

**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA**  
**Neurologists Professional Liability Insurance**  
**Individual Application**

**INSTRUCTIONS:**

- Carefully review and **answer each** of the following questions.
- Continue with completion of the application and **return it along with a copy of your most recent certificate of insurance or declarations page and a claims history report from the carrier.**
- Complete the application in its entirety. Do not leave any question unanswered. Please use a separate sheet of paper for any additional information, explanation or clarification.

**ALL APPLICATIONS ARE SUBJECT TO UNDERWRITING APPROVAL.**

*If you answer "YES" to any question,  
please provide a detailed written explanation and attach copies of all pertinent official documentation.*

- Yes     No    Has your license to practice medicine been revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?
- Yes     No    Has your license to prescribe controlled substances been revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?
- Yes     No    Have you had an application for a license to practice medicine or prescribe controlled substances result in a denial?
- Yes     No    Have you been previously or currently diagnosed with any physical or mental condition that impairs or could impair your ability to practice medicine?
- Yes     No    Have you ever been denied a specialty board certification or re-certification?
- Yes     No    Has your application (new or renewal) for hospital privileges been denied, suspended, or accepted subject to conditions and restrictions?
- Yes     No    Have you been the subject of an investigation or disciplinary proceedings by any governmental agency (e.g., State Medical Board, DEA, HHS), professional society (e.g., AAN or State Neurological or Medical Society) or a professional review board of a hospital, HMO, PPO, or IPA; Or, are you aware of any incident that could lead to such action? (Please provide updated information for any previously reported incidences.)
- Yes     No    Have you been charged with, convicted of, or pleaded guilty or no contest to a felony?
- Yes     No    Have you ever been, or are you currently sexually, romantically, or socially involved with any current or former patient or with a key third party of a patient? (Key third parties include, but are not limited to, spouses or partners, parents, guardians, surrogates, and the like.)
- Yes     No    Have you ever been, or are you currently involved in a business venture with any current or former patient or with a key third party of a patient?
- Yes     No    Have you ever had a settlement or judgment alleging undue familiarity, professional misconduct, or assault in connection with undue familiarity? **If yes**, please complete the Claims History Supplemental Application.
- Yes     No    Have you reported any malpractice claims or incidents to any carrier **other than** The Neurologists' Program in the past ten years? **If yes**, please complete the Claims History Supplemental Application.
- Yes     No    Are there any incidents, occurrences, accidents, conduct, circumstances, complications, or unexpected outcomes resulting in injury or death that might reasonably be expected to result in a claim or suit known to you or which should have been known to you on the date of this application?  
**If yes**, please complete the Claims History Supplemental Application.

**IMPORTANT INFORMATION:**

- All questions must be answered fully and completely. If any question does not apply to you, state N/A. Please use additional sheets to give complete answers where necessary.
- This is only an application. No coverage exists until a policy is issued in your name.

**A. GENERAL INFORMATION: (Please type or print)**

- Applicant Name: \_\_\_\_\_  
 First Middle Last (MD or DO)
- Mailing Address: \_\_\_\_\_  
 Street City/State/Zip
- Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ EMail: \_\_\_\_\_
- If we need to contact you for additional information, please indicate your preferred method of contact:  Email  Phone  Fax  
Note: All insurance documents, premium invoices and correspondence will be mailed to the address entered above.
- Date of Birth: \_\_\_\_\_
- Current Medical Licenses: Please provide the following information for all of the states in which you practice:  

State	License No.	Effective Date	Expiration Date	Active (Yes/No)
- Current Member of AAN:  Yes  No AAN Membership ID#: \_\_\_\_\_
- List All Other Active Professional Association Memberships: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**B. EDUCATION AND TRAINING**

- Name and Location of Medical School Granting Degree:  
 Medical School Name \_\_\_\_\_ City/State/Country: \_\_\_\_\_  
 Graduation Date: \_\_\_\_\_  
 If you are a graduate of a non-US medical school, have you obtained an ECFMG Certificate?  Yes  No
- Are you Board Certified in any of the following specialties?  

