GeneralStar™

General Star National Insurance Company

NEW BUSINESS APPLICATION
PROFESSIONAL LIABILITY INSURANCE

PHYSICIANS AND SURGEONS CLAIMS-MADE AND REPORTED COVERAGE

Please complete this application in ink and answer all questions. An incomplete application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

INSTRUCTIONS TO THE APPLICANT:

- You must provide a fully completed application, signed and dated by you within 45 days of the desired effective date of coverage.
- Appropriate Supplementary Applications, Claim Information Supplement(s) and additional documentation must also be completed as needed.
- If a question is not applicable, state "N/A". If more space is required to answer a question, continue on your letterhead.
- The following additional information must be provided:
  - Copy of your current professional liability insurance Declarations Page.
  - Copy of your Curriculum Vitae.
  - Copies of all advertising that you use.
  - Copy of your business letterhead.
  - Company loss runs, valued within the last 90 days.

I. GENERAL INFORMATION

Social Security #: _____

Applicant's Name:_____ Date of Birth: _____

Professional Designation: ☐ M.D. ☐ D.O. ☐ D.P.M. ☐ Other (describe) _____

1. Mailing Address:_____
   Street/P.O. Box City County State Zip Code
2. Primary Practice Location:_____ Number of years at this location: _____
   Street City County State Zip

   Do you have more than one practice location? **If YES**, on a separate sheet please provide the following information: location address, hours of operation, procedures performed at each location, number of years at each location. ☐ Yes ☐ No
3. Office Telephone:_____ E-mail: _____
   Office facsimile: _____ Web Site:_____
4. Applicant is a(n): ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership
   ☐ Employed Physician By Whom _____
   ☐ Other (describe):_____
   Practice is a: ☐ Solo Practice ☐ Group Practice
   Entity Name: _____ Applicant's percentage of ownership: ____%
   How many other physicians practice at this entity? _____
   Do you use any "doing business as" (d/b/a) name? ☐ Yes ☐ No
   If YES, specify: _____
5. Residence Address:_____
   Street/P.O. Box City County State Zip Code
   Residence Telephone: _____

II. MEDICAL TRAINING & EDUCATION

1. Medical Specialty: _____ Percentage of Practice: _____%

   Sub-Specialty: _____ _____%

2. Date you began practicing medicine:_____

3.	Hospital / College	City & State	Completed?	Dates – From / To
Medical School			☐ Yes ☐ No	
Internship			☐ Yes ☐ No	
Residency			☐ Yes ☐ No	
Additional Residency			☐ Yes ☐ No	
Fellowship			☐ Yes ☐ No	

4. Are you a U.S. citizen? **If NO**, please provide a copy of documents confirming your status. ☐ Yes ☐ No

5. Are you a Foreign Medical School Graduate? **If YES**, please provide: ☐ Yes ☐ No
   Date of ECFMG certification: _____

6. Are you currently Certified by any board recognized by the **American Board of Medical Specialties**? **If YES**, please provide: ☐ Yes ☐ No
   Name of Board: _____ Certificate expiration: _____

7. Are you a member of any medical association? **If YES**, please list memberships: ☐ Yes ☐ No
   _____
   _____

8. Please indicate the number of CME hours you have completed in the past two years:_____

III. MEDICAL PRACTICE HISTORY

1. Within the last five (5) years have your practice characteristics, procedures performed, or business association(s) changed? **If YES**, please describe on additional sheet. ☐ Yes ☐ No

2. List all primary office locations where you have practiced in the last ten (10) years.
   (Use separate sheet if more space is needed)

Street Address & City	County	State	Dates – From / To

3. List all hospitals where you have staff privileges:
   (*If no hospital privileges, attach protocol for patient hospital admission)*

Hospital	City / State	County	% of Practice	Type of privilege

4. List all states where you practice or have a medical license:	Medical License Number(s):	DEA License Number(s):	% of practice in each state:

5. Legal / Professional / Administrative Actions against you:

a. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked? **If YES,** please describe on separate sheet. ☐ Yes ☐ No

b. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? **If YES,** please describe on separate sheet. ☐ Yes ☐ No

c. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **If YES,** please explain on a separate sheet. ☐ Yes ☐ No

d. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? **If YES,** please complete **Substance Impairment Supplemental Application**. ☐ Yes ☐ No

e. Have you ever been charged with, or convicted of a crime other than minor traffic violations? **If YES,** please explain on a separate sheet. ☐ Yes ☐ No

f. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s), or a state licensing authority? **If YES,** please explain on a separate sheet. ☐ Yes ☐ No

