**Physicians, Surgeons and Dentists Excess Professional Liability Insurance Policy**

This Declarations Page is attached to and forms part of the insurance policy.

**DECLARATIONS**

1. **Named Insured**:
2. **Named Insured**’s Address:
3. Producer:
4. Policy Number:
5. **Policy Period** From: To:

*Both days at 12.01 A.M. Local Standard Time at the Named Insured’s address shown in Item 2.*

1. Retroactive Date:
2. Limits of Liability:

*The insurance afforded is only with respect to the following coverages as are indicated by specific premium charge or charges, subject to the Limits of a Liability stated herein and to all the terms of this policy relating thereto. Furthermore, separate policies will be issued for each Coverage A and Coverage B when applied for and both coverages are provided by the* ***Company****.*

1. Coverage A – Individual Coverage

|  |  |  |
| --- | --- | --- |
| Limits of Liability | $ \_\_\_\_\_\_\_\_\_\_\_ per **Medical Incident** | $ \_\_\_\_\_\_\_\_\_\_ aggregate |
| Premium |  | |

1. Coverage B – Partnership, Association or Corporation Professional Liability

|  |  |  |
| --- | --- | --- |
| Limits of Liability | $ \_\_\_\_\_\_\_\_\_\_\_ per **Medical Incident** | $ \_\_\_\_\_\_\_\_\_\_ aggregate |
| Premium |  | | |

1. **Underlying Insurance** Information

Underlying Insurer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Underlying Insurer’s** Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Underlying Insurer’s Policy Period**: From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Coverage A – Individual Coverage | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ per **Medical Incident** | $ \_\_\_\_\_\_\_\_\_\_\_\_\_ aggregate |
| Coverage B – Partnership, Association or Corporation Professional Liability | $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ per **Medical Incident** | $ \_\_\_\_\_\_\_\_\_\_\_\_ aggregate |

1. The number of professional **employees** employed by the **Insured** under Coverage B

|  |  |
| --- | --- |
| **Professional Employees** | **Coverage B** |
| Physicians/ Surgeons / Dentists |  |
| Allied Healthcare Providers |  |

1. Additional locations under Coverage B:

1. The **Named Insured** is engaged in the practice of **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_and is dully registered and licensed to practice this profession under the laws of the Commonwealth of Puerto Rico.
2. Puerto Rico Physician, Surgeon or Dentist License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
3. The **Named** **Insured**:
   1. is not connected with any partnership other than that described in item (9);
   2. is not an owner or operator of a hospital, sanatorium or clinic with bed and board facilities;
   3. does not perform major surgery;
   4. does not perform minor surgery;
   5. does not use X-Ray apparatus for therapeutic treatment;
   6. has no other professional specialty;

Please list any exceptions to a., b; c; d; e; or f.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. Forms and endorsements forming part of this policy at time of issue:
   1. Form SED- E: Schedule of Endorsements
   2. Form E-102: Mandatory Premium and Coverage Conditions Endorsement Puerto Rico
   3. Form E-103: Continuous Renewal Endorsement

Countersigned on \_\_\_\_\_\_\_\_\_\_\_\_\_\_in San Juan, PR, by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Authorized Representative