



Anesthesiologists' Professional Assurance Company

Application for Increased Policy Limits
Increased Limits are subject to Underwriting approval.

Name _____
Policy # _____ License # _____

I request that my policy limits be increased to _____

Desired effective date of this change _____

Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to an incident, claim or suit being brought against you, even if you believe the incident, claim or suit would be without merit:

- Yes No 1. A request for records from a patient and/or attorney related to an adverse outcome?
- Yes No 2. A letter or communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient?
- Yes No 3. Intra-operative or post-operative complications or other complications resulting in death, paralysis or other significant disabilities?
- Yes No 4. Have any unexpected or potentially problematic results or incidents occurred in the past five years such as, but not limited to cardiac arrest, postoperative coma, postoperative neurological deficits or unexpected death within 48 hours postoperatively?
- Yes No 5. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis?
- Yes No 6. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits (**even if you believe the outstanding claim or suit would be without merit**) that have not been reported to APAC or prior professional liability carrier?

NOTE: If you have answered yes to any of the questions above, please complete the second page of this form.

Why do you want to increase your policy limits?



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1. Name of patient:	_____
2. Age:	_____
3. Date of Incident:	_____
4. Your relationship to patient:	_____
5. Carrier:	_____
6. Date reported to carrier:	_____
7. Allegations:	_____
8. Location of incident:	_____
9. Dates and description of treatment rendered:	_____
10. Condition of the patient:	_____
11. Present status of claim:	_____

The above statements are true to the best of my knowledge and I have not knowingly withheld information. I also acknowledge that the increased limit of liability shall not apply to any claim outstanding prior to the effective date of the endorsement that will be issued, nor to any incident which could give rise to a claim about which the insured had knowledge prior to the effective date of the endorsement issued.

Signature _____

Date _____

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