IV. OFFICE STAFF

1. Do you employ, contract with, or supervise any **physician(s) or surgeons(s)**? **If YES,** enter information below and attach current certificate(s) of insurance. ☐ Yes ☐ No

Physician/Surgeon Name	Medical Specialty	Limits of Liability	Employ (E) Contract (C) Supervise (S)	Insurer
			☐E ☐C ☐S	
			☐E ☐C ☐S	
			☐E ☐C ☐S	
			☐E ☐C ☐S	

2. Do you employ, contract with, or supervise any non-physician health care extenders? **If YES,** enter information below: ☐ Yes ☐ No

TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY	TYPE	NUMBER EMPLOYED	NUMBER SUPERVISED ONLY
Midwife			Medical Lab Technician		
CRNA			Pharmacist		
Nurse Practitioner			Nurse (RN/LPN)		
Physician Assistant			X-Ray Technician		
Surgeon Assistant			Physical Therapist		
Optometrists					

☐ OTHER (Please provide detail on separate page)

V. PROCEDURES/PRACTICE SPECIFICS

1. a. Average Weekly Patient Encounters:		
b. Average Weekly Practice Hours:		
c. Percentage Of Locum Tenens Work:	%	

2. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgicenter, abortion clinic, walk-in clinic, or birthing center? **If YES**, please describe on separate sheet. ☐ Yes ☐ No

3. Does your practice include the following? Check all that apply.

☐	**No Surgery**	No surgery with the exception of: suture of minor lacerations, incision of sebaceous boils and cysts, needle aspiration of cysts (limited to subcutaneous tissue), incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.
☐	**Minor Surgery**	Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: ▪ Colonoscopy, sigmiodoscopy, endoscopic procedures including endoscopic retrograde cholangiopancreatography (ERCP), ▪ Pneumatic or mechanical esophageal dilation (not with bougie or olive), ▪ Angiography; Arteriography; Catheterization – arterial, cardiac or diagnostic (applies only to internists who have completed a cardiovascular subspecialty training.), ▪ Needle biopsy – including lung, breast, prostate and superficial and subcutaneous tissue, ▪ Radiopaque Dye injection into blood vessels, lymphatics, sinus tracts or fistulae ***No procedures performed on a patient while under general anesthesia***.
☐	**Major Surgery**	Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It includes discograms, lymphangiography, myelography, phlebography, pneumoencephalography and radiation therapy. It also includes removal of tumors (except skin tumors), liver/kidney/bone marrow biopsy, reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.
☐	**Gynecology / Obstetrics**	If checked, please indicate which procedures: ☐ Office Gynecology only ☐ Pre-natal care through 1st trimester only ☐ Pre-natal care through 2nd trimester only ☐ Pre-natal care full term ☐ Amniocentesis ☐ High Risk Pregnancies ☐ Toxemia Management ☐ Dilation and Curettage ☐ Cryosurgery ☐ Norplant Insertion ☐ Elective Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____ ☐ Therapeutic Abortions Number each month _____ Maximum Gestation Age _____ Where performed _____
☐	**Obstetrics**	**Indicate annual number of:** ☐ Vaginal Deliveries: _____ Indicate the percentage of: Low forceps deliveries _____% Mid forceps deliveries _____% Breech Deliveries _____% ☐ Cesarean Sections: _____ ☐ VBAC Deliveries: _____ ☐ Non-Hospital Deliveries _____ (Please describe circumstances on separate sheet) ☐ Episiotomies: _____ Do you personally attend each delivery? ☐ Yes ☐ No Does a Midwife perform any actual deliveries/births? ☐ Yes ☐ No **If YES**, annual number performed by Midwife: _____
☐	**Radiology**	☐ Diagnostic ☐ Interventional Annual number of readings performed: _____ Type of readings performed: _____ Do you perform any non-physician-referred screening mammographies? ☐Yes ☐No **If YES**, on a separate page, please describe your procedures for assuring continuity of care/follow up. Do you read, interpret, and/or diagnose files, electronic images, or slides of patients residing in any state(s) other than your primary practice state address? ☐Yes ☐No **If YES,** specify on additional pages the state(s), percentage of your total practice, and other pertinent details.

