

4. 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
Name	Specialty	Insurer	Exp. Date
Name	Specialty	Insurer	Exp. Date
Name	Specialty	Insurer	Exp. Date
Name	Specialty	Insurer	Exp. Date

5. 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

6. PRACTICE INFORMATION

Do you operate any hospital, sanitarium, clinic with bed facilities, laboratory or business enterprise other than X-ray or pathological laboratory?

7. CLAIM INFORMATION

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

8. INSURANCE INFORMATION

Is the professional association, partnership or business currently insured?

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

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.

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