HALLMARK Pro
PROFESSIONAL LIABILITY
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Substance Abuse Supplement

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

All questions require a response. If space is insufficient, please attach additional pages. Sign and date by the Applicant.

Applicant's Name:

Please specify the substance for which you have been treated:

☐ Alcohol ☐ Amphetamines ☐ Cocaine ☐ IV Opiates/Narcotics Other (specify):

Are you currently participating in a treatment program? ☐ Yes ☐ No

If "Yes", does the program include random drug screening? ☐ Yes ☐ No

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Please provide the following information regarding your treatment program:

Name of Program:

Location Address:

County: PO Box: State: Zip Code:

Monitoring Physician Name:

Phone: Email Address:

Please describe the status of your treatment program:

☐ None or non-completion ☐ Outpatient ☐ Inpatient less than one month

☐ Inpatient more than one month Length of Stay: Other (specify):

If you have completed the treatment program, specify completion date:

Have you experienced any relapses since the completion of treatment? ☐ Yes ☐ No

If "Yes", describe the number of times, dates and circumstances:

Are you participating in a 12 step program? ☐ Yes ☐ No If "Yes", number of meetings attended weekly:

Please specify the length of your sobriety:

Please describe any licensure, legal or criminal actions that have been taken against you to date:

I understand the information submitted herein is considered legally material to underwriting evaluation and pricing, and that it becomes part of my application and as such is subject to the same warranty and conditions.

Signature: _____ Date:

Name of Applicant: (Please Print)

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