**NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA**

# Psychiatrists’ Professional Liability Insurance Individual Renewal Application

## GENERAL INFORMATION: (Please type or print)

* 1. Applicant Name:
  2. Mailing Address:

First Middle Last (MD or DO)

Street City/State/Zip

* 1. Phone: Fax: E-Mail:

## ATTESTATION QUESTIONS:

* Carefully review and answer each of the following questions.
* If you answer “YES” to any question, please provide a detailed written explanation and attach copies of all pertinent official documentation.
* Please sign and date this application and return the entire form in the enclosed return envelope.

## Since you first applied for coverage or last renewed your coverage (whichever is later):

|  |  |  |
| --- | --- | --- |
| Yes | No | Has your license to practice medicine been revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?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| Yes | No | Has your license to prescribe controlled substances been revoked, suspended, voluntarily surrendered or not renewed, reprimanded, fined, or subjected to probationary terms?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 | Have you ever experienced any dependency upon or been treated for alcohol, narcotics, or other drugs? |
| 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., APA or its District Branches) 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 Psychiatrists’ Program in the past ten years? **If yes**, please complete the Claims History Supplemental Application. |
| Yes | No | Are you aware of 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. |

1. **PRACTICE PROFILE:**

**All of the following questions must be answered fully and completely.** 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? **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.

D Yes D No

* 1. Do you practice as a medical director?

**If yes,** type and name of facility: Briefly describe your responsibilities:

D Yes D No

If this location is not already listed on the enclosed Proposal of Insurance, please add it to Section D. New Practice

Location of the Application.

* 1. Do you have admitting privileges? **If yes** and the hospital is not already listed on the enclosed Proposal of Insurance, please add it to Section D. New Practice Location of the Application. **If no**, please describe your mechanism for handling your patients who may require immediate in-patient

care:

D Yes D No

* 1. Do you create and maintain a psychiatric/medical record for each patient under your care?

If no, please explain:

D Yes D No

* 1. Do you prescribe controlled substances? D Yes D No
  2. Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics?

D Yes D No

* 1. Do you have patients sign an arbitration agreement? If yes, is signing a condition of treatment?

D Yes

D Yes

D No

D No

* 1. 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.

**If yes**, please explain under what circumstances:

D Yes D No

* 1. Do you provide medication management for patients who see another professional (e.g., Ph.D., MSW) as their primary therapist and see you for medication management only?

For how many patients per week? How often do you see each patient?

D Yes D No

* 1. Do you regularly treat general medical conditions presented by your psychiatric patients? **If yes**, please indicate D Yes D No
     + 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:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 11. Do you now practice any specialty other than psychiatry?  **If yes**, check applicable specialty(ies) below and indicate % of practice: |  | D | Yes | D | No |
| D General Practice % D Pediatrics %  D Family Practice % D Other (Specify) | % |  |  |  |  |
| 12. Do you advertise as a **specialist**\* in the evaluation and treatment of any of the following? |  | D | Yes | D | No |

|  |  |  |
| --- | --- | --- |
| D Borderline Personality Disorder | D Chronic Pain | D Multiple Personality Disorder or Dissociative Disorders |
| D Childhood Sexual Abuse | D Eating Disorders | D Sex Therapy |

If yes, how many patients for each specialty? What percentage of your total patient load?

***\*Note: “Specialist” is indicated by 1) advertisements, 2) marketing materials, 3) letterhead, or 4) employment, contractual relationship or admitting privileges at any institution with a special interest in any of the above.***

1. Do you supervise any other psychiatrist or other mental health care providers specializing in the disorders/activities listed in #12?
2. Does your treatment include use of abreaction, rage, sodium amytal, sex, antiandrogen or recovered memory therapies? **If yes**, please explain the clinical details regarding this treatment.
3. Does your practice include forensic activities, e.g., child custody and visitation; criminal responsibility; competence, civil and criminal; correctional psychiatry; juvenile justice and violence?
   * What is the percent of your total practice time devoted to this activity?
   * On a separate sheet, please explain the exact type of forensic activities.

