Print Form

Gulf Atlantic Legal Defense Insurance, Inc.

Prior Acts Request

Client Name
and Mailing Address:

_____ Policy Effective Date: _____

_____

_____ Retroactive Date: _____

_____

The undersigned agrees that, as of the date of execution of this form:

1. I have disclosed on my application for insurance coverage with Gulf Atlantic Legal Defense Insurance, Inc.:

   A. All known Claims (defined as actual, threatened or possible demands for money or services arising out of my Professional Services or the services of anyone for whose acts or omissions I may be legally responsible, and includes, but is not limited to, any patient complaint, poor or unexpected results, an attorney's request for medical records, a notice of intent to file a lawsuit, or a lawsuit);

   B. All known Medical Incidents (defined as acts, errors or omissions in my providing or failure to provide Professional Services, or any such acts, error or omission by any person for whose Professional Services I may be legally responsible); and

   C. Any circumstance of which I am aware that might reasonably be expected to result in a Medical Incident or Claim.

2. All Claims or Medical Incidents have been reported to my previous insurance carrier.

3. I acknowledge and agree that the policy to be issued to me by Gulf Atlantic Legal Defense Insurance, Inc., specifically excludes coverage for any Claim or Medical Incident of which I am or reasonably should be aware of prior to the start of the Policy Period.

_____ _____
Date Signature

Agency: _____

_____

_____

2549 Barrington Circle (32308) ? **PO Box 12200 (32317-2200)** ? **Tallahassee, FL** ? **Tel 800.839.2944** ? **Fax 800.357.0652**