TEXAS MEDICAL LIABILITY INSURANCE UNDERWRITING ASSOCIATION (JUA)
505 E. Huntland Dr., Suite 160 Austin, Texas 78752 (512) 452-4370

SUPPLEMENT TO APPLICATION FOR PHYSICIANS AND OTHER
NON-INSTITUTIONAL HEALTH CARE PROVIDERS
MEDICAL (PROFESSIONAL) LIABILITY INSURANCE

PRIOR ACTS COVERAGE

PRIOR ACTS COVERAGE is available except under the following circumstances:

A. Health Care Providers continuing practice in the State of Texas, but not purchasing continuing coverage through the Association.

B. Health Care Providers uninsured for 30 consecutive days or more within the 12 months prior to the requested effective date of coverage.

C. Any portion of the Health Care Providers' practice performed outside the boundaries of the State of Texas.

CLAIMS INFORMATION:

A. Are you aware of any incidents (patient expressions of dissatisfaction or fee disputes resulting from treatment rendered) which you have a reason to believe may lead to a claim or suit against you?

_____ YES _____ NO

B. Have you reported any incidents (which have not yet resulted in a claim or suit) to another insurance carrier?

_____ YES _____ NO

C. Have you received any oral or written threats of legal action, request for patient records, subpoena, petition, complaint, summons, citation or other legal process or notification?

_____ YES _____ NO

If you answered "yes" to A, B or C above, please provide details, including dates, below. Report all incidents identified under A or C to your current insurance carrier.

Patient Name	Date of Incident	Date incident report sent insurance carrier (provide copies)

COVERAGE CANNOT BE CONSIDERED UNLESS:

A. All questions are fully answered.

B. A copy of the DECLARATIONS PAGE from your current or most recent policy which documents your retroactive date to be used as the effective date for PRIOR ACTS COVERAGE accompanies this supplement to your application. THE DECLARATIONS PAGE IS NOT REQUIRED FOR THE RENEWAL OF A JUA POLICY.

The following questions apply to your **past** claims made coverage and need to be answered for the entire time period following your retroactive date:

A. Has any portion of your practice been performed outside the State of Texas? _____ YES _____NO
If yes, please list the state(s) and dates:

_____ _____

_____ _____

B. Was your practice during the period for which you are requesting prior acts coverage any different from your practice as described in the application accompanying this supplement? (For example have you added or deleted procedures?) _____YES _____ NO. If yes, please describe:

_____

_____

I understand that there may be differences in coverage between that provided by my current or prior carrier and the ASSOCIATION. **PRIOR ACTS COVERAGE** afforded by the ASSOCIATION will be subject to the terms, conditions and exclusions of the ASSOCIATION's policy.

I warrant and represent that the foregoing information in this Application for **PRIOR ACTS COVERAGE** is true and complete to the best of my knowledge. All potential claims or suits to the best of my belief have been disclosed herein and have been reported to the applicable prior professional liability insurance carrier. I understand any policy issued by the ASSOCIATION will exclude coverage for any claims or suits which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.

I here authorize all insurance carriers who have previously provided me with professional liability insurance or any licensing agency in this or any other state to supply any information regarding previous claims or lawsuits to the ASSOCIATION upon its request.

I understand and agree that this is not a binder or acceptance of **PRIOR ACTS COVERAGE** and that, if any policy is issued, such policy shall be issued in reliance upon the warranties and representations made herein and that any misrepresentation or concealment in this application for **PRIOR ACTS COVERAGE** will render the **PRIOR ACTS COVERAGE** issued by the ASSOCIATION completely void.

_____ _____

Date Applicant's Name (Please PRINT)

_____

Applicant's Signature