LANCET INDEMNITY
"THE INSURANCE COMPANY PHYSICIANS TRUST"

APPLICATION FOR PRIOR ACTS COVERAGE

(Must Be Returned With the Professional Liability Application)

Name of Applicant: _____

Earliest Date of Prior Acts Coverage Requested: _____

At all time, from the date above, have you been continually covered by a claim-made policy?
☐ Yes ☐ No

If No, please explain: _____
_____

In the last 24 months (or if retroactive date is more than 24 months), do you have knowledge of any unsatisfactory outcome or event?
If so, please complete one form for EACH unsatisfactory outcome or event

Patient's Name: _____

Date(s) of Treatment in question: _____

Outcome / Result: _____
_____

I. Medical Care (Please Circle)

A. Any patient(s) who had a significant injury resulting from your treatment? ☐ Yes ☐ No

B. Any patient(s) who had any unexpected compromise to airway or neurovascular bundle that led to injury? ☐ Yes ☐ No

C. Any patient(s) who had a poor result that was not expected and became angry at you? ☐ Yes ☐ No

D. Any patient(s) who died unexpectedly while under your care? ☐ Yes ☐ No

E. Any patient(s) who died unexpected respiratory or cardiac arrest? ☐ Yes ☐ No

F. Any patient(s) who sustain a major organ failure (heart, lung, or kidney) not present at time of treatment was rendered? ☐ Yes ☐ No

G. Any case(s) where a foreign body was retained? ☐ Yes ☐ No

H. Any written or verbal contact from patient, family, attorney or other representative with a demand for money or service or other indication of an intent to file a claim, lawsuit or other complaint against you? ☐ Yes ☐ No

II. Surgical Care (Please Circle)

A. Unexpectedly returned to the operating room during the same admission? ☐ Yes ☐ No

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B. Sustained an acute MI or CVA during or within 72 hours of elective surgery or other major diagnostic or therapeutic procedure? ☐ Yes ☐ No

C. Patient with post operative curse that led to permanent injury? ☐ Yes ☐ No

III. Obstetrical Care

A. Any result that led to injury of the mother? ☐ Yes ☐ No

B. Any result that led to injury of the infant? ☐ Yes ☐ No

C. Specially:

Cerebral palsy? ☐ Yes ☐ No

Mental Retardation? ☐ Yes ☐ No

Fracture? ☐ Yes ☐ No

Brachial Plexus? ☐ Yes ☐ No

DEATH(s)? ☐ Yes ☐ No

IV. Other, please explain: _____
_____
_____

Item 4

Has your practice changed in any way since the date noted in Item 2 (classification or procedure changed?)

_____
_____
_____

Item 5

ATTACH A COPY OF THE MOST RECENT CLAIMS-MADE POLICY ISSUED TO YOU. This must contain the retroactive date noted in Item 2 above. If it does not, attach all policies pertaining to the continuous claims-made coverage which you have had back to the date stated in Item 2.

Item 6

If you require coverage for "Additional Insured" that were on prior policies, you must include any endorsements showing the type and name of those Additional Insured. This includes group coverage. Each proposed Additional Insured is subject to a separate underwriting decision.

Date: _____ Signature: _____