



Medical Security  
PROTECTING OUR PROFESSION



**PRIOR ACTS COVERAGE CERTIFICATION**  
**(Increased Limits of Liability)**

**NAME OF INSURED:** \_\_\_\_\_

**POLICY #:** \_\_\_\_\_

**EFFECTIVE DATE OF INCREASE:** \_\_\_\_\_

**DESIRED LIMITS:** \_\_\_\_\_

I hereby certify that I have no knowledge of any occurrence, incident or circumstance likely to result in a professional liability claim on or after the effective date of the increase in limits of liability, except as indicated below.

Please give a brief description of each such occurrence, incident or circumstance. *Notice of any such occurrence, incident or circumstance should be given to the Company immediately if such notice has not already been provided.*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above is true, complete and correct to the best of my knowledge, information and belief. I understand that my misrepresentation of the facts or failure to provide a true and accurate response to the above questions may result in the denial of claims under any policy or policies issued. I understand that any incident already reported to the Company or known about before the effective date of the increase in limits of liability will be settled according to the limits in force at the time of the incident and in accordance with the terms and conditions of the policy.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Insured)