Princeton Insurance
a MedPro/Berkshire Hathaway company

Supplemental Prior Acts Application for Professional Liability

IMPORTANT: Please read all of the following information carefully. Should you have any questions, please contact your agent prior to completing any information on this page.

- It is not the intent of Princeton Insurance Company to cover any incident, circumstance, act, error or omission of which you are currently aware, which may reasonably be expected to result in a claim or suit.
- This information must be completed in its entirety before you can be considered for Prior Acts Coverage.
- A complete copy of all professional liability insurance policies (including all Declaration Pages and Endorsements) you maintained during the period for which you are requesting Prior Acts Coverage must accompany your application for coverage and also your current CV.
- In addition, you are eligible for Prior Acts Coverage only if you maintained continuous Claims Made Professional Liability Insurance, with your own limits of liability, during the entire requested Prior Acts Coverage Period.
- Prior Acts Coverage is optional and subject to separate underwriting approval. For your own protection, unless you are specifically notified by your agent that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Reporting Endorsement Coverage ("tail" coverage) from your current carrier. Your agent is not authorized to bind prior acts coverage.

1. Name of Applicant: _____
2. Agent: _____
3. Name of Prior Carrier: _____
4. Retroactive Date used by your prior carrier: _____
5. Did any previous policy(s) carry any kind of deductible or self insurance retention? _____ Yes _____ No
   If YES, please describe and indicate amounts. _____
6. List all states where you have practiced or taught and the years associated with these states since your earliest retroactive date:
   (Use separate sheet if necessary) _____
7. Please check all types of practices that applied during the period for which you are requesting prior acts:
   _____ Sole Proprietor/unincorporated _____ Partnership _____ Employed Physician _____ Independent Contractor
   _____ Professional Association/Corporation _____ Limited Liability Corp.
   a. Professional Association/Professional Corporation Prior Acts coverage desired? _____ Yes _____ No
   b. If so, was your PA/PC insured during the period you had prior acts? _____ Yes _____ No
   c. If so, provide a copy of the declaration page/endorsement evidencing prior coverage for the PA/PC, the name of the PA/PC, and all the members of the PA/PC.
8. In what specialties have you practiced during the period that you have requested prior acts? _____
9. Have you changed, added or deleted any aspects of your practice, including change in hours, after your requested retroactive date? _____ Yes _____ No
   If YES, please describe and indicate date(s): _____
10. Has coverage been continuously in force since the retroactive date you are requesting? _____ Yes _____ No
11. Any incident, circumstance, act, error, or omission, including a request for records, of which you are aware, must be reported to your current carrier. You must describe all of the above incidents below that might reasonably result in a claim. (Use a separate sheet, if necessary; **IF NONE, SO STATE**):

Patient Name	Date of Incident	Date Reported to Insurance Carrier	Description

All of the information above is true and correct to the best of my knowledge and belief. Any and all acts, incidents, and/or circumstances of which I am aware, and which might reasonably be expected to result in a claim, have been disclosed on this application in the section above.

NAME OF APPLICANT: _____ (Print or Type)

SIGNATURE OF APPLICANT: _____ DATE: _____