☐	**Anesthesia/ Office Surgery**	Performance or assistance in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis. Indicate annual number and description of procedures: **#** **Description of Procedures** ☐ General Anesthesia _____ _____ ☐ Spinal or Caudal Anesthesia _____ _____ ☐ Other _____ _____ Anesthesia administered by: _____ Distance to nearest hospital: _____ Description of life saving equipment/supplies: _____
☐	**Elective Plastic Surgery**	Describe procedures and annual number performed on separate sheet.
☐	**Pain Management**	Check the procedures that you perform: ☐ Blocks ☐ Epidurals ☐ Trigger Point Injections ☐ Surgically Implanted Devices Do you prescribe synthetic opiates? ☐ Yes ☐ No **If YES**, a. Indicate the annual number of prescriptions written: _____ b. On a separate sheet, describe your controls in place to reduce or eliminate drug-seeking behavior.
☐	**Alternative Medicine**	Describe procedures and annual number performed on separate sheet.
☐	**Weight Control/ Bariatrics**	On a separate sheet, describe procedures for weight reduction/control by other than diet and exercise. Percentage of patients treated exclusively for weight control _____% List injections used for weight control: _____ If you prescribe or dispense drugs for weight control, please list drugs and describe protocols: _____ Complete the **Bariatric Surgery Supplemental Application**.
☐	**Podiatry**	Check the procedures that you perform: ☐ Reduction of simple fractures of the heel or ankle ☐ Reduction of compound factures of the heel or ankle ☐ Use of lasers ☐ Cutting or penetration of tissue other than that as defined as “No Surgery” above ☐ Arthrodesis ☐ Permanent removal of nail plate except by the use of electrical or chemical cautery ☐ Surgical procedures of the ankle joint which includes any of the following: ▪ Tibia and/or fibula and their related structures ▪ Arthroplasty ▪ Grafts and/or implants ☐ Surgical treatment of the muscles and tendons at the level of the ankle joint ☐ Any other surgical procedures performed on the foot and/or ankle Please describe: _____ _____

4. Please check any procedures that you perform:

☐ Abortions	☐ Kidney, Ureter and Bladder Surgery
☐ Acupuncture	☐ Laparoscopies
☐ Adenoidectomy	☐ Laser Treatments Via Endoscope
☐ Amputations	☐ Liposuction Procedures
☐ Anal Fissure	☐ Malignant Lesion Surgical Procedures
☐ Angiography	☐ Mastoidectomy
☐ Arterial Catheterization	☐ Middle or Inner Ear Surgery
☐ Arteriography	☐ MOHS Micrographic Surgery
☐ Assisting in surgery on other than your own patients	☐ Myleography
	☐ Needle Biopsies
☐ Assisting in surgery on your own patients	☐ Neurological Surgery
☐ Bariatric Surgeries	☐ Norplant Insertion
☐ Blepharoplasty	☐ Obesity/Weight Control Surgery
☐ Breast Implants, Augmentation or Reduction	☐ Office Gynecology
☐ Cardiac Catherizations	☐ Oophorectomy
☐ Cervical Biops?	☐ Open Reduction of Fractures (Plating and Pinning)
☐ Cervical Cautery	☐ Ophthalmologic Surgery
☐ Chelation Therapy – for cardiac care	☐ Ophthalmologic Surgery (LASIK)
☐ Chelation Therapy – for heavy metal poisoning	☐ Orchidectomy
	☐ Organ Transplants
☐ Chemical Peels	☐ Orthopedic Surgery (Including Spinal Surgery)
☐ Cleft Lip or Palate Surgery	☐ Orthopedic Surgery (No Spinal Surgery)
☐ Clinical Trials	☐ Otoplasty
☐ Closed Reduction of Fractures	☐ Pain Management
☐ Cholecystectomies	☐ Pedicle Screw Insertion
☐ Collagen Lip Injection	☐ Penile Augmentation
☐ Colonoscopy	☐ Penile Implants
☐ Complex Flaps and Grafts	☐ Pericardiocentesis
☐ Conization of Cervix	☐ Permanent Eyeliner Procedures
☐ Culdocentesis	☐ Photorefractive Keratotomy
☐ Diagnostic Radiology	☐ Pregnancy Care into Second Trimester
☐ Electroshock Therapy	☐ Pregnancy Care into Third Trimester
☐ Endometrial Biopsy	☐ Prostatectomy
☐ Endoscopic Retrograde / Cholangiopancreatography	☐ Radial Keratotomy Annual number of procedures: _____
☐ Experimental Procedures	☐ Radiation Therapy (Radium Implants)
☐ Gastric Bubble Procedures	☐ Reconstructive Plastic Surgery
☐ Hair Transplant Procedures	☐ Salpingectomy
☐ Hemorrhoidectomies	☐ Scalp Reduction Surgery
☐ Hernioplasty	☐ Sex Change Operations
☐ Hyperbaric Chamber Treatments	☐ Sterilization Procedures
☐ Hypnosis	☐ Thrombectomy of Arteries and Veins
☐ Hysterectomies	☐ Tubal Ligation
☐ Interphalangeal Joint Surgery	☐ Vascular Surgery
☐ Joint Replacement Surgery	☐ Other, List _____

