



**Professional Liability/Medical Malpractice  
Preferred • Standard • Non-Standard**

303 Middletown Park Place • Suite F • Louisville KY 40243  
Nationwide 1 (800) 216-1056 • (502) 244-1056 • FAX (502) 254-1056  
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WARNING – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or files a 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.

Date: \_\_\_\_\_

Named Insured & Agent \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**NOTICE**

Dear Insured:

At your request placed through your agent \_\_\_\_\_ your \_\_\_\_\_ (policy type) coverage has been placed with \_\_\_\_\_ (insurance company and/or Risk Retention Group). This insurer is currently \_\_\_\_\_ rated by the AM Best Company, a leading monitor of the financial performance and stability of Insurance companies. A rating by AM Best Company is an indication of the Insurance company's financial strength performance with the top rating being A++ (superior).

The only market available to you through PBS Insurance Underwriting Corporation providing the coverage's you requested through your agent at the premium outlined in our proposal to your agent is with \_\_\_\_\_ (company name).

PBS Insurance Underwriting Corporation does not have the expertise to analyze the financial stability of Insurance companies, thus we rely on AM Best Company for rating analysis. Should \_\_\_\_\_ (company name) become unable to satisfy its obligations to pay its claims, PBS Insurance Underwriting Corporation will not be held responsible. **YOUR SIGNATURE WARRANTS THAT YOU HAVE READ AND AGREE TO THE TERMS OF THIS NOTICE & HEREIN BECOMES PART OF YOUR/MY PROFESSIONAL LIABILITY APPLICATION.**

Sincerely,  
PBS Insurance Underwriting

By: \_\_\_\_\_  
Underwriter

\_\_\_\_\_ Date

**UNDERSIGNED – AGREED**

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_ Date

\_\_\_\_\_  
Address of Agent

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_ Date

\_\_\_\_\_  
Address of Insured