

- h. Have any claims for the use of Public Access Defibrillators (PAD's) been made against you in the past 5 years? Yes No. If Yes, provide details, including the status of the claim (s), amounts demanded or paid, date of claim, and action taken to prevent a claim of similar nature from occurring in the future.
- i. Are you aware of any incidents which might give rise to a professional liability claim against you? Yes No. If "yes", provide details, including the status of the claim (s), amounts demanded or paid, date of claim, and action taken to prevent a claim of similar nature from occurring in the future.

* NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. **I/We authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Underwriting Manager for the Company.**

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.



SHAND MORAHAN & COMPANY, INC.

Ten Parkway North, Suite 100, Deerfield, Illinois 60015
(847) 572-6000

BROKER RISK SUMMARY **(Medical Malpractice and Specified Medical)**

ACCOUNT NAME:

Address
City, State, Zip
States of Licensure
New or Renewal for Shand

DESCRIPTION OF SERVICES:

(Include management experience & staffing)

CURRENT INSURANCE PROGRAM:

Name of Carrier: _____

Limits: _____ Deductible: _____ Premium: _____

Expiration Date: _____ Retro Date: _____

LOSS EXPERIENCE:

(7-10 years currently valued loss information)

RISK MANAGEMENT/QUALITY ASSURANCE PROGRAM:

(Including Credentialing/hiring protocols)

DATE QUOTE NEEDED: