LAMMICO

APPLICATION FOR INCREASED LIMITS
MEDICAL PROFESSIONAL LIABILITY

A. Personal Information

Full Name (Last, First, Middle Initial)	Suffix ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV	Policy Number
Primary Practice Address (include city, state, zip)		

B. Medical Professional Liability Limits

CURRENT LIMITS	Each Medical Incident: $	Annual Aggregate: $
INCREASED LIMITS REQUESTED	Each Medical Incident: $	Annual Aggregate: $

Requested Effective Date of Change: _____
(MM/DD/YYYY)

Please indicate reason(s) for requesting this increase: _____

_____

Please answer the following questions. They apply **only to events you have not already reported to LAMMICO or your previous insurer.** For all YES answers, please explain in "Remarks".

1. Is any claim or suit pending against you? ☐ Yes ☐ No
2. Has any attorney inquired about the care you rendered to a patient? ☐ Yes ☐ No
3. Has any patient, patient's family member or attorney asked you for copies of your medical records, or to your knowledge, the records of a hospital or laboratory? ☐ Yes ☐ No
4. Are you aware of any medical or surgical outcome or other circumstance that makes you believe or anticipate that a claim or suit is likely to arise from the care you gave a particular patient? ☐ Yes ☐ No

Sign and date

I CERTIFY THAT MY ANSWERS ARE TRUE AND CORRECT to the best of my knowledge.

I understand that I have a duty under my policy to report events of the type listed above without undue delay.

I further understand that submitting this application does not bind LAMMICO to increase my limits, but that this application will be the basis of such an increase if my request is approved.

_____ _____

Applicant Signature **Date (MM/DD/YYYY)**

_____

Please Print Your Name

LAMMICO

SUPPLEMENTAL REMARKS PAGE

Question No.	"Remarks" (Attach additional sheets, if necessary)