Additional Insured Application for Corporations

All information below must be completed and all questions answered "Yes" or "No". Please provide any extra explanations on separate page.

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Full Legal Name of Entity **Federal Tax ID Number** **Date of Incorporation**

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Mailing Address **Office Phone Number**

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Primary Insured **Entity Contact Person** **Email Address**

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Effective Date **Retroactive Date**

Corporation Questions:

(Please explain all "Yes" answers on separate page)

1. Does anyone other than the Primary Insured own this Entity? ☐Yes ☐No
2. Do any other medical providers practice medicine under this entity? ☐Yes ☐No
   If yes, do they carry their own medical professional liability insurance? ☐Yes ☐No
   Limits: ______________________________
3. Has this entity ever been named in a claim or had any other action brought against it for professional negligence? ☐Yes ☐No
4. Has this entity ever had a gap in coverage for medical professional liability insurance? ☐Yes ☐No
5. Are you aware of any negative out comes that could potentially bring a claim against this entity? ☐Yes ☐No
6. Does this entity practice under multiple names or have multiple locations? If yes, please list all on separate page. ☐Yes ☐No

I HEREBY DECLARE THAT I HAVE READ THE ABOVE APPLICATION AND THAT ALL STATEMENTS MADE IN THIS APPLICATION ARE TRUE, MATERIAL AND COMPLETE. I FURTHER ACKNOWLEDGE ANY MISREPRESENTATION OR LACK OF NOTIFYING THE CARRIER OF CHANGES IN MY PRACTICE MAY RESULT IN COVERAGE BEING VOIDED.

______________________________ ______________________________
Authorized Representative Signature Date

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Print Name