

PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION

1777 Sentry Parkway West, VEVA 14, Suite 300, Blue Bell, PA 19422

(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com

Extended Reporting Period (Tail) Supplemental Application

This application supplements the standard Association application. The standard application must be completed and submitted with this application in order for a quotation to be provided. Failure to do so will delay quotations.

Applicant:

First Name (or Legal Name if Corporation)	Middle Name	Last Name
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PA Medical License Number	<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> D.P.M. <input type="checkbox"/> C.N.W. <input type="checkbox"/> Other: _____
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Note: This coverage provides an extended reporting period (tail) for a claims-made policy that was terminated because of: the liquidation of the insolvent carrier that issued the policy; such tail coverage was not available because of the carrier's liquidation; or tail coverage was not obtained from a prior carrier resulting in noncompliance with medical professional liability insurance laws and regulations. This coverage is only available if the claims-made coverage was replaced by another carrier that does not offer Prior Acts coverage.

Previous Policy Information

Please tell us about the policy that this coverage applies to:

Insurance Carrier		Original Effective Date *	
Policy Number		Expiration Date or Termination Date	
Retroactive Date			

* Note that it is critical that the original effective date of the policy and its subsequent renewals be listed. Otherwise any policy issued based on this application will only provide coverage for the listed period. If more than one policy was purchased from the insolvent or prior carrier, attach a list of the policy numbers and the periods each covered.

Please attach a copy of the policy declarations or face sheet.

Current Policy Information

Please tell us about your current policy:

Insurance Carrier		Effective Date	
Policy Number		Retroactive Date	

Individual Health Care Providers

When completing the standard application, complete the information on specialty and procedures the way you would have completed it as of the last day of coverage with the insolvent or prior carrier.

Professional Associations and Corporations

When completing the standard application, complete the information on employed/contracted physicians and other employees based on those employed or contracted as of the last day of coverage with the insolvent or prior carrier.

Institutional Providers

When completing the standard application, complete the exposure information based on the exposures for the 12 months preceding the end of your coverage with the insolvent or prior carrier.

Medical Incidents

Are you aware of any medical incidents which occurred after the Retroactive Date and before the Expiration or Termination Date of your previous policy for which a claim has not yet been made? Yes No If you answered Yes, complete the following:

Date of Incident	Patients Name	Description of incident and injury

Note: The above will not be covered by any policy issued by the Association.

Applicant's Signature*

Date

* If the applicant is not an individual health care provider, authorized signature and title