

**CONVENTUS INTER-INSURANCE EXCHANGE**  
**SUPPLEMENTAL PRIOR ACTS APPLICATION FOR PROFESSIONAL LIABILITY**

**IMPORTANT:** Please read all of the following information carefully. Should you have any questions, please contact Conventus or your agent prior to completing any information on this page.

- It is not the intent of *Conventus* Inter-Insurance Exchange to cover any incident, circumstance, act, error or omission of which you are currently aware which may reasonably be expected to result in a claim or suit.
- This information must be completed in its entirety before you can be considered for Prior Acts Coverage.
- A complete copy of all professional liability Declaration Pages and Endorsements for professional liability policies you maintained during the period for which you are requesting Prior Acts Coverage must accompany your application for coverage.
- In addition, you are eligible for Prior Acts Coverage only if you maintained continuous Claims Made Professional Liability Insurance, with your own limits of liability, during the entire requested Prior Acts Coverage Period.
- Prior Acts Coverage is optional and subject to separate underwriting approval. For your own protection, unless you are specifically notified by *Conventus* that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Reporting Endorsement Coverage ("tail" coverage) from your current carrier. Your agent is not authorized to bind prior acts coverage.

1. Name of Applicant: \_\_\_\_\_

2. Agent: \_\_\_\_\_

3. Name of Prior Carrier: \_\_\_\_\_

4. Retroactive date used by your prior carrier: \_\_\_\_\_

5. Did any previous policy(ies) carry any kind of deductible or self insurance retention?     Yes     No  
If Yes, please describe and indicate amounts: \_\_\_\_\_

6. List all states where you have practiced or taught and the years associated with these states since your earliest retroactive date (use separate sheet if necessary): \_\_\_\_\_

7. Please check all types of practices that applied during the period for which you are requesting prior acts:

<input type="checkbox"/> Sole Proprietor/unincorporated	<input type="checkbox"/> Partnership	<input type="checkbox"/> Employed Physician
<input type="checkbox"/> Professional Association/Corporation	<input type="checkbox"/> Independent Contractor	<input type="checkbox"/> Limited Liability Corp.

a. Professional Association/Professional Corporation Prior Acts coverage desired?     Yes     No  
b. If so, was your PA/PC insured during the period you had prior acts?     Yes     No

8. In what specialties have you practiced during the period that you have requested prior acts?  
\_\_\_\_\_

9. Have you changed, added or deleted any aspects of your practice after your requested retroactive date?  
 Yes     No    If Yes, please describe and indicate date(s): \_\_\_\_\_

10. Has coverage been continuously in force since the retroactive date you are requesting?     Yes     No

11. Any incident, circumstance, act, error, or omission, including a request for records, of which you are aware, must be reported to your current carrier.

All of the above information is true and correct to the best of my knowledge and belief. Any and all acts, incidents, and/or circumstances of which I am aware, and which might reasonably be expected to result in a claim, have been disclosed on this application.

NAME OF APPLICANT: \_\_\_\_\_

SIGNATURE OF APPLICANT: \_\_\_\_\_