



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

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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.

APPLICATION FOR SPECIFIED MEDICAL PROFESSIONS
PROFESSIONAL LIABILITY INSURANCE FOR MEDICAL STUDENTS

NOTICE: THE POLICY FOR WHICH APPLICATION IS MADE APPLIES ONLY TO "CLAIMS" FIRST MADE DURING THE "POLICY PERIOD", UNLESS THE OPTIONAL EXTENSION PERIOD IS EXERCISED. THE LIMITS OF LIABILITY SHALL BE REDUCED BY "CLAIM EXPENSES" AND "CLAIM EXPENSES" SHALL BE APPLIED AGAINST THE DEDUCTIBLE.

If space is insufficient to answer any question fully, attach a separate sheet.

- 1. (a) Full name of Applicant:
(b) U.S. address: (Street) (County) (City) (State) (Zip)
(c) Foreign address (if None, so state): (Street) (City) (Zip) (Country)
(d) Date of birth (MM/DD/YYYY): Place of birth:
(e) Are you a U.S. citizen? [] Yes [] No
If No, provide the following:
(i) Your status in the U.S.:
(ii) Date of entry into the U.S.:
(iii) Visa/Passport Number:
2. (a) Provide the following information for any medical school(s) that you have attended or are currently attending:
Name of Medical School Address Dates
Attended
(b) Provide the month and year of graduation or anticipated month and year of graduation:
3. (a) Provide the name and address of the facility at which you will receive additional medical training:
(b) Provide the duration of your additional medical program (MM/DD/YYYY): From: To:
(c) Provide the name and title of the person(s) who will be supervising your additional medical program:
(d) Will you provide direct patient care: [] Yes [] No
If No, are your activities limited to observation only? [] Yes [] No