D Yes D No

D Yes D No

D Yes D No

%

|  |  |  |
| --- | --- | --- |
| 16. Do you communicate with patients via e-mail? | D Yes | D No |
| * What is the percent of your total patient load that you communicate with by email? * Do you utilize e-mail to render psychiatric services? | %  D Yes | D No |
| * Do the patients reside in a state other than the state in which you are licensed to practice? If yes, please explain. * Do you obtain informed consent regarding at least confidentiality/privacy issues involved with email | D Yes | D No |

communication, the topics generally not appropriate for email, and the risks and benefits including possible clinical limitations when using email?

* On a separate sheet, please explain the nature of communications in detail.

D Yes

D No

1. 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?

If yes:

D Yes D No

%

1. What is the percent of your total practice time devoted to this activity?
2. While being treated, are the patients physically located outside the state or jurisdiction where your practice is located?
   1. If yes, are you currently licensed to practice in the state or jurisdiction where the patient is located at the time of treatment?
   2. Is the jurisdiction outside the U.S.?
3. On a separate sheet, please explain the details of the telemedicine arrangement (i.e. the location, equipment, conditions being treated, number of patients, mental health professionals and/or other resources available to the patient at his/her location, etc.)

D Yes

D Yes

D Yes

D No

D No

D No

1. Do you engage in any clinical and/or pharmaceutical research or research involving medical devices? D Yes D No

**If yes,** please complete the Clinical/Pharmaceutical Research Supplemental Application.

1. Do you treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment?

**If yes**, please describe:

1. Do you have a website, or are you affiliated with a website?

**Website address**:

1. Does your practice include the use of narcotic drugs for opioid addiction treatment? If yes, please provide proof of special DEA registration or of a DATA 2000 waiver.
2. Do you perform Brain Spect Imaging?

If yes, on a separate piece of paper, please describe your weekly patient volume and training related to this procedure.

D Yes D No

D Yes D No

D Yes D No

1. Do you perform Vagus Nerve Stimulation therapy (VNS)? If yes:
   1. Please provide evidence of your completion of training for the use of VNS Therapy. If the training program is one that ***was not*** sponsored by Cyberonics, please include a brochure detailing the program.
   2. Please provide an example of the informed consent form and any other materials that will be used as part of the informed consent process with patients for VNS therapy.
   3. On a separate sheet of paper, please describe:
      1. your methods of monitoring patients using VNS therapy
      2. how you will determine which of your referral physicians are qualified and trained to perform the surgical procedure for implantation of the VNS pulse generator
   4. Will VNS therapy be prescribed for an off-label use?

D Yes

D Yes

D No

D No

**IF ANY OF THE FOLLOWING INFORMATION HAS CHANGED SINCE THE LATER OF WHEN YOU FIRST APPLIED FOR COVERAGE OR LAST RENEWED YOUR COVERAGE,** P**LEASE COMPLETE ALL APPLICABLE SECTIONS BELOW TO ENSURE THAT YOUR COVERAGE IS UPDATED ACCURATELY.**

## NEW ADDRESSES: (See front proposal page for current address on file.) NEW MAILING ADDRESS:

Street Address 1 Telephone Fax

Street Address 2 E-Mail Address

City/State/Zip Website:

## NEW PRACTICE LOCATION:

**(See front proposal page for current locations on file.)**

**This location is a:**

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:

##### *Please attach a separate sheet containing all of the below* information for each additional location.

D Private Office D Admitting Hospital

D Nursing Home D Non-Admitting Hospital

If non-admitting, please explain:

D Office in the Home

D Detention Facility

(Jail, Prison, Home for Juveniles, half- way houses for those convicted of or awaiting trial or criminal charges, or institutions for the treatment and confinement of those found “not guilty by reason of insanity”, “guilty but

D Outpatient Clinic

D Government Hospital (Federal, State, Local)

D Other (Specify):

mentally ill”, etc.)

1. 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:**

D Yes D No

1. Do you want a Certificate of Insurance for this location? D Yes D No
2. Do you serve as the Medical Director or Chief of Psychiatry at this location? D Yes D No
3. If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization? D Yes D No
4. If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization?

