Physicians Insurance
A MUTUAL COMPANY

# INCREASE LIMITS OF LIABILITY APPLICATION

**IMPORTANT:** Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers. If additional space is required, please use the "Remarks" section at the end of the application.

Name:_____ Policy or Reference Number:_____
last first middle

Clinic Name: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Specialty:_____

Current limits of liability: ☐ $1/5 ☐$2/6 ☐ $3/7 ☐ $4/8 ☐ $5/9 Desired limits of liability: ☐ $1/5 ☐$2/6 ☐ $3/7 ☐ $4/8 ☐ $5/9

Once approved, an increase in limits of liability will be effective 60 days after date received. If requesting an effective date **after** our 60 day consideration, please indicate. Date: _____ Reason: _____

Decreases: A signed, written request can be sent in place of this form for requesting a decrease in limits of liability. Please specify your current and desired limits on that (separate) request. Please be advised the effective date of decreases will be one day *after* your request is approved.

## PLEASE ANSWER THE FOLLOWING CLAIM INFORMATION:

1. Have all claims or suits of which you are aware been reported to your insurance carrier? ☐ Yes ☐ No

   *If "No," please use the "Remarks" section to provide a separate narrative of the reason why and include the following information:*

   a) Name, age, and sex of patient/claimant
   b) Date(s) and type of treatment and/or surgery which led to the allegations against you
   c) Nature of allegations in claim or suit
   d) Specify whether a suit was ever filed
   e) Names of other doctors and hospitals, if any, involved in claim or suit
   f) Disposition or current status of claim or suit
   g) If closed, amount of settlement on your policy and if additional defendants involved the total settlement amount
   h) Name and policy number of insurance carrier defending you
   i) If assigned, the name of your defense attorney

2. Applicant warrants that after a careful review of all medical records, he/she is not aware of any circumstances which might give rise to a loss covered by this insurance.

   a) ☐ I am not aware of any such circumstance

   b) ☐ I am aware of such a circumstance

   *If b), please use the "Remarks" section to provide a separate narrative providing the following information for each circumstance:*

   i) Name, age, and sex of patient
   ii) Date(s) and type of treatment and/or surgery surrounding the circumstances
   iii) Names of other doctors or hospitals, if any involved
   iv) Any other information relevant to describe circumstances

## REMARKS

**Question #**

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I authorize release and exchange of information between my past and present medical association/society and their insurance consultant, any hospital where I presently hold or previously held staff privileges, prior insurance carriers, current or past employers and all attorneys who have represented the undersigned in connection with any claim for professional liability and Physicians Insurance involving past and future underwriting and claims matters.

**Applicant's Signature** **Date**

**Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**