<input type="checkbox"/> Yes	<input type="checkbox"/> No	General Neurology	Date Attained: _____	Last Renewal: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Child Neurology	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Clinical Neurophysiology	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hospice and Palliative Medicine	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurodevelopmental Disabilities	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuromuscular Medicine	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain Medicine	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vascular Neurology	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleep Medicine	_____	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (Specify) _____	_____	_____
- Residency: List all resident training and locations. If more than one specialty was completed, please enter each specific specialty.  
 Specialty Type: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Completed?  Yes  No  
 Name of Hospital/Facility: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Specialty Type: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Completed?  Yes  No  
 Name of Hospital/Facility: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

4. Have you participated in any additional training? (i.e., Fellowship, etc.)

Specialty Type: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Completed?  Yes  No  
Name of Hospital/Facility: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Specialty Type: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_ Completed?  Yes  No  
Name of Hospital/Facility: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

5. Have you participated in any Risk Management Seminar(s) during the last 12 months for which you earned at least 4 CME credits?  Yes  No  
**If yes**, please attach a copy of the certification and brochure explaining the content of the seminar.  
If the seminar was sponsored by PRMS, please indicate: \_\_\_\_\_

Location/Date

**C. INSURANCE AND PROFESSIONAL HISTORY**

A "Yes" response to question 1, 2, or 3 requires a detailed explanation outlining the underlying reason(s) for the adverse underwriting decision.

1. Have you ever been denied professional liability insurance coverage?  
**NOTE: MISSOURI APPLICANTS DO NOT RESPOND**  Yes  No  
**If yes**, please attach a separate sheet containing a complete explanation.

2. Has your professional liability insurance coverage ever been cancelled or refused renewal?  
**NOTE: MISSOURI APPLICANTS DO NOT RESPOND**  Yes  No  
**If yes**, please attach a copy of the cancellation or non-renewal notice or letter.

3. Has your application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions?  Yes  No  
**If yes**, please attach a separate sheet containing a complete explanation.

4. Prior Insurance: List insurers or your employers' insurers in the past ten (10) years. Attach a copy of your most recent declaration page, certificates of insurance covering the past 10 years, and claims history reports for each carrier. Attach additional pages as needed.  
**EXPLAIN ANY UNINSURED PERIODS.**

Insurance Carrier	Coverage Dates	Limits of Liability	Coverage Type (Occurrence/Claims-Made)	Claims-Made Retroactive Date
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5. Practice Locations: List ALL locations at which you have practiced in the last ten (10) years.  
**EXPLAIN ANY PERIODS IN WHICH YOU DID NOT PRACTICE.** Attach additional pages as needed.

(a) Name of Practice: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

(b) Name of Practice: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

(c) Name of Practice: \_\_\_\_\_ From: \_\_\_/\_\_\_/\_\_\_ To: \_\_\_/\_\_\_/\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

**D. COVERAGE REQUEST**

Desired Effective Date of Coverage: \_\_\_\_\_

**NOTE:** The earliest effective date we can grant, if your application is approved, is the postmark date of your submission.

**1. Type of Coverage:**

<input type="checkbox"/> Claims-Made (All states) Requested Retroactive Date: _____	<input type="checkbox"/> Claims-Made w/Prepaid Tail (May not be available in all states)	<input type="checkbox"/> Occurrence (May not be available in all states)
<ul style="list-style-type: none"> <li>If prior coverage was on a claims-made policy, was the Extended Reporting Period Endorsement Purchased? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please attach a copy.)</li> <li>Are you requesting Prior Acts coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the Prior Acts Coverage Supplemental Application.</li> </ul>		
Additional information <u>must</u> be completed on the SUPPLEMENTAL APPLICATION for Kansas.		

**2. Limits of Liability:** (Additional Underwriting Guidelines may apply to selected Limits of Liability; All Limits of Liability may not be available at all states)

- \$2,000,000/\$6,000,000
- \$500,000/\$1,500,000
- \$200,000/\$600,000
- \$250,000/\$750,000 (Indiana Only)
- \$1,000,000/\$3,000,000
- \$1,300,000/\$3,900,000 (New York Only)
- \$100,000/\$300,000 (Louisiana Only)

**3. Type of Practice:**

- Neurology without procedures
- Child Neurology
- Neurology WITH procedures (including but not restricted to angiograms, myelograms, and arteriograms)
- Other Neurologic Specialty: \_\_\_\_\_

**Residents, Fellows, and New Neurologists (First time in practice after completion of formal training):**

- Residents and Fellows coverage for "moonlighting" practice confined to neurology and totaling 20 hours or less per week. (Must be in an ACGME or RCPS(C) approved Residency/Fellowship Training Program full time and in PGY2 or later.)  
 Training Program/School: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Expected Residency/Fellowship Completion Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- First, second or third year of practice following completion of residency or fellowship: **Beginning Practice Date:** \_\_\_\_\_  
 Residency Completed Date (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Fellowship Completed Date (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_
- First, second or third year of practice following discharge from active duty in the military: **Beginning Practice Date:** \_\_\_\_\_  
 Discharge Date (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_