D Yes D No

1. Do you teach at this location? D Yes D No

D Classroom Teaching D Clinical Teaching Average number of weekly hours spent clinical teaching:

**LOCATIONS DELETED/EXPIRED:** a) Date:

*(include date)* b) Date:

## COVERAGE CHANGES

#### PRACTICE TYPE

D General Psychiatry

D Neuropsychiatry

D Child & Adolescent Psychiatry (Please complete the Child &

D Neurology WITH minor surgery (including but not restricted to CAT scans and NMR imaging, angiograms, myelograms, arteriograms, and pneumoencephalograms)

D Neurology – *no surgery*

Adolescent Psychiatry Supplemental Application) D Other Psychiatric Specialty:

**LIMITS OF LIABILITY:** *(***All limits of Liability may not be available in all states.)**

##### *This change will be effective going forward only and requires agreement with the claims disclosure statement shown below.*

$2,000,000/$6,000,000 $250,000/$750,000

$1,300,000/$3,900,000 (NY ONLY) $200,000/$600,000

$1,000,000/$3,000,000 (WI – REQUIRED LIMIT) $100,000/$300,000 (LA – REQUIRED LIMIT)

$500,000/$1,500,000 (PA – REQUIRED LIMIT)

#### Claims Disclosure: The applicant declares that as of the date of this application there have been no material change(s) in any fact or circumstance from those set forth in the most recent Application submitted to this Company relating to the insurance to be afforded by this Policy and that the applicant has no knowledge of any circumstance, incident or loss that is reasonably likely to give rise to a claim under this Policy.

**I AGREE**

**RISK MANAGEMENT SEMINAR(S):**

Have you participated in any Risk Management Seminar(s) of four (4) credit hours or more during the last 12 months? Yes

**If Yes**, please attach a copy of the certification and brochure explaining the content of the seminar.

**PRACTICE HOURS:**

Full-time Practice -- **professional activities at all covered locations totaling more than 20 hours per week**.

Part-time Practice -- **LIST EACH LOCATION AND THE CORRESPONDING HOURS OF PRACTICE TIME PER WEEK**.

1 to 10 Hours 11 to 15 Hours 16 to 20 Hours

**PRACTICE STRUCTURE:** *Please indicate all practice situations that now apply to you.*

|  |  |
| --- | --- |
| (a) Unincorporated Solo Private Practice | (e) Employer of other Professionals |
| (b) Independent Contractor to Another Provider, a Hospital or Another Facility | (f) Contractor of the Services of other Professionals |
| (c) Employee of a Hospital or Another Facility, or Another Physician | (g) Professional Corporation with More Than One Shareholder |
| (d) Incorporated Solo Private Practice | (h) Professional Partnership/Association |
|  | (i) Fictitious Name Entity or DBA |

##### *If you checked Items d, e, f, g, h, or i above AND you are the President, Managing Partner,* Employer, or Contractor of others please contact your Underwriter for the appropriate application.

**Vicarious Liability Employee/Independent Contractor Roster Update: Include on roster: Date of Hire**

1. Name Degree Practices As

Insurance Carrier Coverage Limits

If insured with this program, please provide the Customer ID#:

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Insurance Carrier Coverage Limits

If insured with this program, please provide the Customer ID#:

#### Remove from roster:

Name: Date: Name: Date:

## LICENSURE AND MEMBERSHIPS

#### MEDICAL LICENSE NUMBER:

*(This is required if the New Practice Location involves a change*

*in state or if you have obtained a license in a new state.)* State/Number

Effective Date: Expiration Date:

#### LIST NEW ACTIVE PROFESSIONAL ASSOCIATION MEMBERSHIPS:

1. **CERTIFICATION AND TRAINING**

**Board Certification:** Specialty: Date Attained: **Post-graduate Fellowship:** Training Program: Date Completed: Other training:

#### Return to Member-In-Training (MIT) status:

Member-In-Training’s coverage for “moonlighting” practice confined to psychiatry and totaling 20 hours or less per week. (Must be in an ACGME or RCPS(C) approved Residency Training Program full time and in PGY2 or later.

Name of Training Program/School Specialty

#### No longer MIT status:

First, Second or Third Year of Practice immediately following completion of residency or fellowship. Residency Completion Date (MM/DD/YY)

## 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 IN THE THIRD DEGREE.

**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

*The Psychiatrists’ Program*

### 1515 Wilson Boulevard, Suite 800

Arlington, VA 22209

Name of Agent:

License #:

Signature:

Date:

**NOTES SECTION**

**Question # Comments**