PENNSYLVANIA PROFESSIONAL LIABILITY JOINT UNDERWRITING ASSOCIATION
1777 Sentry Parkway West, VEVA 14, Suite 300, Blue Bell, PA 19422
(610) 828-8890 - Fax: (610) 825-0688 - E-mail: Insurance@PAJUA.com

Tail Replacement Supplemental Application

This application supplements the standard Association application. The standard application must be completed and submitted with this application in order for a quotation to be provided. Failure to do so will delay quotations.

Applicant:

_____
First Name (or Legal Name if Corporation) Middle Name Last Name

PA Medical License Number	☐ M.D. ☐ D.O. ☐ D.P.M. ☐ C.N.W. ☐ **Other:** _____

Note: This coverage replaces the extended reporting period (tail) that the applicant has already purchased for a terminated claims-made policy issued by an insolvent carrier**.**

Previous Policy Information
Please tell us about the policy that this coverage applies to

Insurance Carrier		**Original Effective Date***	
Policy Number		**Expiration Date or Termination Date**	
Retroactive Date:			

* Note that it is critical that the original effective date of the policy and its subsequent renewals be listed. Otherwise any policy issued based on this application will only provide coverage for the listed period. If more than one policy was purchased from the insolvent carrier, attach a list of the policy numbers and the periods each covered.

Please attach a copy of the policy declarations or face sheet.

Current Policy Information
Please tell us about your current policy

Insurance Carrier		**Effective Date**	
Policy Number		**Retroactive Date, if applicable**	

Individual Health Care Providers
When completing the standard application, complete the information on specialty and procedures the way you would have completed it as of the last day of coverage with the insolvent carrier.

Professional Associations and Corporations
When completing the standard application, complete the information on employed/contracted physicians and other employees based on those employed or contracted as of the last day of coverage with the insolvent carrier.

Institutional Providers
When completing the standard application, complete the exposure information based on the exposures for the 12 months preceding the end of your coverage with the insolvent carrier.

Medical Incidents: Are you aware of any medical incidents which occurred after the Effective date and before the Expiration or Termination Date of your previous policy for which a claim has not yet been made? ☐ Yes ☐ No If you answered Yes, complete the following (attach a list if necessary)

Date of Incident	Patients Name	Description of incident and injury

Note: The above will not be covered by any policy issued by the Association

_____ _____
Applicant's Signature* **Date**
*** If the applicant is not an individual health care provider, authorized signature and title**