



Anesthesiologists' Professional Assurance Company

Request for Decreased Limits of Liability

I hereby request a decrease in the limits of liability for my Anesthesiologists' Professional Assurance Company (APAC) professional liability coverage, as follows:

from \$ _____ per claim/\$ _____ aggregate
to \$ _____ per claim/\$ _____ aggregate
effective _____

I understand the lower limits will apply to any and all claims or incidents yet to be reported regardless of the limits that were in effect at the time, all subject to my prior acts/retroactive date of _____.
Prior Acts/Retroactive Date

Signature of Insured

Print Name of Insured

Date

Policy Number & License Number

Return Application to:
APAC
1000 Riverside Avenue, Suite 800
Jacksonville, Florida 32204
Mailing Address: P. O. Box 44033
Jacksonville, Florida 32231-4033
904-354-5910 • 1-800-741-3742
Fax: 904-358-6728
www.medmal.com