



ENTITY PROFESSIONAL LIABILITY APPLICATION – SHARED LIMITS COVERAGE
Non-Assessable Claims-Made Coverage

(Please type or print in black ink.)

APPLICANT'S INSTRUCTIONS

- A separate application must be completed for each joint venture, partnership, or corporation.
- Attach copies of all Articles of Incorporation, Partnership Agreements, etc.
- If space is insufficient to answer any questions fully, use the Additional Comments Section at the bottom of this form, or attach separate documentation.

Practice

Full Name _____

Suffix Sr. Jr. I II III IV Professional Designation MD DO

Web Site Address _____

Tax ID _____

Office Manager

Full Name _____

Email _____

Phone (_____) _____ Fax (_____) _____

Practice Mailing Address

Address Line 1		Address Line 2	
City	State	Zip Code	

Practice Names

If the Applicant does business under any other name, please list all additional names:

Practice Locations

Address Line 1		Address Line 2	
City	State	Zip Code	
Phone (_____)		Fax (_____)	
Address Line 1		Address Line 2	
City	State	Zip Code	
Phone (_____)		Fax (_____)	

Address Line 1		Address Line 2	
City		State	Zip Code
Phone ()		Fax ()	

Address Line 1		Address Line 2	
City		State	Zip Code
Phone ()		Fax ()	

Organization

1. Type of Practice (select the one most appropriate)

- | | | |
|--|---|---|
| <input type="checkbox"/> Single Specialty Practice | <input type="checkbox"/> University/Teaching Facility | <input type="checkbox"/> Psychiatric/Substance Abuse Center |
| <input type="checkbox"/> Multi-Specialty Practice | <input type="checkbox"/> Certified Trauma Center | <input type="checkbox"/> Community Based Health Center |
| <input type="checkbox"/> Blood Bank | <input type="checkbox"/> Hospital Based Practice | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Emergency Center | <input type="checkbox"/> MRI/CT (Fixed/Mobile) | <input type="checkbox"/> Physical Fitness Center |
| <input type="checkbox"/> Laboratory (Pathology) | <input type="checkbox"/> Free Clinic | <input type="checkbox"/> Renal Dialysis |
| <input type="checkbox"/> Outpatient Surgery Center | <input type="checkbox"/> Rehabilitation/Chronic Disease | <input type="checkbox"/> State/County Health Department |
| <input type="checkbox"/> Physical Therapy Center | <input type="checkbox"/> Urgent Care Center | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Walk-in Center | | |

If other, please explain:

2. Type of Organization (select the one most appropriate). *Note: Non-Profit Organizations must attach list of Board of Directors and Shareholders along with proof of non-profit status.*

- | | | |
|--|---|---|
| <input type="checkbox"/> Solo Incorporated | <input type="checkbox"/> Professional Corporation | <input type="checkbox"/> Other - describe legal entity: _____ |
| <input type="checkbox"/> Solo Unincorporated | <input type="checkbox"/> Government Agency | _____ |
| <input type="checkbox"/> Multi-Shareholder Corporation | <input type="checkbox"/> Partnership | _____ |
| <input type="checkbox"/> Non-profit Organization | <input type="checkbox"/> Joint Venture | _____ |

3. List any non-physician owners and their percentage of ownership.

4. If the Applicant is a joint venture, disclose the parties in the joint venture and their percentage participation.

5. If the Applicant owns a subsidiary(ies), disclose that subsidiary here and indicate its type of organization.

Coverage

Practice State	Practice County	Desired Effective Date
----------------	-----------------	------------------------

Desired Limits (Each Claim/Aggregate) Choose One Option

- | | | |
|--|--|---|
| <input type="checkbox"/> Same As Employer | <input type="checkbox"/> \$3,000,000/\$3,000,000 | <input type="checkbox"/> \$5,000,000/\$7,000,000 |
| <input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$3,000,000/\$5,000,000 | <input type="checkbox"/> \$6,000,000/\$6,000,000 |
| <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> \$4,000,000/\$4,000,000 | <input type="checkbox"/> \$6,000,000/\$8,000,000 |
| <input type="checkbox"/> \$2,000,000/\$2,000,000 | <input type="checkbox"/> \$4,000,000/\$6,000,000 | <input type="checkbox"/> \$2,000,000/\$6,000,000 Available in Virginia only |
| <input type="checkbox"/> \$2,000,000/\$4,000,000 | <input type="checkbox"/> \$5,000,000/\$5,000,000 | |