**Additional Entity Coverage requested: (If you checked any of these boxes, please complete the Supplemental Application for Practice Structure/Vicarious Liability Coverage. Coverage for your entity will not be provided without this additional application.)**

- Employer of other Professionals
- Contractor of the services of other Professionals
- Professional Partnership/Association
- Incorporated Solo Private Practice
- Professional Corporation with more than one shareholder
- Fictitious Name Entity or DBA
- Joint Venture or LLC

**E. CURRENT PRACTICE LOCATIONS:**

Please complete a section for **EACH** location at which you are currently practicing (Please list principal location first). **Include current practice locations covered by another carrier. Copy this page for additional locations as needed.**

1. Entity Name: _____
Street Address: _____
City/State/Zip: _____
County: _____
Telephone: _____ Fax: _____
Beginning Date of Practice: _____
Average weekly practice (in hours): _____
Average number of patients per week: _____

**This location is a:**

- Private Office
- Outpatient Clinic
- Hospital
  - Admitting
  - Non-Admitting
 If non-admitting, please explain: \_\_\_\_\_
- Nursing Home
- Office in the Home
- Government Hospital (Federal, State, Local)
- Other (Specify): \_\_\_\_\_

- a) Is coverage desired for your work at this location? **If your practice activities at this location will be covered by another professional liability insurance carrier, please provide the name of the carrier:** \_\_\_\_\_  Yes  No
- b) Do you want a Certificate of Insurance for this location?  Yes  No
- c) Do you serve as the Medical Director or Chief of Neurology at this location?  Yes  No
- d) If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization?  Yes  No
- e) If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization?  Yes  No
- f) Do you teach at this location?  Yes  No
  - Classroom Teaching
  - Clinical Teaching; Average number of weekly hours spent clinical teaching: \_\_\_\_\_

2. Entity Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 County: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Beginning Date of Practice: \_\_\_\_\_  
 Average weekly practice (in hours): \_\_\_\_\_  
 Average number of patients per week: \_\_\_\_\_

**This location is a:**

- Private Office
- Outpatient Clinic
- Hospital
  - Admitting
  - Non-Admitting
- Nursing Home
- Office in the Home
- Government Hospital (Federal, State, Local)
- Other (Specify): \_\_\_\_\_

\_\_\_\_\_  
 -  
 \_\_\_\_\_  
 -  
 \_\_\_\_\_  
 -

- a) Is coverage desired for your work at this location?  Yes  No  
**If your practice activities at this location will be covered by another professional liability insurance carrier, please provide the name of the carrier:**  
 \_\_\_\_\_
- b) Do you want a Certificate of Insurance for this location?  Yes  No
- c) Do you serve as the Medical Director or Chief of Neurology at this location?  Yes  No
- d) If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization?  Yes  No
- e) If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization?  Yes  No
- f) Do you teach at this location?  Yes  No
  - Classroom Teaching
  - Clinical Teaching; Average number of weekly hours spent clinical teaching: \_\_\_\_\_

**F. PRACTICE PROFILE:** Please attach a separate sheet for any required explanations.

- 1. Do you sign insurance or other reimbursement forms for patients where you have not participated in their care and treatment?  Yes  No  
**If yes,** please describe in what capacity (e.g., as a Medical Director) and indicate if you clarify what your signature means on such forms: \_\_\_\_\_
- 2. Do you practice as a medical director?  Yes  No  
**If yes,** type and name of facility: \_\_\_\_\_  
 Briefly describe your responsibilities: \_\_\_\_\_  
 Please be sure to include this location in Section E. Current Practice Locations of the Application.
- 3. Do you have admitting privileges?  Yes  No  
**If yes,** make sure the hospital is listed in Section E. Current Practice Locations of the Application.  
**If no,** please describe your mechanism for handling your patients who may require immediate in-patient care:  
 \_\_\_\_\_
- 4. Do you create and maintain a neurologic/medical record for each patient under your care?  Yes  No  
**If no,** please explain: \_\_\_\_\_
- 5. Do you prescribe controlled substances?  Yes  No
- 6. Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing or performing procedures?  Yes  No
- 7. Do you have patients sign an arbitration agreement?  Yes  No  
**If yes,** is signing a condition of treatment?  Yes  No
- 8. Do you write prescriptions for patients you have not clinically evaluated **other than to cover for another colleague** whose patient requires a minimal refill on an existing prescription?  Yes  No  
**If yes,** please explain under what circumstances: \_\_\_\_\_
- 9. Do you regularly treat general medical conditions presented by your neurologic patients?  Yes  No  
**If yes,** please indicate:
  - Average number of patients per week you provide general medical treatment to: \_\_\_\_\_
  - Nature of the conditions you treat and the type of treatment you provide: \_\_\_\_\_

