HALLMARK Pro
PROFESSIONAL LIABILITY
20 North Wacker Drive, Suite 770, Chicago, Illinois 60606 MEDMAL@hallmarkgrp.com

Warranty of No Known Claims or Circumstances

Physicians & Surgeons Medical Professional Liability Insurance Claims Made & Reported Coverage

NOTE: This Signed Document Must be Returned with the Completed Application

The signature below warrants that other than that disclosed on my application:

1. I have **NO** known losses or claims that have not been reported to my prior insurance carrier or any other source from which payment might be made;
2. I have **NO** knowledge of facts, circumstances, situations, incidents, conditions, defects or suspected defects that relate to a medical incident(s) arising from professional services which could reasonably result in a claim, that have not been reported to a prior insurer or any other source from which payment might be made;
3. I have **NO** knowledge of any request for medical records by a patient and/or his/her attorney which might result in a claim;
4. I have **NO** knowledge or information relevant to service or services on a Board which might result in a claim; and
5. I have **NO** knowledge of any prior professional liability carrier refusing coverage for, or declining to accept a report of a medical incident, threat of claim, letter of intent, adverse result notice or attorney contact.

The Applicant warrants that the information contained herein is accurate and that no material facts have been suppressed. The Applicant understands and acknowledges that the information contained in the application and this document is deemed material, and that any policy issued by the Company is done so in reliance upon the truth of the Applicant's representations. The Applicant understands that incorrect information could void coverage.

Signature: _____ Date: _____

Name of Applicant: (Please Print) _____ Title: _____

Signing this form does not bind the Applicant or the Company to complete the Insurance.