SIMED

APPLICATION FOR EXCESS OVER PRIMARY POLICY LIMITS

Name of Applicant: _____   Policy Number: _____

1. I declare that the nature of my current practice is as follows: (Please be specific. Indicate your specialty, subspecialty, the type of medical and/or surgical procedures that you perform, and any of specific patient(s) and/or group(s) of patients that you serve. Include copy of your Curriculum Vitae and, if you are Board Certified by the American Board of Medical Surgical Specialties, please include copy of it.

   _____

   _____

   _____

2. The limits of liability desired are (Please mark one):
   ( ) $150,000 per medical incident/$300,000 annual aggregate
   ( ) $400,000 per medical incident/$800,000 annual aggregate
   ( ) $650,000 per medical incident/$1,300,000 annual aggregate
   ( ) $900,000 per medical incident/$2,700,000 annual aggregate

3. I understand and accept that signing this application and tendering premium does not bind or obligate the Syndicate to grant the limits of liability of the policy as requested. If the Syndicate determines that the applicant is eligible for the limits, the corresponding quote indicating the additional premium will be provided.

4. I hereby give permission to the Syndicate to request information regarding my professional credentials and qualifications from any educational facilities, the chief(s) of the clinical department(s) of any hospital(s) in which I may currently have, or formerly have had staff privileges to any professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

5. The information requested may include otherwise privileged and/or confidential material related to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter having bearing on the underwriting procedures. I release and agree to hold harmless the Syndicate and its representatives, employees and agents which may result from the gathering or legal use of such information to evaluate the insurance of the request excess policy.

6. I hereby authorize the educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, any professional certification boards, state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities and any present and/or past employers to submit information request by the Syndicate, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and suit information clinical and/or further release and agree to hold harmless all such

entities, their representatives, employees and agents from any and all liability for any damages, which may result from providing this information.

7. I understand any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, or will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with pain of no smaller fine of five thousand (5,000) dollars, nor greater of ten thousand (10,000) dollars or imprisonment by a fixed term of three (3) year, or both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances , it could be reduced until a minimum of two (2).

8. Understands that any person who knowingly renders a false report, makes a misrepresentation of facts or includes in any application for insurance any matter such person knows is untrue, commits a fraudulent act and is in violation of section 12.190 of the Insurance Code of Puerto Rico and certifies that the foregoing answers and statements are complete, true and correct to the best of his or her knowledge and belief.

AVISO IMPORTANTE

El Artículo 27.320 del Código de Seguros de P.R. dispone lo siguiente:

"Cualquier persona que a sabiendas y que con la intención de defraudar presente información falsa en una solicitud de seguro o, que presentare, ayudare o hiciere presentar una reclamación fraudulenta para el pago de una pérdida u otro beneficio, o presentare más de una reclamación por un mismo daño pérdida, incurrirá en delito grave y convicto que fuere, será sancionado, por cada violación con pena de multa no menor de cinco mil (5,000) dólares, ni mayor de diez mil (10,000) dólares o pena de reclusión por un término fijo de tres (3) años, o ambas penas. De mediar circunstancias agravantes, la pena fija establecida podrá ser aumentada hasta un máximo de cinco (5) años; de mediar circunstancias atenuantes, podrá ser reducida hasta un mínimo de dos (2)".

IMPORTANT WARNING

Article 27.320 of the Insurance Code of P.R. arranges the following:

"Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, or will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with pain of no smaller fine of five thousand (5,000) dollars, nor greater of ten thousand (10,000) dollars or imprisonment by a fixed term of three (3) years, or both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2)".

Applicant's Signature	**Date**

**Authorized Representative
or Broker Name:**

Telephone Number:

Mobile Phone Number:

Fax Number:

Website Address:

Mail Address: