

APPLICATION FOR CORPORATION/PARTNERSHIP PROFESSIONAL LIABILITY INSURANCE AS ADDITIONAL NAMED INSURED

PLEASE TYPE OR PRINT RESPONSES AND ANSWER ALL QUESTIONS. COVERAGE WILL NOT BE CONSIDERED UNTIL THIS APPLICATION IS COMPLETE.

COVERAGE REQUESTED TO COMMENCE 12:01 AM ON _____ (MO/DAY/YR)

COVERAGE INFORMATION **Policy Number** _____
(For UMIA use only)

1. NAME AND ADDRESS OF CORPORATION/PARTNERSHIP

Name _____

Address _____	City _____	State _____	Zip _____	Telephone _____
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President/Director _____ Tax I.D. # _____

Business Manager/Administrator _____

Please identify the name, address and telephone number of any satellite offices.

Name _____	Address _____	City _____	State _____	Zip _____	Telephone _____
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Name _____	Address _____	City _____	State _____	Zip _____	Telephone _____
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Name _____	Address _____	City _____	State _____	Zip _____	Telephone _____
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2. SHAREHOLDERS/PARTNERS

Please list all shareholders or partners of the corporation or partnership. Include specialty, current insurer, and expiration date of current professional liability policy.

Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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3. PHYSICIAN EMPLOYEES

Please list all physician employees of the corporation or partnership. Include specialty, current insurer, and expiration date of current professional liability policy.

Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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Name _____	Specialty _____	Insurer _____	Exp. Date _____
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4. ANCILLARY PERSONNEL

Please list all professional employees of the corporation or partnership. Include the degree/title and insurer for each.

Name	Degree/Title	Insurer
Name	Degree/Title	Insurer
Name	Degree/Title	Insurer
Name	Degree/Title	Insurer
Name	Degree/Title	Insurer

Individual coverage is not offered for professional or other employees.

5. PRACTICE INFORMATION

Do you operate any hospital, sanitarium, clinic with bed facilities, laboratory or business enterprise other than X-ray or pathological laboratory?
 Yes No

6. CLAIM INFORMATION

Has a claim or suit for alleged malpractice been brought against the applicant in the past ten years?
Please give details on a separate sheet. Yes No

7. INSURANCE INFORMATION

Is the professional association, partnership or business currently insured? Yes No

Company Name	Limit of Liability	Policy Number
Has any insurer canceled, declined coverage or refused renewal for any similar insurance? If "Yes" give complete details on a separate sheet. <input type="checkbox"/> Yes <input type="checkbox"/> No		

Does the professional association, partnership or business currently contract with an HMO or PPO which requires you to hold them harmless or indemnify them with the contract? Yes No

PLEASE NOTE:

All agreements or contracts, including hold harmless agreements and agreements to assume the liability of others are specifically excluded from coverage under the insurance applied for herein.

When the corporation/partnership is named as an Additional Named Insured on the policies of the individual physician members, the individual physician shares his/her limit of liability with the corporation/partnership. In the event a claim is made against both an individual physician member and the corporation/partnership arising from the same loss, the limit of liability is the same as though a claim had been made against the individual physician only.

Independent corporation/partnership liability coverage is now available to groups of five or more as a separate vicarious or non-vicarious coverage limit. Do you wish further information about this type of coverage. Yes No

I certify that all information is true and correct and I authorize release and exchange of information involving either underwriting or claims matters between all prior insurance carriers and the Utah Medical Insurance Association.

Signature - President/Partner

Date