TDC Specialty Insurance Company
(hereafter, the "Underwriter")
A wholly owned subsidiary of The Doctors Company
Servicing Address: 1888 Century Park East, Suite 850
Los Angeles, CA 90067

# Prior Acts Coverage Supplemental Questionnaire & Warranty Statement

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

Applicant Name:

Expiring Policy Number (if applicable):

1. Have any of the following occurred in your practice during the past 5 years?
   **If you answer "Yes" to any, please complete a Claims Information Form for each such instance.**
   a) Any unexpected death (including stillbirth)? ☐Yes ☐No
   b) Any unexpected neurological or functional impairment? ☐Yes ☐No
   c) Any injury to a fetus or a child during birth? ☐Yes ☐No
   d) Any unexpected organ failure or removal? ☐Yes ☐No
   e) Any unanticipated removal of any body part during or after any invasive procedure? ☐Yes ☐No
   f) Any tear, perforation or unplanned cutting of any organ or body part? ☐Yes ☐No
   g) Any suspicious or positive x-ray, Pap smear or mammogram where the patient was not contacted? ☐Yes ☐No
   h) Emergency surgery, myocardial infarction or cerebral vascular incident within 96 hours of your previous treatment or surgery? ☐Yes ☐No
   i) Complications arising from improper medication, contraindicated medication and/or improper medication dosage? ☐Yes ☐No
   j) If you answer "Yes" to any of the above, have all such instances been reported to and has coverage been confirmed by a prior insurance carrier? ☐Yes ☐No
2. Does your current professional liability insurer allow you to report adverse outcomes, medical incidents and/or medical records requests? ☐Yes ☐No
   If "Yes," will your current insurer provide coverage from any future claims or suits that may arise from such adverse outcomes, medical incidents and/or medical records requests? ☐Yes ☐No
3. Are you aware of, or do you have any knowledge of, any act, failure to act, error, omission, circumstance or attorney contact which could result in a claim or suit being made against you? ☐Yes ☐No
   If "Yes," have all such circumstances been reported to and accepted by a prior carrier? ☐Yes ☐No
   **If "Yes," please complete a Claims Information Form for each such instance.**
4. Has any professional liability insurer refused to accept your notice or report of a medical incident, threat of claim, letter of intent to commence legal action, attorney contact, adverse outcome, notice of claim, records request, or any circumstance or occurrence which could reasonably be expected to result in a claim or suit being made against you? ☐Yes ☐No

## SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, warrants that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this supplement are true and complete, and understands that the information submitted herein becomes a part of the Application and that such information is material and is used to influence the judgment of the Underwriter in determining whether to offer coverage. The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this supplement.

| Applicant Name | |
|---|---|
| By (Authorized Signature) | |
| Name/Title | |
| Date | |