10. Do you now practice any specialty other than neurology?  Yes  No  
**If yes**, check applicable specialty(ies) below and indicate % of practice:
- General Practice % \_\_\_\_\_  Pediatrics % \_\_\_\_\_  
 Family Practice % \_\_\_\_\_  Other (Specify) % \_\_\_\_\_
11. Have you ever practiced a specialty other than neurology?  Yes  No  
**If yes**, what specialty? \_\_\_\_\_ When? \_\_\_\_\_
12. Do you communicate with patients via email?  Yes  No
- What is the percent of your total patient load that you communicate with by email? \_\_\_\_\_%
  - Do you utilize email to render medical services?  Yes  No
  - Do the patients reside in a state other than the state in which you are licensed to practice?  Yes  No  
**If yes**, please explain.
  - Do you obtain informed consent regarding at least confidentiality/privacy issues involved with email communication, the topics generally not appropriate for email and the risks and benefits including possible clinical limitations when using email?  Yes  No
  - On a separate sheet, please explain the nature of communications in detail.
13. Does your practice include telemedicine activities (e.g., direct interaction with patients through electronic means: video, computer, or telephone) in order to provide healthcare to patients who are geographically separated from the clinicians involved?  Yes  No  
**If yes**:
- a) What is the percent of your total practice time devoted to this activity? \_\_\_\_\_%
  - b) While being treated, are the patients physically located outside the state or jurisdiction where your practice is located?  Yes  No  
**If yes**, are you currently licensed to practice in the state or jurisdiction where the patient is located at the time of treatment?  Yes  No  
Is the jurisdiction outside the U.S.?  Yes  No
  - c) On a separate sheet, please explain the details of the telemedicine arrangement (i.e. the location, equipment, conditions being treated, number of patients, health professionals and/or other resources available to the patient at his/her location, etc.)
14. Do you engage in any clinical and/or pharmaceutical research or research involving medical devices?  Yes  No  
**If yes**, please complete the Clinical/Pharmaceutical Research Supplemental Application and submit it along with a copy of the indemnification agreement provided by the pharmaceutical company.
15. Do you treat patients with unconventional therapy (i.e., treatment not considered to be mainstream neurologic treatment)?  Yes  No  
**If yes**, please describe: \_\_\_\_\_
16. Do you have a website, or are you affiliated with a website?  Yes  No  
**Website address**: \_\_\_\_\_
17. Do you perform any of the following procedures?  Yes  No  
**If yes**, check all that apply and give percentage:
- Angiography % \_\_\_\_\_  Arteriography % \_\_\_\_\_  Electromagnetic Therapy % \_\_\_\_\_  
 Myelography % \_\_\_\_\_  Nerve Blocks (**if yes**, please state type \_\_\_\_\_) % \_\_\_\_\_  
 Other Procedures
18. Will you be performing any activities which will be covered by another professional liability policy?  Yes  No  
**If yes**, complete the following:  Employee  Independent Contractor  Resident/Fellow  Faculty  
Please be sure to list the practice location in Section E. Current Practice Locations of the application.

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## G. DECLARATIONS

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance.

Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy.

All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

**NOTICE TO APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO COLORADO APPLICANTS:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

**NOTICE TO FLORIDA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NOTICE TO KANSAS APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**NOTICE TO LOUISIANA APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MAINE APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

**NOTICE TO MARYLAND APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

**NOTICE TO MINNESOTA APPLICANTS:** A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

**NOTICE TO NEW JERSEY APPLICANTS:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

**NOTICE TO OHIO APPLICANTS:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO OKLAHOMA APPLICANTS:** WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

**NOTICE TO OREGON APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO PENNSYLVANIA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO VERMONT APPLICANTS:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

\_\_\_\_\_  
Physician's Personal Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature

\_\_\_\_\_  
Date

*The Neurologists' Program Administered By:*  
PRMS  
1515 Wilson Boulevard, Suite 800  
Arlington, VA 22209

