGREGATE																
EACH OCCURRENCE																

GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	Y / N
1. HAVE YOU EVER BEEN INSURED BY MUTUAL ASSURANCE OR MEDICAL ASSURANCE FOR PROFESSIONAL LIABILITY? (If "YES", list policy # or name of previous employer) POLICY #: PREVIOUS EMPLOYER NAME:	
2. IF PROFESSIONAL LIABILITY COVERAGE IS PROVIDED THROUGH YOUR EMPLOYER, DO YOU MAINTAIN A SEPARATE POLICY FOR PROFESSIONAL LIABILITY? (If "YES", please provide a copy of your Declarations page. A Certificate of Insurance may also be required.)	
3. HAVE YOU EVER BEEN DIAGNOSED WITH OR PROFESSIONALLY ADVISED TO SEEK TREATMENT FOR ALCOHOL/DRUG ABUSE OR ADDICTION, MENTAL ILLNESS OR CHRONIC PHYSICAL ILLNESS?	
4. HAVE ANY FEE OR PROFESSIONAL RELATION COMPLAINTS BEEN REGISTERED AGAINST YOU WITH YOUR PROFESSIONAL ASSOCIATION(S), HOSPITAL(S) OR ANY STATE LICENSING AUTHORITY?	
5. HAVE YOU EVER BEEN CHARGED WITH OR CONVICTED OF A CRIMINAL OFFENSE?	
6. HAS YOUR PROFESSIONAL LIABILITY INSURANCE EVER BEEN CANCELLED, SUSPENDED, NON-RENEWED, DECLINED OR ISSUED ONLY ON SPECIAL TERMS? **(Missouri Applicants - Do not answer this question)**	
7. ARE YOU A SUBSIDIARY OF ANOTHER ENTITY OR DO YOU HAVE ANY SUBSIDIARY?	

REMARKS (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

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SIGNATURE

THIS APPLICATION IS THE BASIS FOR COVERAGE; THEREFORE, ANY INCORRECT OR INCOMPLETE STATEMENTS OR ANSWERS COULD NULLIFY COVERAGE. COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.

I HEREBY REQUEST THAT MY APPLICATION FOR INSURANCE COVERAGE BE SUBMITTED FOR CONSIDERATION TO THE COMPANY SHOWN IN THIS APPLICATION. ACCORDINGLY, I AUTHORIZE AND DIRECT ANY PERSON OR ORGANIZATION WHATSOEVER TO RELEASE AND FURNISH TO THAT COMPANY ANY AND ALL INFORMATION REQUESTED WHICH MAY RELATE TO MY INSURABILITY.

I HEREBY INDICATE THAT THE AFOREMENTIONED STATEMENTS AND ANSWERS ARE CORRECT AND COMPLETE. I FURTHER UNDERSTAND THAT AN INCORRECT OR INCOMPLETE STATEMENT OR ANSWER COULD VOID MY PROTECTION.

I HEREBY CONSENT TO THE REVIEW BY THE COMPANY SHOWN IN THIS APPLICATION OF ANY INCIDENTS OR OCCURRENCES LIKELY TO RESULT IN MALPRACTICE ALLEGATION OR CLAIM. I AGREE TO COOPERATE IN THE REVIEW OF CLAIMS AND INCIDENTS WHICH APPLY TO THE COVERAGE REQUESTED.

WHERE APPLICABLE, I HEREBY CONSENT TO THE REVIEW OF MY APPLICATION BY THE COMMITTEES APPOINTED BY MY COUNTY OR STATE PROFESSIONAL ASSOCIATION / SOCIETY. I AGREE TO COOPERATE WITH THESE COMMITTEES.

NOTICE OF INSURANCE INFORMATION PRACTICES

PERSONAL INFORMATION ABOUT YOU, INCLUDING INFORMATION FROM A CREDIT REPORT, MAY BE COLLECTED FROM PERSONS OTHER THAN YOU IN CONNECTION WITH THIS APPLICATION AND SUBSEQUENT RENEWALS. SUCH INFORMATION AS WELL AS OTHER PERSONAL AND PRIVILEGED INFORMATION COLLECTED BY US OR OUR AGENTS MAY IN CERTAIN CIRCUMSTANCES BE DISCLOSED TO THIRD PARTIES. YOU HAVE THE RIGHT TO REVIEW YOUR PERSONAL INFORMATION IN OUR FILES AND CAN REQUEST CORRECTION OF ANY INACCURACIES. A MORE DETAILED DESCRIPTION OF YOUR RIGHTS AND OUR PRACTICES REGARDING SUCH INFORMATION IS AVAILABLE UPON REQUEST. CONTACT YOUR AGENT OR BROKER FOR INSTRUCTIONS ON HOW TO SUBMIT A REQUEST TO US.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND [NY: SUBSTANTIAL] CIVIL PENALTIES. (Not applicable in CO, DC, FL, HI, KS, MA, MN, NE, OH, OK, OR, VT or WA; in LA, ME, TN and VA, insurance benefits may also be denied)

IN THE DISTRICT OF COLUMBIA, 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 FLORIDA, 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.

IN KANSAS, 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.

IN MASSACHUSETTS, NEBRASKA, OREGON AND VERMONT, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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, WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

IN WASHINGTON, IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

PRODUCER'S SIGNATURE	PRODUCER'S NAME (Please Print)		STATE PRODUCER LICENSE NO (Required in Florida)
APPLICANT'S SIGNATURE		DATE	NATIONAL PRODUCER NUMBER