5. Do you own or operate a Laboratory? **If YES**,
   a. Does the laboratory provide services solely for your patients? ☐ Yes ☐ No
   b. If not limited to your patients, please explain on separate sheet. ☐ Yes ☐ No

6. a. Are you now performing experimental or investigational procedures or prescribed/ dispensed experimental drugs? ☐ Yes ☐ No
   b. Have you ever performed experimental or investigational procedures or prescribed/ dispensed experimental drugs? ☐ Yes ☐ No
   If YES to either of the above, please explain on a separate sheet.

7. a. Do you now treat prisoners in a state, federal or any correctional institution? ☐ Yes ☐ No
   If YES, please complete the **Correctional Facility Supplemental Application**.
   b. Have you ever treated prisoners in a state, federal or any correctional institution? ☐ Yes ☐ No
   If YES, please provide last date of treatment._____

8. Do you practice as a company doctor (excluding treatment of workers compensation patients)? **If YES,** ☐ Yes ☐ No
   a. What products are manufactured by the company? _____
   b. Do you review or establish plant / employer safety standards? ☐ Yes ☐ No
   c. Do you provide medical treatment to company employees? ☐ Yes ☐ No
   d. Company name:_____ Location: _____

9. Do you work in an Emergency Room? ☐ Yes ☐ No
   b. **If YES**, is this solely to satisfy requirements for hospital privileges? ☐ Yes ☐ No
   c. Indicate the average number of hours you work in the Emergency Room each month: _____

10. Are you a sports team physician or health care provider? **If YES,** check all that apply: ☐ Yes ☐ No
    ☐ High School ☐ College ☐ Professional Other:_____
    Name and location of team(s): _____

11. Do you treat patients in a Nursing Home or a similar care facility? ☐ Yes ☐ No
    If YES, how many patients currently reside in a Nursing Home or similar care facility? _____

12. Indicate if you now, or have ever been, any of the following at any Nursing Home, Hospital, Hospital Department, Sanitarium, HMO, PPO, Ambulatory Care Clinic with bed and board facilities, or any other business enterprise?

	Now	% of Practice	In the Past	% of Practice	Type of Facility (identify from list above)
Proprietor	☐	____%	☐	____%	
Partner	☐	____%	☐	____%	
Officer	☐	____%	☐	____%	
Director	☐	____%	☐	____%	
Administrator	☐	____%	☐	____%	
Executive Director	☐	____%	☐	____%	
Medical Director	☐	____%	☐	____%	
Contractor	☐	____%	☐	____%	
Provider of Services	☐	____%	☐	____%	
Employee	☐	____%	☐	____%	

If YES, provide name(s) of facilities and explain details:
_____
_____

13. Do you serve in a "Gatekeeper" capacity (that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization)? ☐ Yes ☐ No
    If YES, please advise of percentage of your practice devoted to Gatekeeper activity: _____%

14. Do you engage in tele-medicine activity? **If YES,** do you outsource radiology "reads" to another source? If YES, identify source, location, and licensing credentials of that other source. _____ ☐ Yes ☐ No
    _____

15. Do you prescribe drugs or provide diagnosis via the Internet? **If YES,** please describe on separate sheet. ☐ Yes ☐ No

16. Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)? **If YES,** please describe on separate sheet. ☐ Yes ☐ No

VI. PRIOR POLICY AND LOSS INFORMATION

1. Please provide the following information pertaining to your past 5 years of professional liability coverage:

Policy Period	Insurance Carrier	Policy Limits	Deductible	Type of Policy	Premium	* Total # of Claims
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		
				☐ CM ☐ Occ		

✳**Total # of claims, by carrier, regardless of payment, no-payment, dismissal or status.**

2. Have you ever practiced without professional liability insurance? ☐ Yes ☐ No
   If YES, specify dates: from _____ until _____

