Gulf Atlantic Legal Defense Insurance

Premium Indication Only Application

Fax Number: 1-800-357-0652

Email Form | Print Form

General Information

Name			☐ MD ☐ DO
Address			
City	County	State	Zip
Medical License No.	Home Phone No.		Email Address:
Date of Birth:	Office Phone No.		Fax No.

Policy Information

Date you desire coverage to begin: First Practice Date:

Do you desire Prior Acts coverage? ☐ No ☐ Yes
If YES, retroactive date requested:

Do you desire increased limits above the standard $100,000 / $200,000? ☐ Yes ☐ No
If YES, select desired additional coverage: ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

Practice Information

Does the address provided above represent the only location/facility at which you provide professional services? ☐ Yes ☐ No
If NO, please provide the name, address and phone/fax number for each on a separate page.

Your Practice Specialty: Subspecialty:

List invasive procedures which you perform:

1. ☐ Yes ☐ No Has your professional liability insurance application/coverage ever been canceled, non-renewed or issued on special terms?
2. ☐ Yes ☐ No Has your license to practice, authority to prescribe drugs, or hospital privileges ever been restricted, suspended, revoked, acted upon or non-renewed in any State?
3. ☐ Yes ☐ No Do you have or have you ever had any drug or alcohol-related problem, emotional/mental disorder, major illness or physical impairment? If YES, please describe all treatments, hospitalization and the current status on a separate page.

Partnership / Corporation / Professional Association Information

4. Do you practice as: ☐ Partnership ☐ Professional Association ☐ Solo PA ☐ Corporation ☐ Other (describe)
   If so, name of entity:
   Is this application part of a group application? ☐ Yes ☐ No If YES, is the group requesting shared limits? ☐ Yes ☐ No

Supplemental Waiver / Release

Any person knowing and with intent to injure, defraud or deceive any insurer files any statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I hereby certify that the above statements, representations and responses are true, complete and correct, and I understand and agree that you will rely on such statements, representations and responses in making a decision as to whether to issue a policy to me. If the answers contained in the application or this certification materially change during any policy period, I agree to immediately notify you. If transmitted to Gulf Atlantic by facsimile, I agree that the facsimile copy of this application received by Gulf Atlantic shall be, and shall have the same effect for all purposes, as the original. I hereby authorize any person or organization, including attorneys who now or in the past have represented me, to release to Gulf Atlantic any and all information, whether privileged or not, relating to my employment, education, training, hospital privileges (whether granted or not), my malpractice insurance (including but not limited to the underwriting and claims files of any present or former malpractice carrier insuring me), and any and all information which Gulf Atlantic may reasonably request to assist it in underwriting my application for insurance or in administering any claim made against me under my Gulf Atlantic policy.

Applicant Signature: **Date**