

MUST BE ON PHYSICIAN'S LETTERHEAD

**ACKNOWLEDGEMENT AND WAIVER
OF APPLICANT
REGARDING UNCOVERED PERIODS.**

THE UNDERSIGNED APPLICANT ("Applicant") for professional liability insurance with _____ ("Company") hereby acknowledges that certain claims may exist against the Applicant or which may arise at some future date against the Applicant hereafter will not be covered by the Company policy of insurance ("Policy") which the Applicant seeks to purchase from the Company. The Applicant acknowledges that any such claim(s) will not be covered as the result of professional services rendered prior to the effective date as stated in the Company policy during the period of time which the Applicant has no professional liability policy in force with the Company ("Uncovered Period"). The Applicant acknowledges their continued non-insured personal exposure for their own defense and any damages related to previous services rendered prior to the effective date as stated in _____ policy.

The Applicant further acknowledges and agrees that in the event a claim arises which may or could be allocated either to the Uncovered period or to the Policy (including any renewal of the Policy) or could be allocated both to an Uncovered Period and to the Policy (including any renewal of the Policy), the Applicant hereby agrees to accept the implementation of claim guidelines then in force and effect by the Company's Law Department for allocating between and among various policies and periods of coverage. The Applicant agrees that the determination of the Company's Law Department with regard to such allocation shall be final and hereby waives the right, which the Applicant may have or could have to contest such determination.

The Acknowledgment And Waiver Of Applicant Regarding Uncovered Periods is a condition precedent for insurance of a Policy, and renewal Policies by _____. The Applicant acknowledges and holds harmless PBS INSURANCE UNDERWRITING CORPORATION and Affiliates and any RPG'S that the Applicant may be insured through for his/her actions in regards to lowering and/or waiving prior acts coverage.

I ACKNOWLEDGE THAT I HAVE CAREFULLY READ AND I UNDERSTAND THIS DOCUMENT AS WITNESS BY MY SIGNATURE BELOW.

SIGNATURE OF APPLICANT: _____

NAME OF APPLICANT: _____

DATE OF SIGNATURE: _____

WITNESS: _____