3. Have you ever had any insurance company decline, cancel, rescind or non-renew any Professional Liability Insurance Policy? *(Response not required in the State of Missouri)* ☐ Yes ☐ No
   If YES, please provide details:
   _____
   _____

4. Are you aware of any of the following:
   a. known losses or claims that have not been reported to a prior insurance carrier or any other source from which payment might be made? ☐ Yes ☐ No
   b. a specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, that has not been reported to a prior insurance carrier? ☐ Yes ☐ No
   c. any request for medical records by a patient or his/her attorney which might result in a claim? ☐ Yes ☐ No
   d. information relating to service(s) on a Board which might result in a claim? ☐ Yes ☐ No
   e. any prior professional liability carrier refusing coverage for, or declining to accept a report of a specific act, omission or circumstance involving particular and specific professional service(s) that may result in a claim, claim, threat of claim, letter of intent, adverse result notice or attorney contact? ☐ Yes ☐ No
   f. any involvement, now or ever, in any Professional Liability claim or suit? ☐ Yes ☐ No
      If YES, a **Claim Information Supplemental Application** *must* be completed for each claim.

   If YES to any of the above, please provide details:
   _____
   _____

VII. COVERAGE REQUESTED

NOTE: The Company may not offer or quote requested coverage.

Effective Date: _____ **Retroactive Date:** _____
Important: Declarations Page of your current policy must be attached if a retroactive date is requested.

Limits of Liability:
- ☐ $ 100,000 / $ 300,000
- ☐ $ 200,000 / $ 600,000
- ☐ $ 250,000 / $ 750,000
- ☐ $1,000,000 / $3,000,000
- ☐ Other $_____

Deductible:
- ☐ None
- ☐ $ 5,000
- ☐ $7,500
- ☐ $10,000
- ☐ Other $_____

VIII. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

PLEASE PROVIDE ADDITIONAL COMMENTS THAT WOULD FURTHER CLARIFY THE INFORMATION ABOVE OR ADDRESS CHARACTERISTICS OF YOUR PRACTICE NOT SPECIFICALLY ADDRESSED HEREIN.

By signing this Application, you represent and agree to each of the following five (5) items:

1. You have made a comprehensive internal inquiry or investigation to determine whether anyone in your organization is aware of any actual or alleged fact, circumstance, situation, act, error or omission which may reasonably be expected to result in a claim, and have fully and completely divulged any and all such situations in this Application; and

2. This Application, along with each of the following applicable Supplemental Applications, are hereby being submitted to the Company (Please check all that apply):

   ☐ Bariatric Surgery Supplemental Application ☐ Statement of No Known Claims Letter

   ☐ Claim Information Supplemental Application ☐ Other _____

3. Each of the statements and answers given in this Application, and in each of the Supplemental Applications checked in Number 2. above, are:

   a. Accurate, true and complete to the best of your knowledge;
   b. No material facts have been suppressed or misstated;
   c. Representations you are making on behalf of all persons and entities proposed to be insured;
   d. A material inducement to the insurance company to provide insurance, and any policy issued by the insurance company is issued in specific reliance upon these representations.

4. This Application, along with each of the Supplemental Applications checked in Number 2. above, are hereby deemed to be attached to the policy contract, and incorporated into the policy contract, whether or not any of the Supplemental Applications are physically attached to a particular copy of the policy contract, and regardless of whether any of the Supplemental Applications are signed or dated.

5. You agree to promptly report to the Company, in writing, any material change in your operations, conditions, or answers provided in this Application, or any Supplemental Application, that may occur or be discovered after the completion date of said Application(s), but before the inception date of the policy. Upon receipt of any such written notice, the Company has the right, at its sole discretion, to modify or withdraw any proposal for insurance.

FRAUD WARNING

Notice to Applicants of all states except Colorado, New York, and Pennsylvania:
Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits.

Notice to Colorado Applicants:
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Notice to New York Applicants:
Any person who knowingly and with intent to defraud any insurance company or other 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Pennsylvania Applicants:
Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

IMPORTANT NOTICE: Failure to report any claim made against you during your current policy term, or facts, circumstances or events which may give rise to a claim against you to your current insurance company BEFORE expiration of your current policy term may create a lack of coverage.

COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED PRIOR TO BINDING COVERAGE AND POLICY ISSUANCE. IT IS AGREED THAT THIS FORM SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL ATTACH TO THE POLICY.

The applicant must sign this Application within thirty (30) days prior to the policy inception date.

_____ _____

Signature of Applicant Date

_____

Print or Type Name and Title